FRANKLIN DERMATOLOGY GROUP, PLC/LATOUR SKIN CARE CENTER

I am here to see: ☐ Charity McConnell, MD ☐ Eva Parker, MD ☐ Leslie J. Caudill, M.D
☐ Emily Stewart, NP ☐ Paige Hastings, NP ☐ Molly Boring, NP
☐ Sunny Birdsong, Aesthetician ☐ Ashley Lane, Aesthetician

PATIENT INFORMATION (please print):

Date: _____/_____/_____ Did a physician refer you? If yes, who?_____

Patient's Name: Mr./Mrs./Ms.(last)_____,(first)_____ (Mi)____

Address: _____

City: _____**State:** _____ **Zip:** _____

Date of Birth: _____/_____/_____ **Age:** _____ **Social Security Number** _____-____-_____

Gender: ☐Male ☐Female **Status:** ☐Married (to)_____ ☐Single ☐Minor

Phone: ***DO NOT PROVIDE NUMBERS WHERE YOU DO NOT WISH TO BE CONTACTED***

**Minimum one required*

Home: (____)_____ Cell: (_____)_____ Work: (_____)_____

Employer/City: _____

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT)

Name: _____ Social Security # _____

Date of birth: _____/_____/_____

Address: _____(city)_____(State)____(zip)_____

PLEASE LIST THE PERSON WHOM THE INSURANCE IS UNDER (REQUIRED)

Name: _____ Social Security #_____

Date of birth: _____/_____/_____ Relationship to patient: _____

Employer: _____

AGREEMENT TO PAY

•In order to establish an optimal relationship and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required at the time of services are rendered unless you are covered by an insurance company with which Franklin Dermatology participates. We accept payment in the form of cash, check, or credit card (we do not accept American Express).There is $25 charge for returned checks.

•I understand that it is my responsibility to cancel my appointment with Franklin Dermatology Group 24 hours prior to the appointment date and time or I may be billed $35 for the missed appointment.

•I understand that it is my responsibility to present accurate, current insurance coverage information at the time of check in. At that time, I will be asked to pay for all services not covered, deductible amounts, co-pays, past due balances, as well as balances due resulting from invalid insurance information. For patients with HMO coverage or other third party insurance that require authorizations, I will be held responsible for payment if this referral authorization is not provided at the time of service. I, as the patient or responsible party for the patient, agree to be responsible for charges or services referred to another physician or laboratory by any physician/practitioner of Franklin Dermatology Group.

•I understand that failure to make payment when due is the basis for legal action, and agree to pay any and all cost of collection, including attorneys' fees.

•I understand it is the policy of Franklin Dermatology Group to collect any outstanding balance before additional services are rendered.

•I authorize and request that payment by an authorized insurance company be made payable to Franklin Dermatology Group on my behalf for the services furnished to me by the physician(s)/practitioner(s) of Franklin Dermatology Group.

•This signature verifies the agreement to the above as the patient or the responsible party for the patient.

Signed: _____ Date: _____/_____/_____