Adult & Pediatric Dermatology
Skin Solutions
151 Ledford Mill Rd. Tullahoma, TN 37388

PATIENT INFORMATION

PLEASE PRINT

Full Name _____ Social Security Number _____
Last First Middle Preferred Name

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Other Spouse's Name _____

Date Of Birth ____/____/____ Gender ☐ Male ☐ Female Race _____
Month / Day / Year

Home Number _____ Can we leave a message on your home / mobile phone?
☐ YES ☐ NO

Mobile Number _____

We NEED at least one other person to contact in the event we are unable to reach you.

Contact Name _____ Relationship _____ Phone # _____

Contact Name _____ Relationship _____ Phone # _____

Can we discuss your medical condition with your contacts? ☐ YES ☐ NO, But you may leave a message for me to return the call.

Your E-Mail _____ Would you like to opt in to email notifications? ☐ YES ☐ NO
Please write clearly

Place of Employment _____ Phone # _____

Occupation _____ As a LAST RESORT, may we contact you at work? ☐ YES ☐ NO

Your Home Address _____
Street Number & Street Name or PO BOX City State Zip Code

Do we have a copy of your most recent Insurance Card/Cards? ☐ YES ☐ NO

Primary Insurance Company _____ Secondary Insurance Company _____

Primary Care Physician? _____ Preferred Pharmacy? _____

Are you up to date on the following vaccines? Flu ☐ YES ☐ NO Pneumonia ☐ YES ☐ NO Covid ☐ YES ☐ NO

Please read carefully - failure to understand the following information will NOT prevent you from being charged a cancelation / no-show fee.

YOUR SIGNATURE BELOW ACKNOWLEDGES: 1) AGREE TO TREATMENT BY ASHLEY MESSICK-HITE, PA-C
2) NOTICE OF PRIVACY PRACTICE 3) CANCELATION POLICY

By signing below, I acknowledge that I understand that Ashley Messick-Hite is a certified Physician Assistant/Associate under the supervision of Ronald A. Nelson, MD, FAAD, a board-certified dermatologist at Stones River Dermatology, PLC in Murfreesboro, TN. My signature below acknowledges that I agree to be examined and treated by Ashley Messick-Hite, PA-C.

I also acknowledge that I have read / received a copy of Adult & Pediatric Dermatology Skin Solutions PLLC (APD Skin Solutions) Notice of Privacy Practices. This notice describes how APD Skin Solutions may use and disclose my protected health information, certain restrictions on the use and disclosure of my health information and rights I may have regarding my protected health information.

By signing below, I acknowledge that I have read and understand the APD Skin Solutions Cancelation Policy. I agree to give at least 24 hours notice when canceling / rescheduling an appointment. I understand that failure to give at least 24 hours notice will result in a $25 fee that is NOT covered by my health insurance policy. I also understand that failing to show up for a scheduled appointment will also result in a $25 fee that is NOT covered by my health insurance policy.

_____ ____/____/____
SIGNATURE of Patient / Guardian Today's Date

Adult & Pediatric Dermatology
Skin Solutions
151 Ledford Mill Rd. Tullahoma, TN 37388

PATIENT INFORMATION

PLEASE PRINT

Full Name _____
Last First Middle Preferred Name

Consent to Import Medication List from Pharmacies

By signing this consent form you are agreeing that your provider, Ashley Messick-Hite, PA-C, may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or deny consent may not be the basis for denial of health services. Your also have a right to request and receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent in writing. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Ashley Messick-Hite, PA-C, to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ / /
SIGNATURE of Patient / Guardian **Today's Date**

IF YOU CHOOSE NOT TO SIGN THE ABOVE CONSENT. PLEASE PROVIDE A LIST OF YOUR CURRENT MEDICATIONS BELOW.

Medication _____ **Dose** _____ **Frequency** _____

Medication _____ **Dose** _____ **Frequency** _____

Medication _____ **Dose** _____ **Frequency** _____

Medication _____ **Dose** _____ **Frequency** _____

Medication _____ **Dose** _____ **Frequency** _____

This section for MINOR PATIENTS ONLY

If the patient is a minor, our office WILL NOT perform any procedures on the patient without a parent or legal guardian being present in the exam room. With written consent, our office will allow minor patients to be seen for general exams if accompanied by an adult listed below. With written consent, a minor patient who is 16 years of age or older, may come unaccompanied for routine acne exams or continued care exams.

