



Welcome to our office

Where did you hear about us?
Yellow Pages (YP) Newspaper (NP) Website (WS)
Friend or Family (FF) Physician Referral (PR)
Other (OT)

OFFICE USE ONLY
Physician:
Approved by:
Date:

NEW PATIENT INFORMATION (Complete if different from billing party)

Name First Middle Last
Address
City State Country Zip Phone #
Birthdate Sex M or F Race Marital Status S M W D
Social Security # Employer
Address of Employer Work Phone #
May we contact you at work? Y N By E-Mail Y N E-Mail Address
Emergency Contact Name Emerg. Phone #
Relationship to billing party

Guarantor/Responsible Party

Name First Middle Last
Address
City State Zip Phone #
Birthdate Sex M or F Marital Status S M W D
Social Security # Driver's License #
Place of employment Work Phone #

OTHER INFORMATION

Name and address of nearest relative not living with you
Address City State Zip Phone #

If you are currently under another physician's care, please list:

Name
Address City State Zip

Whom may we thank for referring you to us?

INSURANCE

1. Primary Insurance Company Name
Group # Policy Member #
Subscriber Name Subscriber Birthdate Sex M or F Social Security #
Subscriber Employer and Address

2. Secondary/Supplemental Insurance Name
Group # Policy/Member #
Subscriber Name Subscriber Birthdate Sex M or F Social Security #
Subscriber Employer and Address

Please note whomever brings a child in to be seen is responsible for payment at time of service unless prior arrangements have been made.
It is the custodial parent's responsibility to arrange reimbursement from a non-custodial parent.
By signing below I hereby give my consent for Holston Medical Group to treat my minor child, under 18 years of age

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I understand that I am financially responsible for any medical service at time of service. I authorize my insurance carrier to pay to Holston Medical Group any assigned claims filed by them and authorization for release of medical information requested by my insurance company. For Medicare beneficiaries: I request payment of authorized Medigap benefits be made to me or on my behalf to Holston Medical Group and medical information about me to be released to my Medigap insurer.

Date Signature



Patient: _____

MRN: _____

Communicating with Your Specialist

Access to Your Physician and Staff

Your Holston Medical Group (HMG) health care team can be reached either by telephone or electronically through our patient portal, FollowMyHealth®. If you wish to communicate electronically, you may sign up at any office location on our website at your convenience. Please remember, electronic communication is for routine matters and never should be used for emergencies.

It **is not** appropriate to communicate with your health care team through social media, such as **Facebook**, or **texting**. Your privacy is important to us and these are not secure methods of communication. Any questions or concerns should be directed to the patient portal or office during normal business hours.

After Hours Care

HMG is dedicated to serving our patients 24 hours a day, 7 days a week. The most effective way to serve you is during regular clinic hours, but we understand acute illnesses can occur at any time. Your Primary Care Provider's telephone message will direct you on how to contact the HMG Physician on Call.

HMG Urgent Care

Please use the Emergency Room only in a true emergency (i.e. chest pain, shortness of breath, stroke-like symptoms).

To avoid long wait times in the ER, come to our Urgent Care clinics for routine health concerns such as colds, ear aches, flu symptoms, sprains and strains, etc. We have two locations conveniently located in Bristol and Kingsport. For hours and specific information call (423) 230-2420 (Kingsport) or (423) 990-2466 (Bristol).

Prescription Refills

To avoid delays and busy phone lines, the best time to obtain your medication refills is at your office visit. While we realize there may be a need to request a refill via telephone or patient portal, please allow at least 48 hours for all refill request before checking with your pharmacy.

Sample medication will only be distributed during normal business hours.

Monthly refills of any controlled medications (pain medication, anxiety, etc) will only be given during an office visit within regular business hours.

Signature: _____

Date: _____

Witness: _____

Date: _____

Holston Medical Group complies with applicable Federal civil laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Holston Medical Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Attention: If you need language or translation services, please ask to speak with the Office Manager.
La atención: Si usted necesita servicios de idiomas o traducción, pida hablar con el Gerente de la oficina.
تنبه: كم رمدي مع تفتت الالب طت ان رجي ي مترجمة ال او عة ل ال خدمات ال ال حاجة ب ت ك اذا: تفتت ان



MRN:

DATE RECEIVED:

No Show Policy

Welcome to Holston Medical Group. Please take time to review the following information pertaining to our policy for no show appointments.

We understand that scheduling conflicts occur from time to time. However, we request at least 24-hours advance notice if you are unable to keep your scheduled appointment(s). Two or more missed appointments may result in your family being dismissed from Holston Medical Group. Patients who fail to show up for a scheduled appointment may be charged a fee for not providing the office with prior notice of cancellation.

