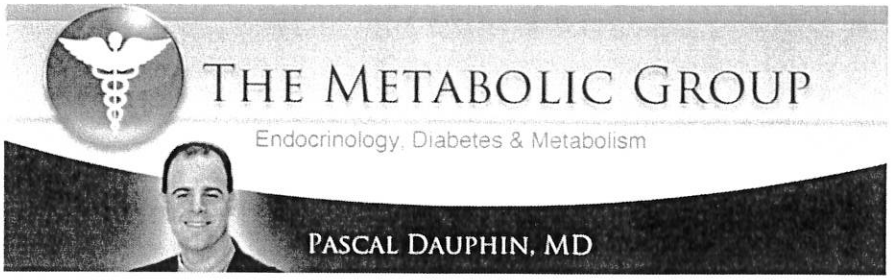


107 Glen Oak Blvd Suite 201B

Hendersonville, TN 37075

Phone: 615-499-4545 Fax: 615-499-4546

# Financial Policy

Dear Patients,

Welcome to The Metabolic Group, PLLC! In our efforts to provide better service, we recommend that you call our office for an estimate of current billing rates for services/appointments. We will gladly provide you with an estimate; however, this is an estimate only and estimates are subject to change according to the services that are provided on your date of service. We will bill your insurance company as a courtesy. Please check with your insurance provider to determine your current benefits, and if our providers are in network with your insurance plan. It is very important that you know if your deductible has been met, what your co-pay is for a specialist, and if your insurance covers at 100% once your deductible has been met. **It is our policy to collect all co-payments and deductibles at time of service.**

Thank you for this opportunity to provide excellent care with the utmost respect. If you have any questions regarding a billing issue, please do not hesitate to call and talk to our office manager.

Sincerely,

The Staff at The Metabolic Group PLLC

Patient Statement:

I have read and understand that I am responsible for the patient portion of office visit, appropriate lab work, and other services. I understand that if my insurance does not cover services rendered that I am responsible for any remaining balances.

Print Name: _____ Date: _____

Signature: _____

# Patient Financial Policy

*This is an agreement between AdvancedHEALTH, as creditor, and the Patient/Debtor named on this form and indicated by patient/debtor signature below.*

*In this agreement the words "you", "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to AdvancedHEALTH. By executing this agreement, you are agreeing to pay for all services that are rendered.*

*Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. A copy of your signed financial agreement will be provided to you.*

**HEALTH INSURANCE - It is YOUR responsibility to:**

- Ensure we have been provided with the most current insurance information relative to filing your claim including insurance card, ID number, employer, birth date and patient address. This information will be located on our patient registration form.
- Ensure we are contracted with your insurance carrier to receive maximum benefits.
- Pay your co-payment or patient portion at the time of service.
- Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within your insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.
- Contact your insurance company if no correspondence is received by you within 45 days of the date of service.

**It is OUR responsibility to:**

- Submit a claim to your health insurance carrier based on the information provided by the patient/debtor at the time of service or as updated information is provided.
- Provide your health insurance carrier with information necessary to determine benefits. This may include medical records and/or a copy of your insurance card.

**PAYMENT OPTIONS:** Per our contracted agreement with your insurance carrier, we are required to collect your co-payment on the day of service. If you do not have insurance, you are required to pay for treatment at the time of service unless other arrangements have been formally made. A separate self-pay financial agreement will be provided to you. Our office collects all copays plus estimated coinsurance and deductibles at the time of service

**We accept the following: Cash Check Credit Card** ***(Visa, MasterCard, Discover, American Express). A twenty-five dollar ($25.00) returned check fee will be assessed to the patient account per incident.***

For convenience, payments may be made online at **www.ePayItOnline.com.** To utilize this service, you will need your account number, access code, and Code ID. This information can be found on the patient statement you will receive reflecting your balance.

***Patients who miss an appointment with-out a minimum 24-hour business day notification will be subject to a $50.00 no-show fee.***

**PENDING APPROVALS FOR SERVICES:** In the event we are unable to obtain approval for services and you wish to proceed, we will not bill your insurance. Services will be reduced to the in-network insurance allowable amount and will apply to the patient's responsibility.