The following adults may accompany my minor child to general exams:

Name _____ **Relation to minor patient** _____ **Phone #** _____

Name _____ **Relation to minor patient** _____ **Phone #** _____

By signing below, I authorize Ashley Messick-Hite, PA-C, to examine / treat my minor child in my absence.

_____ / /
SIGNATURE of Patient / Guardian **Today's Date**

Adult & Pediatric Dermatology Skin Solutions, PLLC – New Patient Form

To serve you more efficiently, please complete this form and return it to the front desk before you are called to the exam room.

Date: _____ Name:_____ Date of Birth:_____

Select any of the following medical conditions you currently have:

- ◯ Anxiety
- ◯ Arthritis
- ◯ Asthma
- ◯ Atrial fibrillation
- ◯ Benign prostatic hyperplasia
- ◯ Cerebrovascular accident
- ◯ COPD
- ◯ Coronary Artery Disease
- ◯ Depression
- ◯ Diabetes
- ◯ Disease caused by 2019-nCOV
- ◯ End-stage renal disease
- ◯ Epilepsy
- ◯ GERD
- ◯ Hypertension
- ◯ Hearing Loss
- ◯ HIV
- ◯ Hypercholesterolemia
- ◯ Hyperthyroidism
- ◯ Hypothyroidism
- ◯ Inflammatory disease of liver
- ◯ Leukemia
- ◯ Malignant lymphoma
- ◯ Malignant tumor of breast
- ◯ Malignant tumor of colon
- ◯ Malignant tumor of lung
- ◯ Malignant tumor of prostate
- ◯ Radiation therapy treatment
- ◯ Bone marrow transplant
- ◯ Other:_____

Select any of the following surgeries you have had:

- ◯ Appendix (Appendectomy)
- ◯ Bladder
  - ◯ Total cystectomy
- ◯ Breast
  - ◯ Biopsy: RT / LT / Both
  - ◯ Lumpectomy: RT / LT / Both
  - ◯ Mastectomy: RT / LT / Both
- ◯ Colon
  - ◯ Resection
  - ◯ Diverticulitis
  - ◯ Inflammatory Bowel Disease
  - ◯ Colostomy
- ◯ Gallbladder (Cholecystectomy)
- ◯ Heart
  - ◯ Valve Replacement
  - ◯ Stent (PTCA)
  - ◯ Coronary artery bypass graft
  - ◯ Transplant
- ◯ Joint Replacement
  - ◯ Hip: RT / LT / Both
  - ◯ Knee: RT / LT / Both
- ◯ Kidney
  - ◯ Stone Removal
  - ◯ Biopsy: RT / LT / Both
  - ◯ Nephrectomy: RT / LT / Both
  - ◯ Transplant: RT / LT / Both
- ◯ Liver
  - ◯ Hepatectomy
  - ◯ Shunt
  - ◯ Transplant
- ◯ Ovaries
  - ◯ Endometriosis
  - ◯ Oophorectomy
  - ◯ Ovarian Cancer
  - ◯ Ovarian Cyst
  - ◯ Tubal Ligation
- ◯ Pancreas (Pancreatectomy)
- ◯ Prostate
  - ◯ Biopsy
  - ◯ Prostate Cancer
  - ◯ Prostatectomy
  - ◯ TURP
- ◯ Skin
  - ◯ Basal Cell Carcinoma
  - ◯ Biopsy
  - ◯ Melanoma
  - ◯ Squamous Cell Carcinoma
- ◯ Spleen (Splenectomy)
- ◯ Uterus
  - ◯ Cervical Cancer
  - ◯ Fibroids
  - ◯ Hysterectomy
  - ◯ Uterine Cancer
- ◯ Other_____

If you have an artificial joint, is it within the past 2 years? Yes / No

Female Patients

Are you pregnant or planning on becoming pregnant? Yes / No

Are you nursing? Or will you start nursing soon? Yes / No

Adult & Pediatric Dermatology Skin Solutions, PLLC – New Patient Form

To serve you more efficiently, please complete this form and return it to the front desk before you are called to the exam room.

Have you had any of the following skin conditions?