Holston Medical Group physicians have developed our No Show policy in an effort to better serve our patients by providing same day appointments to those who are sick and need to be seen. If someone schedules an appointment and does not show for the visit, we have lost an available time that could have been used for a sick patient.

We look forward to providing your health care needs. Your understanding and cooperation helps us to provide available appointments for patients who urgently need them.

Please sign below as confirmation that you have read, acknowledge and understand our policy regarding no show appointments.

Please Print Patient Name

Date of Birth

Patient Signature / Authorized Representative

Relationship to Patient

Witness

Date

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ان ت باه : إذا كنت بحاجة إلى خدمات الترجمة، يرجى أن ت طلب ال تحدث مع مندي ر م ك تيب .

Revised:

FINANCIAL POLICY

Holston Medical Group believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to have an understanding of our financial policy.

- 1. PAYMENT** is expected at the time of your visit. Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. Payment is due at the time services are provided or upon receipt of a statement from our billing office. ***We will accept cash, check, debit, credit or health savings accounts.*** You may also make a payment online through our patient portal, FollowMyHealth®.

Payment will include any unmet deductible, co-insurance, co-payment amount or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause payment in full is expected at the time of your visit. For visits under a "global" or a follow up trauma visit (from a procedure performed by an HMG physician) or for ongoing rehabilitation treatment plans, you will only be responsible for your co-payment if applicable based on your insurance. We do ask for a ***copy of your current insurance card*** at the time of your visit to ensure we properly file your claim.

- 2. SURGERY PATIENTS:** You may be responsible or required to pay a percentage of surgery charges prior to any surgeries or procedures. This will be determined by information given to us by your insurance company in regard to patient percent responsibility.
- 3. INSURANCE:** We participate with several insurance plans and will file your claims on your behalf. It is your responsibility to ensure coverage for services prior to your visit. You will be responsible for the complete charges for any non-covered services provided. In addition, all co-payments, deductibles or non-covered charges will be due at the time of service. You must provide proof of insurance at each visit so we can ensure proper billing to your benefit plan. If there is an overpayment on your account, we will refund any overpayment to you after overpayment credit is applied to any outstanding account balance(s). We do not bill third party payors, but will be happy to provide a copy of the original claim if requested.
- 4. HIGH-DEDUCTIBLE PLANS:** Under these plans, your insurance company will provide you a discount off our billed charges, but you are responsible for the entire amount due until you meet your deductible. ***We will accept cash, check, debit, credit or you may use your health savings account.***
- 5. RETURNED CHECKS** will incur a \$30.00 service charge.
- 6. ACCOUNTING PRINCIPLES:** If there is an overpayment on your account, we will refund any overpayment to you after overpayment credit is applied to any outstanding account balance (s). Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding date of service
- 7. FORMS FEES:** Medical records, except those involving worker's compensation cases, will be billed at the rates listed below:

Simple Forms (completed within 2 business days)

DURING an office visit: No Charge

AFTER an office visit: \$5 / form

Examples of Simple Forms: Handicap tag/sticker, work re-entry forms, immunization, medication, sports, concussion clearance, WIC, Home Bound Status Short form, Disability Short Form, Bank Loan Form, Foster Parent Health Form, College & Camp Forms

Complex Forms: \$25 (completed within 10 business days)

Examples of Complex Forms: FMLA (per illness per year), Disability Long Form, Home Bound Status Long Form.

FINANCIAL POLICY



8. MISSED APPOINTMENTS: If you fail to cancel a previously scheduled appointment at least 24 hours in advance, you may be charged a fee as outlined below:

- Established office visit: \$20
- Allergy Testing: \$75
- New patient visit or consultation: \$100
- GI Procedure: \$250

This charge cannot be billed to the insurance company. Failure to pay a no show fee will be treated according to our policy on unpaid balances, with the exception of collection accounts. This charge is not applicable to patients with Medicaid/TennCare insurance coverage.

After 2 no-show appointments in a rolling calendar year, you may be discharged from the practice, at the discretion of the responsible provider and management. Medical care will not be withheld for a medical emergency for thirty days from date of dismissal.

9. UNPAID BALANCES: All outstanding balances shall be due within 30 days of the date of service. At that time, all past due balances in their entirety must be paid prior to the time of your next visit. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency and could affect your credit.

10. FINANCIAL DISMISSAL: Patients who do not make payment arrangements risk being dismissed from the practice. Holston Medical Group reserves the right to dismiss patients for delinquent financial accounts on personal balances. If dismissed, medical care will not be withheld for a medical emergency for thirty days from date of dismissal.