_____ Initials

Patient and/or Debtor Signature: _____ Date _____/_____/_____

BILLING INFORMATION

STATEMENTS:

A statement of account will be provided to you if insurance has paid leaving a patient portion, denied or no response is received. Due to the type of service we provide, you may receive billing from more than one practice, otherwise known as split billing. The balance on your statement is due and payable within 30 days of receipt unless other arrangements are made with our billing department. The statement will be sent to the address provided at the time of service. In the event your mailing address changes after your service date and your account has not been paid in full, you are required to notify our billing office of this change by calling 615.851.6033 ext. 2067. In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child at time of service will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, court documentation is required for any guarantor address changes, otherwise, it is the authorizing/custodial parent's responsibility to collect from the other parent. Any account with a credit balance of less than <$5.00> will not be refunded without specific request from the patient/debtor.

DELINQUENT ACCOUNTS:

We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If we refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be Davidson County, Tennessee. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

WAIVER OF CONFIDENTIALITY:

You understand if your account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

MEDICAL RECORDS:

You will be required to request in writing or sign a medical authorization form for the release of your medical records to any organization or physician. We charge a **$20 flat rate** for 1-5 pages plus .50 per additional page and postage.

# General Consent For Treatment

*As the patient, you have the right to be informed about your conditions and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify appropriate treatment and/or procedure for any identified condition(s).*

I request and authorize medical care as my provider, his assistant or designees (collectively called "the providers") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, and routine medical and nursing care. I authorize my provider(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient) care is directed by my provider(s) and that other personnel render care and services to me (the patient) according to the provider(s) instructions.

I understand that I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed. _____ **(initial)**

**I HAVE READ OR HAD READ TO ME AND FULLY UNDERSTAND THIS CONSENT; I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAD THESE QUESTIONS ADDRESSED.**

Name of Patient: _____

Signature of Patient: _____ Date: _____

---

☐ Consent of Legal Guardian, Patient Advocate or Nearest Relative **if patient is unable to sign**

☐ Consent Caregiver **if patient is unable to sign**

Name of Legal Guardian, Patient Advocate, Nearest Relative or Other: _____

Relationship: _____ Telephone: _____

Address: _____

Signature of the above: _____ Date: _____ Time: _____

Signature of Witness: _____ Date: _____

# The Metabolic Group, PLLC

107 Glen Oak Blvd., Ste. 201B
Hendersonville, TN 37075

## REGISTRATION FORM

**Date:**_____

**Patient's Info:**

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth:_____/_____/_____ SSN:_____/_____/_____ Sex: Male or Female

Race: Black Asian White Hispanic Other:_____ Occupation:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone #: _____ Alternate Phone #:_____ Work #:_____
*May we leave a Message? YES or NO*

Primary Care Physician:_____
**IF YOU DO NOT HAVE A PCP – PLEASE WRITE NO PCP**

Email Address:_____ Marital Status: Single____ Married____ Divorced_____ Widowed_____

Emergency Contact:_____ Relationship:_____ Phone #:_____

**For Insurance Purposes:**

Type of Insurance:_____ Subscriber #:_____ Group #:_____

Subscriber Name & Relationship (if other than patient)_____ Date of Birth: _____/_____/_____

**Pharmacy Info:**
Preferred Pharmacy:_____ City:_____ Phone #:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am responsible for any balances. I also authorize The Metabolic Group or my insurance company to release any information required to process my claims.

***DELINQUENT ACCOUNTS***: We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account(s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

***CONSENT TO CONTACT***: I grant permission and consent to AdvancedHEALTH and its agents, assignees, and contractors(which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any scheduled services and my account. I understand that my refusal to provide the consent described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

Patient's Signature:_____ Date:_____

# MEDICAL HISTORY

PATIENTS NAME: _____ DOB: ____/_____/_____

- *PAST MEDICAL HISTORY: Please list past medical illnesses and surgeries:*

| Medical History | Surgical History |
|---|---|
| | |
| | |
| | |
| | |
| | |

- ***ALLERGIES: Please list any allergies and adverse reactions to medications:***

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

- **SOCIAL HISTORY**:

Tobacco use (current or past) _____ How many per day? _____ Years: _____

Recreational drug usage: Yes: ___ No: ____ Type & how much: _____

Alcohol usage: Never: ____ Socially: _____ Daily: _____ Number of drinks per week: _____

Caffeine usage (coffee, tea, & soft drinks) How many drinks per day of average? _____

Do you exercise regularly? Yes: ___ No: ___ What type & how often? _____

- **FAMILY HISTORY**: Do you know of any blood relatives (Parents & Siblings) who have or have had the following condition? Please be as specific as possible.