◯ Acne	◯ Precancerous Moles	◯ Flaking or Itchy Scalp
◯ Actinic keratosis	◯ Eczema	◯ Psoriasis
◯ Dry Skin	◯ Asthma	◯ Squamous cell carcinoma
◯ Basal Cell Carcinoma	◯ Hay Fever	◯ Sunburn (blistering)
◯ Poison Ivy	◯ Melanoma	◯ Other_____

Do you wear Sunscreen? Yes / No If Yes, what SPF?_____

Do you tan in a Tanning Salon? Yes / No

Do you have a family history of Melanoma? Yes / No Which Relative?_____

Medication Allergies *Please List one per line.*

Reaction: Anaphylaxis, Angioedema, Diarrhea, Dizziness, Fatigue, GI Upset, Hives, Liver Toxicity, Nausea, Rash, Shortness of Breath, Swelling

1._____ Reaction: _____

2._____ Reaction: _____

3._____ Reaction: _____

4._____ Reaction: _____

5._____ Reaction: _____

ARE YOU ALLERGIC TO LIDOCAINE? Yes / No

Smoking History (circle answer)

Do you currently smoke? Yes / No If Yes, do you smoke: Every day? Some days?

Do you use smokeless tobacco? Yes / No

Are you a former smoker? Yes / No If Yes, how long ago did you quit? _____

Other needed information (circle answer)

Do you bruise easily? Yes / No

Have you ever had difficulty stopping bleeding? Yes / No

Do you have a pacemaker? Yes / No

Do you have a defibrillator? Yes / No

You have completed this section of the New Patient Packet, please read over the next few pages and sign where indicated.

Thank you – APD Skin Solutions Staff

Adult & Pediatric Dermatology Skin Solutions, PLLC
Ashley Messick-Hite, PA-C
151 Ledford Mill Road
Tullahoma, TN 37388
(931) 800-6400
(931) 800-6401 fax

Patient Insurance and Medicare Information Sheet

We appreciate you choosing our office for your skin care needs. If you have a co-pay due today, we also appreciate your payment, as outlined in your medical benefit plan.

Please read the following carefully to clarify what may or may not be covered under your medical benefit plan or Medicare plan.

If you are anticipating a minor office procedure preformed on your skin, please note that in certain medical insurance plans, this will be considered an out-patient surgical procedure and **may not be covered under your office co-pay.** This amount will go towards your deductible and co-insurance. Therefore, if you have not met your deductible, you will be responsible for payment on your bill today, up to the deductible amount, after your office visit.

If you are here today for a "spot" on your skin, and it is determined by the physician or physician assistant that the spot is benign, it will not be considered "medically necessary" to remove that benign growth. However, if you would like to have the benign growth removed, this removal will be considered **cosmetic** by your medical benefit plan. These growths may include, but are not limited to, skin tags, benign moles and seborrheic keratoses (age spots).

Services considered "cosmetic" may not be covered under your benefit plan since they do not affect your overall medical health. However, we understand that you may have personal reasons for wanting treatment of these conditions. **Therefore, we can perform these services for you and your payment will need to be made at the time of the procedure.**

If you are here today for hair loss related to a medical condition, such as undiagnosed loss of blood, low iron, low thyroid hormone, or a condition called Lupus, treatment would be covered under your medical benefit plan or Medicare. However, if your hair loss is not associated with any underlying medical condition, then the visit and any procedure or test associated with the diagnosis of hair loss may be considered cosmetic and you will be responsible for the bill.

If you are here today for the treatment of warts, we must inform you that there is no guaranteed treatment method available for this condition. Multiple visits and treatments may be required. The cost of the procedure and visit will be charged to your account **which may or may not be covered by your insurance plan.** Furthermore, the treated area(s) may develop new lesions, complicating treatment. **There can be no guarantee that, even after multiple treatments, warts will be cured.**

Since each medical insurance company, including Medicare, has its own policy regarding the coverage of the above conditions, your signature below signifies that you understand the above information and acknowledge your responsibility regarding the charges incurred in this office.

Patient or legal guardian: _____ Date: _____

Witness (Office Staff): _____ Date: _____

ADULT & PEDIATRIC DERMATOLOGY SKIN SOLUTIONS PLLC

Financial Policy (Revised November 2020)

Dear Patient:
Due to the reduction in reimbursements from Medicare and insurance companies, and the cost of balance billing, we must ask you to pay your part at the time of service. Your cooperation and understanding are greatly appreciated.

