Palmetto
Skin & Laser Center
Richard E. White, MD Timothy G. Woodall, MD Matthew Janowicz, PA-C

Welcome to our Practice!

We are honored that you have chosen our practice for your dermatology care. Whether you are coming to us for general skin care concerns or for cosmetic services, our number one priority is you, your healthy skin, and your time. You will find that you are not just another patient. You are an individual with individual needs and concerns. So please, feel free to ask questions and take an active part in your skin's health.

We encourage you to get to know our practice by visiting our website at **www.palmettoskinandlasercenter.com**. You can browse at your leisure and learn more about our philosophy on patient care, our physicians and their expert credentials, our state-of-the-art facility, and directions to our office. Please also use our website as a resource as we have an abundance of information on common skin diseases, what to expect with the treatments, and a comprehensive listing of our services and procedures.

We also offer a wide range of cosmetic treatments where we help you improve your skin's cosmetic health. We want your skin to be healthy and for you to be happy with how it looks and feels. Please browse our website to get a full description of services we offer, or you may simply schedule a free cosmetic consultation at your convenience.

In this packet, you will find registration, medical history, office policy, and privacy forms. Please complete each of the forms, bring the packet with you to your first appointment, and plan to arrive **thirty minutes** early. If appropriate, please remove your makeup prior to your appointment.

We look forward to meeting you soon!

1563 Health Care Drive Rock Hill, SC 29732 | PHONE 803-329-6030 | FAX 803-329-6035

The Palmetto Skin and Laser Center is pleased to announce that we accept the following insurances for all of our medically necessary procedures:

- Aetna
- Blue Cross Blue Shield- BCBS (including Preferred Blue, BCBS Federal, PAI, and out of state Blue Card)
- State Health Plan
- Blue Choice
- Cigna
- Cigna Health Springs
- First Health PPO
- Humana PPO
- Mail Handler's
- Medcost
- Medicare Part B
- MultiPlan
- Premier Health PPO
- Primary Physician Care
- Private Healthcare Systems – PHCS (both PPO and POS plans)
- Provider Select
- USA Managed Care PPO
- Wellpath Select

Please contact our office if you have questions regarding your particular insurance company. If your insurance company is not listed, we do also accept all major credit cards.

At this time we are not in network and can not accept United Healthcare, Medicaid, Healthcare Exchange Plans, or most Medicare Advantage Replacement Plans.

REGISTRATION

(PLEASE PRINT)

The Palmetto Skin and Laser Center

1563 Health Care Drive
Rock Hill, SC 29732
803-329-6030

PATIENT INFORMATION

Date _____ Driver's License No _____ Home Phone _____

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Cell Phone _____ E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified?_____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc Sec #_____

Address (if different from patient's)_____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient's)_____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Occupation _____

Insurance Company _____ Soc Sec # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to The Palmetto Skin & Laser Center, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____

The Palmetto Skin and Laser Center

Authorization for Release of Information

PATIENT IDENTIFICATION

NAME OF PATIENT: _____ DATE OF BIRTH: _____

Palmetto Skin & Laser Center, LLC is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

RELEASE INFORMATION TO **ME**

HOME #: _____

CELL #: _____

☐ OK to leave Voicemail

RELEASE INFORMATION TO **SOMEONE ELSE**

NAME: _____

PHONE #: _____

RELATIONSHIP: _____

☐ **All** information
☐ Appointment information
☐ Medical information
☐ Billing/financial information

NAME: _____

PHONE #: _____

RELATIONSHIP: _____

☐ **All** information
☐ Appointment information
☐ Medical information
☐ Billing/financial information

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority (attach necessary documentation) _____

_____ _____

PSL Employee Witness Date

The Palmetto Skin and Laser Center

Medical History

We appreciate your effort in completing the following questions.

Name: _____Date of Birth: _____ Chart # _____ Date: _____

MEDICATION ALLERGIES: _____

Have you had an allergic reaction to: Latex/rubber: ☐ Yes ☐ No Adhesive tape: ☐ Yes ☐ No Local anesthesia: ☐ Yes ☐ No

MEDICATIONS: (Please list ALL medications):

_____

_____

MEDICAL HISTORY: Do you have now, or have you ever had any of the following symptoms or diseases?

