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Hello,

We are Louisiana Dermatology Associates, affiliates of PhyNet Dermatology LLC. We would like to take this opportunity to say Thank You for choosing us for your Dermatological needs.

We have a comprehensive dermatologic practice bringing together a great network of dermatologists. Our commitment to empowering physicians and providers to provide superior dermatological care to our patients is unwavering.

We have a few requests regarding your visit: Please arrive at your appointment 15 to 20 minutes before your scheduled appointment time. Bring a physical copy of your insurance card and identification. To make the New Patient registration process move more quickly, we have included all required documentation for a New Patient, our HIPPA form, Patient Financial responsibility form and Notice of Privacy Practices. We ask you to review, complete and bring these documents with you for your first appointment. This will shorten your wait time.

Should you have any questions about the included documents or need to reschedule your appointment, please contact us at 225/927-5663.

Best Regards,

Louisiana Dermatology Associates and Staff

Enclosures (3)



PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent to Louisiana Dermatology Associates to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Louisiana Dermatology Associates Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Louisiana Dermatology Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Louisiana Dermatology Associates management.

With my consent, Louisiana Dermatology Associates may call my home or other designated locations and leave a message on voice mail or in-person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Louisiana Dermatology Associates may communicate with me via SMS/TEXT or iMessage in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Louisiana Dermatology Associates may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

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* With my consent, I hereby give Louisiana Dermatology Associates permission to discuss/share my PHI pertaining to my treatment and/or diagnosis with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please initial: \_\_\_\_\_\_\_\_\_\_\_

* I choose not to give consent to Louisiana Dermatology Associates to discuss/share my PHI pertaining to my treatment and/or diagnosis with anyone other than myself at this time. I understand that I may change this decision in the future by submitting a written authorization to Louisiana Dermatology Associates.

By signing this form, I am consenting to Louisiana Dermatology Associates use and disclosure of my PHI to carry out TPO and I verify that I have read and accepted Louisiana Dermatology Associates Notice of Privacy Polices.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Louisiana Dermatology Associates may decline to provide treatment to me.

**Results notification will be primarily through the patient portal for benign or normal pathology/lab results. Benign or normal reports will be uploaded to your portal once reviewed by your provider and you will receive an email informing you when your report(s) have been uploaded. We will call you at your provided phone number(s) for any abnormal results or those that require further explanation. If you wish to opt out of portal notifications, you must do so in writing.**

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Signature of Patient or Legal Guardian Name of Legal Guardian (if applicable)

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Patient’s Name Patient’s DOB Date Signed



**Emergency Contact Information**

Patient's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:** (individual that we can contact if something happens to you at the clinic)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party Information for PATIENTS under 18**: (individual that is responsible for all financial obligations)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different from patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

(Signature is required for this page)



**Patient Financial Policy**

Thank you for choosing us for your healthcare needs. As your Healthcare provider, we are committed to providing you with the best possible care. Please read our financial policy. If you have any questions, please ask one of our associates for assistance or call our billing office at (844) 733-1400.

**You will be asked to show the front office staff your current insurance card at each visit.** Please come prepared. This allows us to verify the information and assist you in collecting the benefits from your insurance company to which you are entitled.

Please be aware that as with many providers offices, there may be services requested by Louisiana Dermatology Associates providers but performed by another doctor and or lab. These services will result in a separate bill from the doctor and/or lab. Examples of services requested of other doctors and or labs are but not limited to testing for biopsies removed by LA Derm providers, the reading and reporting of the results of the testing.

**PATIENTS WITH INSURANCE POLICIES**

*For insurance companies that we participate with:*

We are pleased to bill your insurance on your behalf. If your insurance requires you to make a copay, coinsurance, and/or deductible, we expect this payment at the time of service. Please be aware, we do our best to verify your insurance information prior to requesting payment. We base our request for copays, coinsurance, and deductible based on estimated allowable. These amounts may differ from what your insurance allows for the services rendered, therefore you may receive a bill for any amounts over our estimated allowable once your insurance has processed the charges. In addition, you will be responsible for any amount the insurance plan deems not covered, up to the entire amount. Please reference your Explanation of Benefits (EOB) provided by your insurance carrier. If you are not prepared to pay your copay or coinsurance, your appointment will be rescheduled.

*If we do not hear from your insurance company:*

If we have not received payment or rejection from your insurance company in a timely manner, we will transfer the balance to your responsibility. We request your assistance in following up with your insurance company to resolve any non-payment issues.

*For insurance companies that we DO NOT participate with:*

If your insurance has an out-of-network benefit clause and we are able to verify coverage and obtain authorization, we will submit a claim to the insurance company on your behalf. PhyNet reserves the right to collect any unmet deductible or coinsurance at the time of service. It is ultimately the patient’s responsibility to verify if we are in your insurance network and what the out-of-pocket costs of using an out-of-network provider will be.