If you are a Medicare patient, please read the following paragraph:
We will bill Medicare directly for 80% of the bill. You are responsible for the remaining 20% of the allowable charges, as well as your annual deductible, which varies from year to year. Please advise the staff if you have met some or all of your annual deductible. You will be expected to pay 20% of Medicare's approved amount (your co-payment) and any unmet deductible, and all non-covered services at the time of your office visit. If you have a secondary insurance carrier, we will, as a courtesy, file your claim and you will not have to pay the 20%.

If you are a patient with an insurance plan in which we participate, please read the following paragraph:
You will be expected to pay for non covered services, and for any percentage responsibility you have under your plan, at the time of service. If you are enrolled in a Managed Care plan that requires a co-payment, you must prepay before being seen. We ask that you cooperate with this policy since it is costly to bill you for this small amount. If you are unable to do so on the day of the appointment, your visit will be rescheduled. In addition to the co-payment, some plans also have an annual deductible. If you have not met your annual deductible, you are required to pay this at the time of service. Your payment in full at the time of service is expected and appreciated. Visa, MasterCard, Discover and American Express are accepted for your convenience. Since we do not know ahead of time what your carrier charges for our services, we will refund you the difference immediately upon receipt of the insurance payment. Please keep in mind that insurance carriers frequently notify patients of payments made to the physician before they actually pay the provider of care. Be assured that once a payment is received, a refund will be made if appropriate.

If you are a patient with an insurance plan in which we do not participate, please read the following paragraph:
We realize the cost of medical services may exceed what you are able to pay for during your office visit. We are happy to file to your carrier for reimbursement of the cost of care incurred by your visit. However, the following issues need to be addressed and understood by you. Because we are a small office with limited staff and resources, we cannot verify your coverage and status of your annual deductible. Therefore, you are required to pay the total bill today. Visa, MasterCard, Discover and American Express are accepted for your convenience.

If you are an uninsured patient paying with cash, please read the following paragraph:
We realize the cost of medical services may exceed what you are able to pay for during your office visit. However, you are required to pay the total bill today. Visa, MasterCard, Discover and American Express are accepted for your convenience.

All patients please read the following paragraphs:
In the event that there is a balance due after your insurance carrier has paid its portion, you will receive a bill. Any balance left that is uncollected at time of service is expected to be paid in full within 90 days from the first statement date. If a payment arrangement is needed before the 90 days, please call our office. We will split the balance into three equal payments so that it will be paid within 90 days. Please note, we send only three bills. Thereafter, no further bills will be sent, and the account will be turned over to a national collection service without prior warning. Again to avoid this, please pay your bill promptly after you receive your first statement. Failure to pay your balance in full within 90 days will result in an official notification by mail that you have been dismissed from our clinic. At that point you may sign a release of medical records to send to your new dermatologist

If you do not understand the reason you owe a balance, please do not hesitate to contact our office. Our staff will explain the balance to you and answer any questions you may have. Our staff is dedicated to working with you and your insurance carrier. Patients, however, also have a responsibility regarding their coverage. We appreciate your assistance in working with our staff. Please sign below and return this to our staff. Thank you.

I have read the above and I understand my obligations.

Signature of patient (or legal guardian) _____ Date signed: _____

Adult & Pediatric Dermatology Skin Solutions, PLLC
Ashley Messick-Hite, PA-C
151 Ledford Mill Rd
Tullahoma, TN 37388
(931) 800-6400
(931) 800-6401 fax

Our goal is to serve our patients with compassion and respect as we promote their overall health and well-being. We strive to make appointments available to our patients in a timely and flexible manner. Due to an unusually high number of cancelations and no-show's we are implementing the following cancelation policy.

Patient Acknowledgement Appointment Cancellation Policy

Dear Patient,

Adult & Pediatric Dermatology Skin Solutions has instituted and Appointment Cancellation Policy. A cancellation made with less than a 24 hour notice significantly limits our ability to make the appointment available for another patient in need.