☐ Seasonal allergies	☐ Poor healing	☐ Heart disease	☐ Epilepsy	☐ Anxiety/Panic attacks
☐ Eczema	☐ Anemia	☐ High blood pressure	☐ Dizziness	☐ Depression
☐ Hives	☐ Bleeding disorder	☐ Pacemaker/Defibrillator	☐ Stroke	☐ Claustrophobia
☐ Cold Sores	☐ Blood clots	☐ Emphysema/COPD	☐ Facial weakness	☐ Tuberculosis
☐ Vision loss/Eye Pain	☐ Diabetes	☐ Asthma	☐ Facial numbness	☐ Accutane Therapy
☐ Cataracts	☐ Thyroid problems	☐ Kidney disease	☐ Hearing loss/ear pain	
☐ Glaucoma	☐ Liver disease		☐ Cancer _____	

☐ Are you required to take ANTIBIOTICS prior to minor surgery? Why? _____

Do you have or have you been exposed to HIV/AIDS?	☐ Yes ☐ No	Do you have artificial joints/parts?	☐ Yes ☐ No
Do you have or have you been exposed to Hepatitis?	☐ Yes ☐ No	Alcoholism/Drug Abuse?	☐ Yes ☐ No
Have you ever had local anesthesia (numbing shots)?	☐ Yes ☐ No	Do you take aspirin or blood thinners	
Any adverse reaction?	☐ Yes ☐ No	daily?	☐ Yes ☐ No

List any other conditions we should know about: _____

List surgical procedures you have had in the last 6 months: _____

SOCIAL HISTORY

Do you smoke cigarettes or use tobacco?	☐ Yes ☐ No	Are you pregnant or planning to become pregnant?	☐ Yes ☐ No
Do you drink alcohol?	☐ Yes ☐ No		
Do you use recreational/street drugs?	☐ Yes ☐ No	Do you use contraception?	☐ Yes ☐ No

FAMILY HISTORY

☐ Allergies _____ ☐ Eczema _____ ☐ Asthma _____ ☐ Hay fever _____ ☐ Acne _____

☐ Psoriasis _____ ☐ Skin problems (explain) _____ ☐ Cancer (other than skin) _____

☐ Skin Cancer (specify melanoma, squamous cell, basal cell) _____

SKIN HISTORY

When you are exposed to the sun do you: ☐ Tan Only ☐ Tan more than burn ☐ Burn more than tan ☐ Burn only

Would you describe your CURRENT (last 2 years) sun exposure history as: ☐ Minimal ☐ Moderate ☐ Maximal

Do you actively seek a tan ('laying out' or tanning bed)?	☐ Yes ☐ No
Do you regularly use sunscreen?	☐ Yes ☐ No
Have you had blistering sunburns?	☐ Yes ☐ No
Do you form keloids or hypertrophic (thick) scars?	☐ Yes ☐ No
Have you had cosmetic procedures?	☐ Yes ☐ No What? _____

Were you happy with the results? Explain: _____

Are you interested in cosmetic procedures or treatment of sun damaged or aging skin? ☐ Yes ☐ No

Have you ever visited a dermatologist? ☐ Yes ☐ No Reason? _____ Therapy? _____

Do you have a history of any specific skin diseases? ☐ Yes ☐ No if yes, please explain: _____

Completed by: _____ Date: _____

Patient/Guardian

THE PALMETTO SKIN AND LASER CENTER
1563 HEALTH CARE DRIVE
ROCK HILL, SC 29732
PHONE 803-329-6030 FAX 803-329-6035
Richard E. White, MD Timothy G. Woodall, MD Matthew Janowicz, PA-C

OFFICE POLICY/PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing Palmetto Skin & Laser Center, LLC. We would like to share the following policies with you so that you understand your responsibilities as a patient.

Appointments

The Palmetto Skin and Laser Center respects your time and makes every effort to reduce both the wait to get an appointment and the wait to be seen on your scheduled appointment date. As a result, our office policy is to not overbook appointments. To continue to bring you efficient and accessible service, please note our cancellation policy. If you cancel or reschedule an appointment less than two business days prior to the appointment date you may be charged a fee, which must be paid prior to scheduling future appointments. The minimum fees are as follows:

New Patient: $50.00 Established Patient: $25.00 Surgery or Procedure Patient: $150.00

Please note: Cosmetic surgery appointments require a deposit which is surrendered if two business day cancellation policy is violated.