**SELF PAY PATIENTS**

If you do not have insurance or are seeking care outside of your insurance plan benefits, payment in full is required. For your convenience, we accept cash, check, Visa, Mastercard, Discover, and American Express. A returned check fee of $35 will be assessed on any check returned by the bank. Future services will require payment by cash, money order or credit card.

**COPAYMENTS**

According to the agreement you have with your insurance company, copayments are due at each visit. If you are not prepared to pay your copay prior to your appointment, your appointment will be rescheduled.

**COINSURANCE**

Coinsurance is based on the predetermined level of coverage outlined in your insurance policy. For example, you may have an 80/20 plan, meaning the insurance will consider and pay 80% of the allowable charges and the remaining 20% is your responsibility. It is very important to review your coverage to determine your level of coinsurance.

**CANCELLATION AND NO-SHOW FEES**

Medical appointments missed with no notice or cancelled with less than one (1) business day notice will be assessed a $50 no show/late cancellation fee. We charge a $100 fee for each surgical procedure or cosmetic procedure missed or cancelled with less than three (3) business days’ notice. Appointments cancelled during non-business hours, such as on Saturday or Sunday, will be assessed a late cancellation fee for appointments scheduled on Monday. Patients who miss or cancel without notice on more than two (2) occasions will be required to pay a $50 deposit when scheduling a future medical appointment and a $100 deposit when scheduling a future cosmetic appointment.

**PAST DUE ACCOUNTS**

In the event a balance becomes past due, your account will be considered delinquent. Delinquent accounts are subject to further collection action, including placement with a collection agency. The patient will be responsible for any collection fees associated with collecting the outstanding balance. Outstanding balances will be collected prior to scheduling future appointments and/or prior to your appointment.

**DISABILITY AND OTHER SPECIAL FORMS**

We recognize that special forms are sometimes necessary to provide documentation of medical conditions. Completing forms is time-consuming and generally falls outside of the contractual relationship between you and your insurance company. We will be happy to complete these forms at the following rates:

* FMLA - $25
* Disability/Physician Attestation - $25
* Miscellaneous Forms - $25
* Medical Records - $35

Payment of the form filing fee is due at the time of request and a medical release form must be signed.

We will gladly discuss your proposed treatment and will do our best to answer any questions related to your insurance. You must realize that: A) your insurance is a contract between you, your employer, and the insurance company. B) not all services are a covered benefit in all contracts. Your insurance plan may elect to not cover certain services for various reasons.

As your medical provider, our relationship and concern are with you and your health, not your insurance company. While the filing of insurance claims is a courtesy, **all charges are your responsibility from the date services are rendered.**

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Notice of Privacy Practices**

AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA) THIS REVISED NOTICE OF PRIVACY PRACTICES IS EFFECTIVE AS OF JULY 2024

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED. IT ALSO DESCRIBES HOW YOU CAN OBTAIN YOUR INFORMATION. PLEASE READ IT CAREFULLY AND ASK US IF YOU HAVE ANY QUESTIONS.**

1. WHY WE KEEP INFORMATION ABOUT YOU

PhyNet Dermatology and our affiliated practice sites are committed to maintaining the privacy of your medical information. We keep medical information about you to help care for you and because the law requires us to. We also are required by law to provide you with this Notice of our legal duties and the privacy practices our practice sites maintain concerning your medical information. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time. We must provide you with the following important information:

* + How we may use and disclose your medical information;
  + Your privacy rights regarding your medical information; and
  + Our obligations concerning the use and disclosure of your medical information.

This Notice applies to all Phynet-affiliated practices, including records containing your medical information that are created or retained by our practices. We reserve the right to revise or amend this Notice. Any revision or amendment to this Notice will be effective for all your records that our practices have created or maintained in the past and for any of your records that we may create or maintain in the future. Our practices will post a copy of our current Notice in our offices in a visible location, and you may request a copy of the most current Notice at any time.