To better serve all our patients, we have instituted the following policy:

1. We request that you provide our office a **24-hour notice** if you need to reschedule your appointment. This will allow us the opportunity to provide care to another patient. A message can always be left on the office voicemail to avoid a cancellation fee being charged.
2. **A "No-Show", "No-Call" or missed appointment, without proper 24-hour notification, may be assessed a $25 fee. The patient will be responsible for this fee, as it IS NOT billable to your insurance. This fee will need to be paid before the patient can be scheduled for another appointment.**
3. If you are going to be late for your appointment, please call our office to let us know. If you arrive more than 15 minutes late for your appointment, and have not called to let us know, your appointment may be cancelled and rescheduled.
4. As a courtesy, we have a reminder system for appointments. This is a third-party system that sends automatic call / text / email messages several days prior to the scheduled appointment. Please note, if a reminder call or message is NOT received, the cancellation policy remains in effect.
5. Repeated missed appointments may result in termination of the provider/patient relationship.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. A copy of this policy will be provided to you.

I HAVE READ AND UNDERSTAND THE APPOINTMENT CANCELLATION POLICY AND I ACKNOWLEDGE ITS TERMS. I ALSO UNDERSTAND AND AGREE THAT SUCH TERMS MAY BE AMENDED FROM TIME-TO-TIME BY THE PRACTICE STAFF.

_____	_____	____/____/____
Signature of Patient	Printed Name of Patient	Today's Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW ADULT & PEDIATRIC DERMATOLOGY SKIN SOLUTIONS PLLC MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Adult & Pediatric Dermatology Skin Solutions PLLC is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Adult & Pediatric Dermatology Skin Solutions PLLC or received by Adult & Pediatric Dermatology SKIN SOLUTIONS PLLC from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Adult & Pediatric Dermatology Skin Solution PLLC will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.[1]

Adult & Pediatric Dermatology Skin Solutions PLLC reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not Requiring Your Consent

Adult & Pediatric Dermatology Skin Solutions PLLC may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies.

For example, Adult & Pediatric Dermatology Skin Solutions PLLC may determine that you require the services of a specialist. In referring you to another doctor, Adult & Pediatric Dermatology Skin Solutions PLLC may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Activities undertaken by Adult & Pediatric Dermatology Skin Solutions PLLC to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example, Adult & Pediatric Dermatology Skin Solutions PLLC will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, Adult & Pediatric Dermatology Skin Solutions PLLC may use your diagnosis and treatment, outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Please Sign Here _____

[1]This Notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520.

Adult & Pediatric Dermatology Skin Solutions PLLC maycontact youby telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Adult & Pediatric Dermatology Skin Solution PLLC is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- As permitted or required by law.
  In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.
  Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

- For public health activities.
  We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure. We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- For health oversight activities.
  We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.

- Judicial and Administrative Proceedings.
  Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.

- For activities related to death.
  We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

- For research.
  Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

- To avoid a serious threat to health or safety.
  We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

- For workers' compensation.
  We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Adult & Pediatric Dermatology Skin solutions PLLC will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Adult & Pediatric Dermatology of Tullahoma, PC has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Adult & Pediatric Dermatology of Tullahoma, PC to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Adult & Pediatric Dermatology Skin Solutions PLLC may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records. You may request that Adult & Pediatric Dermatology Skin Solutions PLLC send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Adult & Pediatric Dermatology Skin Solutions PLLC not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Adult & Pediatric Dermatology Skin Solutions PLLC amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Adult & Pediatric Dermatology Skin Solutions PLLC for the six years prior to the date of the request, beginning with disclosures made after November 11, 2020. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with Adult & Pediatric Dermatology Skin Solutions PLLC and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Adult & Pediatric Dermatology Skin Solutions PLLC please contact the Privacy Officer at the following:

Joe Hite
Adult & Pediatric Dermatology Skin Solutions PLLC
315 NW Atlantic St Suit B Tullahoma, TN 37388

(931) 800-6400

It is the policy of Adult & Pediatric Dermatology of Tullahoma, PC that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective November 11, 2020

ADULT & PEDIATRIC DERMATOLOGY SKIN SOLUTIONS PLLC

MEDICARE ASSIGNMENT

WHAT DOES "ACCEPT ASSIGNMENT" MEAN?

The doctor has a "charge" for each service.

Medicare has an "approved amount" for each service.