Procedures

To allow for adequate time with each patient, we must focus on the primary problem for which you made the appointment. The initial appointment is generally for evaluation only. We cannot guarantee that a desired procedure will be performed. If you have multiple concerns or require a procedure, it may be necessary to schedule additional appointments.

Prescriptions

You may require a prescription medication during your visit. It is your responsibility to bring a copy of the drug formulary approved by your insurance carrier with you to every visit to minimize delays in receiving your treatment. You must keep us informed of which medications are covered or require additional approval. Failure to bring a copy of your drug formulary to every office visit may result in additional fees and/or additional office visits.

At the time of your visit the provider will indicate on the prescription the number of refills allowed. If you need a medication refilled, first check with the pharmacy to see if there are any remaining refills on the original prescription. If there are no refills available, please contact the pharmacy and request a refill. To receive a prescription refill, we require that you be seen in the office within the prior 12 months. Some prescriptions require more frequent monitoring. Please note prescription refill requests may take up to 2 business days. If the refill is approved, we will notify your pharmacy. If the refill is not approved, we will notify you. Please do not call our physicians after hours to have medications refilled.

Medical Records Release/Forms

With the proper authorization, we will provide at no charge, copies of your medical records to other physicians that are participating in your care. These records must be released directly to the physician requesting the information. If you would like to obtain a copy of your medical records for private use, there will be a minimum $15 administrative fee as well as an additional $.50 for each additional page not to exceed two hundred dollars per request in accordance with SC State Law Section 44-115-80. Please note all releases require a signed authorization form on file.

If you need a form or document completed in addition to medical records, there will be a fee of $25. This fee includes completing the form as well as copies of office notes and/or pathology report to accompany the form if required. If additional office notes or reports are required there will be an additional charge of $.50 per page in accordance with SC State Law as stated above.

Financial Policy

The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this agreement. By signing below and/or by receiving medical services from Palmetto Skin & Laser Center, LLC ("Palmetto Skin & Laser Center"), you agree:

1. You acknowledge and agree to the PATIENT FINANCIAL RESPONSIBILITY STATEMENT.

2. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier.

3. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at Palmetto Skin & Laser Center, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at Palmetto Skin & Laser Center are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at Palmetto Skin & Laser Center; or (v) you have chosen not to use your health plan coverage.

4. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance, and paying any co-pays or other patient responsibility amount at each visit. Your insurance card or other insurance verification must be on file for your insurance to be billed. If we do not

have your insurance card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If you are not prepared to make your co-pay or other patient responsibility amount there may be an additional fee added or your visit may be re-scheduled by Palmetto Skin & Laser Center.

5. We may verify your insurance benefits or submit your claim to your insurance carrier as a courtesy to you. You agree to facilitate payment of claims by contacting your insurance carrier when necessary. Without waiving any obligation to pay, you assign to Palmetto Skin & Laser Center, for application onto your bill for services, all of your rights and claims for the medical benefits to which you, or your dependents are entitled, under any federal or state healthcare plan (including, but not limited to, Medicare), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you.
   You authorize Palmetto Skin & Laser Center and associated physicians, staff, and hospitals to release patient information acquired in the course of your examination and/or treatment including but not limited to any and all medical records, notes, test results, pathology reports, radiology reports or other documents related to your treatment (including itemization of any charges and payments on your account) that is deemed necessary to process this claim to the necessary insurance companies, third party payors, and/or other physicians or health care entities as they require to participate in your care.
   It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. Palmetto Skin & Laser Center does not accept responsibility for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.

6. If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit same to Palmetto Skin & Laser Center until your patient account is paid in full.

7. You will be mailed a billing statement that contains the total cost of your service(s) or procedure(s) received during your visit(s). You may generally expect this billing statement within twenty (20) days after your insurance company has responded to a submitted claim. You must notify us of any errors or objections to the billing statement within thirty (30) days or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred. If there is a problem with your account, it is your responsibility to contact the Patient Accounts Staff to address the problem or to discuss a workable solution.

8. Whether or not you have insurance or are self-pay, payment of any account balance is due at the time of service or within thirty (30) days of receipt of your billing statement. If any balance on your account is over seventy (70) days past due, your account will be in default, and we will begin collection process and we may send your account to a collection agency.