1. HOW WE MAY USE AND SHARE INFORMATION ABOUT YOU:
2. For Treatment. We may use and disclose your medical information and share it with other professionals involved in treating you to help coordinate your care. For example, treatment information given to another health care provider(s) who, at your request, become involved with the management of your care or related services.
3. For Billing & Payment. We may use and disclose your information in order to bill and collect payment for the services provided to you. For example, we may need to give your insurance company information about your visit so they will pay us or reimburse you for the treatment.
4. For Business Reasons. We may use and disclose your medical information in order to operate our business, improve your care, and contact you when necessary. For example, we use medical information about you to manage your treatment and services. This may also include working with business associates/subcontractors, who PhyNet or our affiliated practices, may have contracted with to perform functions on our behalf or provide us with services, if the information is necessary for such functions or services.
5. To Contact You About Appointments, Insurance, and Other Matters. We may contact you by mail, phone, text or email for many reasons, including to:

* Remind you about an appointment
* Register you for a procedure
* Give you test results
* Ask about insurance, billing, or payment
* Follow up on your care
* Invite you to take part in research

We may leave voice messages at the telephone number you give to us. If you choose to have us contact you by text, texting charges may apply.

1. Sign in Sheet. We may use and disclose medical information about you by having you sign in when you arrive at an office location. We may also call out your name when we are ready to see you.
2. To Tell you About Treatment Options or Health-related Products and Services. We may use or share your information to let you know about treatment options or health-related products or services that may interest you.
3. To Inform Family Members and Friends Involved in Your Care or Paying for Your Care. Our practices will routinely disclose to your responsible party(ies) the medical information directly relevant to his/her involvement with your health care, medical information related to payment of your health care, and medical information used for notification purposes. We may release your medical information to another responsible party(ies) you identify involved in your care.
4. Marketing. We may contact you to give you information about products or services related to your treatment, or care. We will not otherwise use or disclose your medical information for marketing purposes, without your prior written authorization.
5. Sale of Health Information. We will not sell your medical information without your prior written authorization.
6. Disclosures Required by Law. Our practices will use and disclose your medical information when we are required to do so by federal, state, or local law.
7. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law.
8. Responding to Lawsuits. We can share medical information about you in response to a court or administrative order, or in response to a subpoena.
9. **USE AND DISCLOSURE OF MEDICAL INFORMATION IN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your medical information:

1. Public Health Risk Reporting. Our practices may disclose your medical information to public health authorities that are authorized by law. For example, we are required to report certain communicable diseases to the state's public health department.
2. Law Enforcement. Your medical information may be disclosed to law enforcement agencies, military, and national security without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.
3. Workers' Compensation. Our practices may release your medical information for workers' compensation and similar programs that provide benefits for work-related injuries or illnesses.
4. Inmates. If you are an inmate or under the custody of law enforcement, our practices may release your medical information to the correctional institution or law enforcement official. This release is health and safety of others, or for the safety and security of the institution.
5. **YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION**

You have the following rights regarding the medical information that we maintain about you. These include:

1) Restrictions. The right to request restrictions on the use and disclosure of your medical information, including to request that a health plan not be informed of treatment for which you paid entirely out of pocket. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

2) Sale, Marketing, and Research. The right to prohibit the sale of your medical information, its use for marketing purposes, or participation in research.

3) Confidential Communications. The right to request confidential communications concerning your medical condition and treatment in a specific manner.

4) Inspection and Copies of Protected Health Information. The right to inspect and obtain copies of your medical information.

5) Amendment and Correction. The right to request an amendment or corrections to your medical information.

6) Accounting of Disclosures. The right to receive an accounting of how and to whom your medical information has been disclosed outside of our practice if not for treatment, payment, or health care operations.

7) File a Complaint. The right to file a complaint if you believe your privacy rights have been violated. Please file your complaint in writing. You will not be penalized for filing a complaint.

8) Receive a Copy. The right to receive a printed copy of this Notice upon request.

*All requests must be in writing and directed to PhyNet Dermatology (Attention: Privacy Officer), 302 Innovation Drive Suite 400, Franklin, TN 37067. Our practices may charge a fee for the costs associated with any request.*

1. **RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES**

Our practices will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your medical information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your medical information for the reasons described in the authorization. Please note, we are required to retain records of your care.

1. **QUESTION OR CONCERNS REGARDING THIS NOTICE**

If you have questions about this Notice or want to discuss a concern without filing a formal complaint, please contact the Compliance Department at the email located at the end of this Notice. If you believe your privacy rights have been violated, you may complain to the secretary of the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or by contacting the Compliance Department at the information listed below. There will not be retaliation against you for filing a complaint. Again, if you have any questions regarding this Notice or our medical information privacy policies, please contact:

PhyNet Dermatology

302 Innovation Drive, Suite 400, Franklin, TN 37067

Attention: Privacy Officer

Email: compliance@phynet.com

Phone: (615)-224-7755

Fax: (615)-905-9126

1. **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

By signing below, you acknowledge that you have received our “Notice of Privacy Practices” (the “Notice”) as detailed above. This Notice describes in detail how we might use or disclose your protected health information and discusses your rights and our duties with respect to your protected health information.

Patient Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship (if not patient):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_