The doctor must "write off" the difference between his/her "charge" and Medicare's "approved amount".

Medicare pays the doctor 80% of the "approved amount".

The patient is responsible to pay 20% of the "approved amount" and any unmet deductible to the doctor.

EXAMPLE: Charge.....$100.00

Medicare approved.....$80.00

Medicare pays 80%.....$64.00

Patient pays.....$16.00*

PAYMENT FOR YOUR 20% IS REQUIRED AT THE TIME OF SERVICE UNLESS YOU HAVE A SECONDARY INSURANCE PLAN THAT PAYS THIS.

*Additional annual payment may be required, if you have not met your deductible, which may vary from year to year.

Adult & Pediatric Dermatology
Skin Solutions
Dermatology care you can trust!

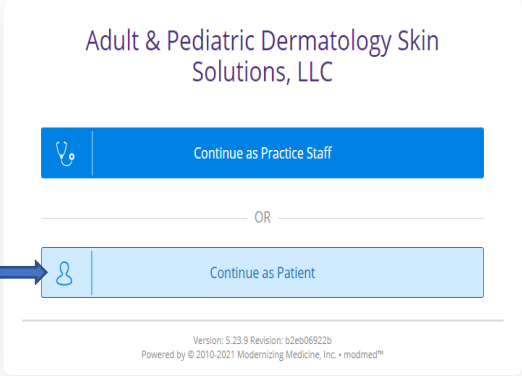
Ashley Messick-Hite, PA-C
315 NW Atlantic St
Tullahoma, TN 37388
(931) 800-6400 office (931) 800-6401 fax

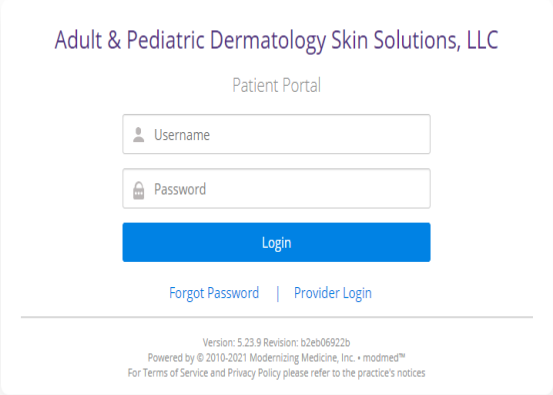
Guide to the Patient Portal

In order to use the Patient Portal, we must have your email address on file.

On your web browser (Chrome or Mozilla Firefox preferred) go to: apdskinsolutions.ema.md

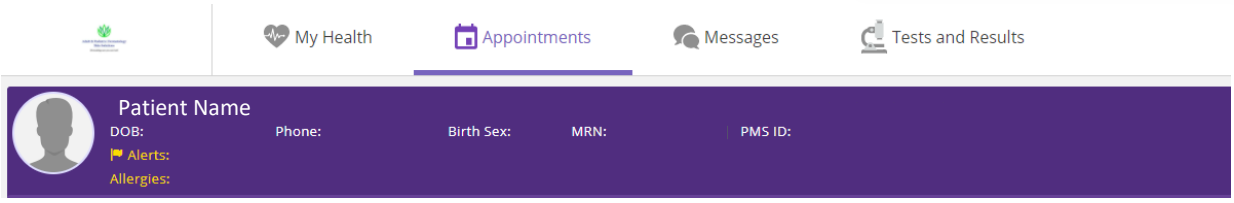
Continue to Patient login





Enter the username and password created for you by our office. Your username will be the first initial of your first name followed by your last name and two-digit year of your date of birth. For example: John Doe born on January 1, 1955, username would be: jdoe55
Your temporary, one time password is: APDskin#1

NOTE: You will be prompted to change your password the first time you login.



The Contact Info, Insurance and Problem List sections are read-only. Any alterations made in these sections will not update in your chart. Please contact the office directly with any changes. The Problem List section will allow you to see a list of diagnoses. To view more information on a condition, select the blue information bubble next to the condition.

The Portal will allow you to update your: Pharmacy, Medications, Allergies, Past Medical History, Social History, Quality Measures, Implantable Devices and Family History. You will also be able to view upcoming appointments as well as lab tests and results.

Call our office with any questions you may have concerning the Patient Portal.