11. BILLING QUESTIONS: We will be happy to help you resolve your balance and can be reached at **(423) 578-1802, Monday – Friday 8:00AM – 5:00PM.**

New Patient Information

MRN: _____ Date: _____

Patient Name: _____ Date of Birth _____

Have you been a patient of Dr. Douglas New in Abingdon? ____ Yes ____ No

How did you hear about HMG Dermatology? _____

Pharmacy you prefer to use (Name and City, State): _____

What is your occupation? _____

Is there a family history of skin cancer? ____ Yes ____ No

If yes, which family member(s)? _____

Smoking History: ____ Never Smoker ____ Former Smoker ____ Current Smoker

If current smoker, how, many packs per day? _____

Do you drink alcohol? ____ Yes ____ No If yes, how many drinks per week? _____

If you are female, are you pregnant? ____ Yes ____ No

If you are female, are you currently breastfeeding/nursing? ____ Yes ____ No

Do you have any of the following?

- Yes / No Pacemaker
- Yes / No Defibrillator
- Yes / No Arthritis
- Yes / No Diabetes
- Yes / No Gastric Reflux (GERD)
- Yes / No Hypertension
- Yes / No Hyperlipidemia (High Cholesterol)
- Yes / No Kidney Disease If yes, specify: _____
- Yes / No Liver Disease If yes, specify: _____
- Yes / No History of Cancer If yes, specify: _____
- Yes / No Tuberculosis
- Yes / No HIV/AIDS
- Yes / No Hepatitis B
- Yes / No Hepatitis C
- Yes / No Latex allergy

Have you had skin cancer treated in the past? ____ Yes ____ No

If yes, please list the year treated, type of skin cancer and location on the body:



FINANCIAL POLICY

MRN#: _____

Date Received: _____

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I have read, understand and agree to the Financial Policy as provided to me. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles and any charges older than 30 days from the date of service are my responsibility.

I authorize Holston Medical Group to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. I authorize my insurance benefits be paid directly to Holston Medical Group.

By signing below, I indicate my agreement with the policy as provided to me.

Date

Signature

Printed Name



Dermatology

Patient: _____

MRN: _____

617 Campus Drive, Abingdon, VA 24210 • Telephone (276) 676-3870 • Facsimile (276) 628-8927

Dr. Doug New

Date: _____ Time: _____

I, _____, a patient in the above named office, hereby authorize _____ (or his associates or assistants) and consent for medical photographs to be taken as deemed necessary. I understand that the use of my photographs is for medical purposes only and that they will become a part of my permanent medical record. I may withdraw this consent at any time, and such withdrawal will not in any way affect me. I understand a withdrawal of consent must be made in writing, and that withdrawal of consent does not affect any information disclosed prior to the written notice of withdrawal.

Patient Signature

Date

Parent/Legal Guardian (if applicable) Signature

Date

Employee Witness

Date

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Attention: If you need language or translation services, please ask to speak with the Office Manager.
La atención: Si usted necesita servicios de idiomas o traducción, pida hablar con el Gerente de la oficina.
مكتب مدير مع التحدث تطلب أن يرجى الترجمة أو اللغة خدمات إلى بحاجة كنت إذا: بقية



MRN: _____

Date Received: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have reviewed and/or received a copy of the *Notice of Privacy Practices*, which provides a more complete description of how my protected health information (PHI) may be used or disclosed. I understand that Holston Medical Group (HMG) reserves the right to change their notice and information practices and that I may view a copy of the current *Notice* on HMG's website, www.holstonmedicalgroup.com/hipaa, in any of their offices, or by a request in writing.

I also understand that Holston Medical Group participates in the OnePartner Health Information Exchange (OnePartner HIE) and may make my medical information available electronically or may electronically transmit my medical information to a third party, in order to fulfill provider obligations to release my medical information in the future.

Print Patient Name

Patient Date of Birth

Patient Signature (if applicable)

Date

Authorized Representative Signature

Relationship to Patient

I understand that my Protected Health Information (PHI) will only be verbally communicated to those individuals listed below and no paper copies of my PHI will be provided without my signature on an *Authorization for Release of Individually Identifiable Health Information* form. I understand that some information may be considered sensitive, including but not limited to pregnancy test results, testing for sexually transmitted infections, Urine Drug Screen results, laboratory test results, medication, or information discussed during an office visit. The individuals listed below, will be required to provide the last four (4) digits of my Social Security Number, along with my date-of-birth, before any information will be discussed with them.

List the individual(s) that you want protected health information verbally discussed with:

| Name | Phone Number | Name | Phone Number |
|------|--------------|------|--------------|
| | | | |
| | | | |

FOR INTERNAL USE ONLY:

Reason Acknowledgement Could Not Be Obtained: _____

Employee Signature

Date

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Atención: Si necesita servicios de idioma o traducción, solicite hablar con el Gerente de Oficina

Medication List

Medication Name

Dosage

Frequency

| | | |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
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Allergies