| Disease: | Relationship: |
|---|---|
| Diabetes | |
| Thyroid Disease | |
| Pituitary Disease | |
| Heart Disease | |
| High Blood Pressure | |
| High Cholesterol | |
| Stroke | |
| Cancer | |

Signature: _____ Date: _____

# MEDICATION FORM

Name: _____

DOB: ____/____/_____

Please list your medications (including over-the-counter medications as well as supplements and herbal remedies), the dosage and how often you take each.

| | Name of Medications, Supplements, and Herbal Remedies | Dosage | Frequency |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |
| 11 | | | |
| 12 | | | |
| 13 | | | |
| 14 | | | |
| 15 | | | |
| 16 | | | |
| 17 | | | |
| 18 | | | |
| 19 | | | |
| 20 | | | |

- Please Check All That Apply.

| *Review of Systems* | | | | | |
|---|---|---|---|---|---|
| **Constitutional** | | Shortness of breath | | Muscle pain | |
| Weight Gain | | Wheezing | | Weakness of muscles | |
| Weight Loss | | Asthma | | Broken bones | |
| Fever | | **Cardiovascular** | | Neurological | |
| Fatigue | | Chest pain | | Headaches | |
| Sweats | | Heart racing | | Dizziness | |
| Heat Intolerance | | Fainting | | Seizures | |
| Cold Intolerance | | Swelling of feet/ankles/hands | | Stroke | |
| **Ophthalmology** | | **Gastrointestinal** | | Memory loss | |
| Eye Disease/injury | | Loss of appetite | | **Endocrinology** | |
| Cataracts | | Constipation | | Excessive thirst/urination | |
| Glaucoma | | Nausea | | Unexpected change in skin color | |
| Blurred Vision | | Vomiting | | Dry skin | |
| Double Vision | | Diarrhea | | **Hematologic/Lymphatic** | |
| Last eye exam date | | Abdominal Pain | | Cuts slow to heal | |
| **ENT** | | Blood in stool | | Easily bruised | |
| Hearing loss | | **Urology** | | Anemic | |
| Ringing in ear | | Waking up to urinate at night | | Swollen lymph nodes | |
| Ear pain or discharge | | Frequent urination | | Recurring infections | |
| Sinus problems | | Burning urination | | **Allergy** | |
| Nose bleed | | Blood in urine | | Hay fever | |
| **Dermatology** | | Incontinence/urine leakage | | Hives | |
| Rashes, itching | | Sexual dysfunction | | **Immunology** | |
| New moles/lesions | | Painful menstrual periods | | History of HIV/AIDS | |
| Sudden hair loss | | Irregular periods | | Herpes | |
| Brittle nails | | Vaginal discharge | | **Psychology** | |
| Nipple discharge | | **Musculoskeletal** | | Nervousness | |
| **Respiratory** | | Joint pain | | Depression | |
| Chronic coughing | | Joint stiffness | | Loss of Concentration | |
| Coughing blood | | Difficulty in walking | | Sleep problems | |

Additional symptoms that were not provided above: _____

_____

# Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

## PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____

_____

**The Metabolic Group/ADI**
Pascal A. Dauphin, M. D., FACE
107 Glen Oak Blvd Suite 201B
Hendersonville, TN 37075

## 24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, The Metabolic Group/ADI reserves the right to charge a fee of $50.00 for all missed appointments ("no shows") which means the appointment is not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice.

Thank you for understanding and cooperating as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Patient Name: _____ Date: _____

Signature: _____

The Metabolic Group
Pascal A Dauphin, MD
107 Glen Oak Blvd Suite 201B
Hendersonville, TN 37075
Phone: 615-499-4545
Fax: 615-499-4546

# The Metabolic Group, PLLC
## Endocrinology & Metabolism
## Pascal A. Dauphin, MD

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize_____ and its physicians employees and agents to release or disclose to the below-named recipient all my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: _____ Date of Birth: _____

I hereby authorize the release of medical records to: _____
_____

Purpose of disclosure: _____
The authorization will expire on: _____
Date or Event may not exceed one year

This request and authorization applies to:

_____ All medical records

_____ Healthcare information relating to the following treatment, condition, or dates of treatment:

_____
_____

_____ Specific records to be released (EEG, Labs, imaging reports, ect.):

_____

**If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.**

_____Substance abuse _____Psychological or psychiatric treatment _____HIV/AIDS/STD

I understand, and I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____

Signature of Patient or Authorized Representative Date Signed

_____

Relationship to Patient