Palmetto
Skin & Laser Center
Richard E. White, MD Timothy G. Woodall, MD

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, and feel free to contact us with any questions.

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 pleased to announce that we accept the following Insurance plans for all our medically necessary procedures.

- Aetna PPO
- Aetna HMO (With Referral)
- Aetna Elect Choice
- Aetna Managed Choice POS
- Aetna Choice POS II
- Aetna Leap Everyday
- Aetna National Advantage Program
- Aetna Select • Aetna Signature
- BCBS Federal Employee Program (FEP)
- BCBS State Health Plan (SC)
- BCBS Preferred Blue Network PPO
- BCBS Medicare Advantage (BlueCross Total) PPO
- BCBS Medicare Advantage (BlueCross Blue Basic) PPO
- Blue Choice HMO Network
- Blue Choice PPO
- BCBS Advantage Network PPO
- BCBS Blue Essential PPO
- BCBS Blue VirtuConnect PPO
- BCBS Blue Option Network PPO
- BCBS PAI
- Cigna Healthsprings
- Cigna CSN (Novant Health Emp Network)
- Cigna Medicare
- Compcare
- Federal Employee Health Benefit Program
- First Health
- Great West Healthcare
- Healthgram
- Human Choice Care PPO
- Humana Choice Care (Medicare)
- Humana Together (Medicare) PPO
- Humana Gold Plus (Medicare)
- Humana Choice Gold (Medicare)
- Humana Honor (Medicare) PPO
- Medcost
- Multiplan NC
- Private Healthcare Systems (PHCS) PPO NC
- Private Healthcare Systems (PHCS) POS NC
- Provider Select

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

At this time, we are not in network and cannot accept United Healthcare or Medicaid. We also do not accept Tricare as a primary payor.

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 PALMETTOSKIN AND LASER CENTER

1563 Healthcare Drive
Rock Hill, SC 29732
Phone: 803-329-6030 Fax: 803-329-6035
Richard E. White, MD Timothy G. Woodall, MD

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. In order 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: $100.00

Established Patient: $50.00

Surgery or Procedure Patient: $300.00

Please note: Cosmetic procedure appointments require a deposit, which is surrendered if the 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 in order 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. In order 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 medication 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:

You acknowledge and agree to the PATIENT FINANCIAL RESPONSIBILITY STATEMENT.

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.

You are responsible for knowing your insurance policy. For example, you will be responsible for any charges for any of the following that 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.

You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting a photo identification card, 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.

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 payers, 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.

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.

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.

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 the collection process and we may send your account to a collection agency.

We accept payment by check, cash, money order, debit cards or credit cards (Visa/MasterCard).

- **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 amount of 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 amount of 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.

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.

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 of 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.

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.

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 in the course of 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 as a result 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.

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.

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 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.

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 a a 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.

Authorization to Contact. You authorize Palmetto Skin & Laser Center personnel to communicate by mail, answering machine messages, and/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.

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 any and 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, heath care providers need to give **patients who don't have insurance or who are not using insurance** as 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 Goof Faith Estimate in writing at least one business day before your medical service or item. You can also ask your healthcare 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 as least $400 or 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 of 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 your 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 the 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 has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing the 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 a $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.

ACKNOWLEDGEMENT

OFFICE POLICY/PATIENT FINANCIAL RESPONSIBILITY

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/Responsible Party/Guardian	Date	Date of Birth

_____

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: _____

The Palmetto Skin and Laser Center
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact the Privacy Officer at 803-329-6030.

Effective Date: April 1, 2003 **Revised: September 1, 2013**

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice. We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **www.palmettoskinandlaser.com**.

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to

appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. The written request document may be obtained from and directed to the Privacy Officer.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact the **Privacy Officer at 803-329-6030.**

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a

complaint. This notice was published and becomes effective on April 1,

2003. Revised September 1, 2013