9. We accept payment by check, cash, money order, debit cards or credit cards.

    - **Payment by Check**: If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $10.00 or up to the applicable state maximum legal limits, whichever is lower, in addition to any costs assessed or charged by any depository institution. When you pay by check you also authorize Palmetto Skin & Laser Center, if your check is dishonored or returned for any reason, to electronically debit your account for the check plus a processing fee of up to the state maximum legal limits (plus any applicable sales tax). PLEASE NOTE: The above language authorizes an electronic debit to your account for the check plus the state-allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, this authorization is to remain in effect until Palmetto Skin & Laser Center has received written notice of termination in such time and in such manner to afford us a reasonable opportunity to act on it. This does not, however, mean that Palmetto Skin & Laser Center cannot collect a returned check fee by other methods.
    - **Payment by Credit Card/Credit Card on File**: When you pay by Credit Card to be held on file, you agree to keep the credit card information current, and you authorize Palmetto Skin & Laser Center to securely store your credit card information, and only charge it should you have an outstanding balance or any leftover balance from a processed claim in the future. You understand that you are responsible for all charges for services that you receive from Palmetto Skin & Laser Center, and if the patient responsibility portion of your charges (including charges applied to your deductible and/or coinsurance) is not paid in full within thirty (30) days following receipt of the financial responsibility statement, then Palmetto Skin & Laser Center will bill your securely stored credit card for the outstanding balance due.

10. Coding/Billing Guidelines. Palmetto Skin and Laser Center conducts business according to the standard guidelines set forth by CMS (Medicare) and utilizes CPT, ICD-10 and HCSPCS documentation for appropriate coding procedures. Our contract with your insurance carrier reflects that they will adhere to these standard coding/billing practices. If your insurance provider deviates from these standard practices, you are responsible for charges for any non-covered services or procedures.

11. Managed Care (HMO, PPO, etc.). All managed care co-payment amounts are due at the time of service. If your insurance plan requires a referral authorization from a primary

care physician, you are responsible for presenting this at your initial visit. If you request an office visit without a referral authorization, your insurance plan may deem this as "out of network" or "non-covered" treatment, and you will be responsible for a larger amount or all the charges. You acknowledge that it is your responsibility to be aware of what services are covered and you agree to pay for any service or procedure deemed to be non-covered or not authorized by the plan.

12. Medicare. Palmetto Skin & Laser Center is a participating provider with the Medicare program and accepts as payment the Medicare allowable, patient deductible and/or 20% co-insurance. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. You understand that you will be responsible for your annual deductible, the co-payment, and any non-covered services specified by Medicare. We may submit a claim to any supplemental plan as a courtesy to you, so long as you provide all necessary policy information.

13. Ancillary Services. You may receive ancillary medical services while a patient of Palmetto Skin & Laser Center such as interpretation of tests, lab services and pathology specimen examination. By signing below and/or receiving medical services, you understand that some physicians may not provide services in your presence but are actively involved during diagnosis and treatment. You authorize payment directly for these services under the policy(s) or plan(s) issued to you by your insurance carrier. You may incur additional charges because of these ancillary services. You agree to pay all charges due with respect to such services after benefits paid on your behalf by any third-party are credited to your account.

14. Additional Charges. Patients may incur and are responsible for the payment of additional charges at the discretion of Palmetto Skin & Laser Center including but not limited to: (i) charges for returned checks; (ii) charges for a missed appointment without 2 business days advance notice; (iii) charges for extensive phone consultations and/or after-hours phone calls requiring treatment, or prescriptions; (iv) charges for copying and distribution of patient medical records; (v) charges for form preparation or completion; or (vi) any costs associated with collection of patient balances, all as allowed by law. (vii) fee for copay not made at the time of service and (viii) extensive time required to compete prior authorizations for medications.

15. Non-payment on Account. Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that Palmetto Skin & Laser Center has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection including, but not limited to: (i) a collection fee to be charged, and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency. If your account is

referred to a collection agency, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history.

16. Minor Patients. The parent/legal guardian of a minor is responsible for payment of the minor's account balance. A parent/legal guardian is expected to accompany minor to every visit unless a consent form is on file. If your child is being seen for a new problem or requires a procedure or treatment you will be required to accompany your child. Responsibility for payment of treatment of minor children, whose parents are divorced, rests with both parents. Any court-ordered responsibility judgment must be determined between the individuals involved, without the inclusion of Palmetto Skin & Laser Center.

17. Authorization to Contact. You authorize Palmetto Skin & Laser Center personnel to communicate by mail, answering machine messages, email, or text message according to the information provided in your patient registration information. Palmetto Skin & Laser Center, or any agent or servicer of your patient account, may use any information you have provided, including contact information, e-mail addresses, cell phone numbers, and landline numbers, to contact you for purposes related to your account, including debt collection. You authorize Palmetto Skin & Laser Center to use this information in any manner consistent with the information you have provided, including mail, telephone calls, e-mails, or text messages. You expressly consent to any such contact being made by the most efficient technology available, including automatic dialing/e-mailing or similar equipment, or pre-recorded or other messages, even if you are charged for the contact.

18. Financial Responsibility Party. If this or a separate Palmetto Skin & Laser Center Financial Responsibility Statement is signed by another person, on your account, then that co-signature remains in effect until cancelled in writing. Cancellation in writing shall become effective the date after receipt and shall apply only to those services and charges thereafter incurred. By signing as Financial Responsibility Party, you hereby guarantee the full and prompt payment to Palmetto Skin & Laser Center of all indebtedness of Patient to Palmetto Skin & Laser Center , whether now existing or hereafter created (the "Indebtedness"); and you further agree to pay all expenses, legal or otherwise, incurred by Palmetto Skin & Laser Center in collecting the Indebtedness, in enforcing this guaranty, or in protecting its rights under this guaranty or under any other document evidencing or securing any of the Indebtedness. This guaranty shall be a continuing, absolute, and unconditional guaranty, and shall remain in force and effect until all said Indebtedness shall be fully paid. There shall be no obligation on the part of Palmetto Skin & Laser Center at any time to first exhaust its remedies against patient, any other party, or any other rights before enforcing the obligations of Financial Responsibility Party.

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

- Make sure your health care provider gives you a Good Faith Estimate in writing at least one business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate or the dispute process visit www.cms.gov/nosurprises, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059

Disclaimer

The Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, and your bill is $400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.

If you are billed for more than this Good Faith Estimate, you may have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

If you dispute your bill, the provider or facility cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing your bill.

There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

The Palmetto Skin and Laser Center

OFFICE POLICY/PATIENT FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

(Please return this form to the front desk staff)

By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of the Palmetto Skin & Laser Center, LLC OFFICE POLICY/PATIENT FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to Palmetto Skin & Laser Center for the below Patient's care and treatment, including co-payments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the Patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (vi) if I failed to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including collection agency fees (to the extent allowed by law); and (vii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report.

I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

Patient Name (please print): _____ DOB: _____

Signature of Patient/ Guardian: _____ Date: _____

PSL Employee Witness: _____

The Palmetto Skin and Laser Center

Acknowledgement of Receipt of Notice of Privacy Practices

(Please return this form to the front office staff)

Patient Name: (please print) _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature of Patient/Guardian Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

_____An emergency existed and signature was not possible at the time.
_____The individual refused to sign.
_____A copy was mailed with request for signature by return mail.
_____Unable to communicate with the patient for the following reasons:
_____
_____
_____
_____Other: _____
_____
_____

Prepared by: _____ Date: _____
(Signature)

MRN: _____

The Palmetto Skin and Laser Center

Credit Card Authorization

Patient Name (please print): _____ DOB: _____

As part of our continuing effort to streamline our office making it more efficient and convenient for our patients, The Palmetto Skin and Laser Center utilizes the latest technology regarding bill payment.

We request that you leave a credit card number on file with us until your insurance company has paid their portion and notified us of the amount remaining deemed as your responsibility. At that time, any remaining balanced owed by you will be charged to this credit card, and a copy of the charge will be mailed to you, indicating the balance paid in full.

The obvious benefit to our patients is the convenience it provides to quickly pay the remaining balance due to our office. Because streamlines our payment process, the ultimate benefit is in keeping your health care costs down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Please note that this policy does not affect co-pays that are due at the time of the visit.

I authorize The Palmetto Skin and Laser Center to charge outstanding patient portion balances for me and my dependents to the following credit card:

Please Circle: VISA MASTERCARD OTHER: _____

Card Number: _____

Expiration Date: _____ CCV Code (on back): _____

Billing Address: _____

City/State/Zip: _____

Name on Card: _____

Signature of Cardholder: _____

PSL Employee Witness: _____