Appalachian Surgery & Vein, Mountain Family Medicine,

and Caudle Cosmetic Surgery, Wellness, & Medical Spa

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information 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.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you. We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is 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. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: 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.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: 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. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

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

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. 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. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by **speaking with Dr. Caudle.**

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set

disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.
You may contact our Privacy Officer, **Saundra Reynolds** at (423) 543-8619 **or manager@thecaudlecenter.com** for further information about the complaint process. This notice was published and becomes effective on 03/01/2012**.**

Patients' Rights and Responsibilities

1. ALL PATIENTS HAVE THE RIGHT TO INFORMED CONSENT IN TREATMENT DECISIONS, TIMELY ACCESS TO SPECIALTY CARE, AND CONFIDENTIALITY PROTECTIONS.
Patients should be treated courteously with dignity and respect. Before consenting to specific care choices, they should receive complete and easily understood information about their condition and treatment options. Patients should be entitled to: coverage for qualified second opinions; timely referral and access to needed specialty care and other services; confidentiality of their medical records and communications with providers; and, respect for their legal advanced directives or living wills.

2. ALL PATIENTS HAVE THE RIGHT TO CONCISE AND EASILY UNDERSTOOD INFORMATION ABOUT THEIR COVERAGE.
This information should include the range of covered benefits, required authorizations, and service restrictions or limitations (such as on the use of certain health care providers, prescription drugs, and "experimental" treatments). Plans should also be encouraged to provide information assistance through patient ombudsmen knowledgeable about coverage provisions and processes.

3. ALL PATIENTS HAVE THE RIGHT TO KNOW HOW COVERAGE PAYMENT DECISIONS ARE MADE AND HOW THEY CAN BE FAIRLY AND OPENLY APPEALED.
Patients are entitled to information about how coverage decisions are made, i.e., how "medically necessary" treatment is determined, and how quality assurance is conducted. Patients and their family caregivers should have access to an open, simple, and timely process to appeal negative coverage decisions on tests and treatments they believe to be necessary.

4. ALL PATIENTS HAVE THE RIGHT TO COMPLETE AND EASILY UNDERSTOOD INFORMATION ABOUT THE COSTS OF THEIR COVERAGE AND CARE.
This information should include the premium costs for their benefits package, the amount of any patient out-of-pocket cost obligations (e.g., deductibles, copayments, and additional premiums), and any catastrophic cost limits. Upon request, patients should be informed of the costs of services they've been rendered and treatment options proposed.

5. ALL PATIENTS HAVE THE RIGHT TO A REASONABLE CHOICE OF PROVIDERS AND USEFUL INFORMATION ABOUT PROVIDER OPTIONS.
Patients are entitled to a reasonable choice of health care providers and the ability to change providers if dissatisfied with their care. Information should be available on provider credentials and facility accreditation reports, provider expertise relative to specific diseases and disorders, and the criteria used by provider networks to select and retain providers. The latter should include information about whether and how a patient can remain with a provider who leaves or is not part of a plan network.

6. ALL PATIENTS HAVE THE RIGHT TO KNOW WHAT PROVIDER INCENTIVES OR RESTRICTIONS MIGHT INFLUENCE PRACTICE PATTERNS.
Patients also have the right to know the basis for provider payments, any potential conflicts of interest that may exist, and any financial incentives and clinical rules (e.g., quality assurance procedures, treatment protocols or practice guidelines, and utilization review requirements) which could affect provider practice patterns.

ALL PATIENTS, TO THE EXTENT CAPABLE, HAVE THE RESPONSIBILITY TO:*

1. PURSUE HEALTHY LIFESTYLES.
Patients should pursue lifestyles known to promote positive health results, such as proper diet and nutrition, adequate rest, and regular exercise. Simultaneously, they should avoid behaviors known to be detrimental to one's health, such as smoking, excessive alcohol consumption, and drug abuse.

2. BECOME KNOWLEDGEABLE ABOUT THEIR HEALTH PLANS.

Patients should read and become familiar with the terms, coverage provisions, rules, and restrictions of their health plans. They should not be hesitant to inquire with appropriate sources when additional information or clarification is needed about these matters.

3. ACTIVELY PARTICIPATE IN DECISIONS ABOUT THEIR HEALTH CARE.
Patients should seek, when recommended for their age group, an annual medical examination and be present at all other scheduled health care appointments. They should provide accurate information to providers regarding their medical and personal histories, and current symptoms and conditions. They should ask questions of providers to determine the potential risks, benefits, and costs of treatment alternatives. Where appropriate, this should include information about the availability and accessibility of experimental treatments and clinical trials. Additionally, patients should also seek and read literature about their conditions and weigh all pertinent factors in making informed decisions about their care.

4. COOPERATE ON MUTUALLY ACCEPTED COURSES OF TREATMENT.
Patients should cooperate fully with providers in complying with mutually accepted treatment regimens and regularly reporting on treatment progress. If serious side effects, complications, or worsening of the condition occur, they should notify their providers promptly. They should also inform providers of other medications and treatments they are pursuing simultaneously.

**It is recognized that some patients may suffer significant physical and/or mental conditions which may limit their ability to fulfill these responsibilities.*

ACKNOWLEDGEMENT of PATIENT'S RIGHTS AND RESPONSIBILITES
A written copy of the Patient's Rights and Responsibilities is also available at the front desk of our offices. If you would like to request a copy, please ask the front desk for a copy.
I have read a copy of the Patient's Rights and Responsibilities which provides a complete description of information uses and disclosures. The clinic reserves the right to make changes to their Patient's Rights and Responsibilities and revised copies are available.

By signing below, I acknowledge that I have been afforded the opportunity to consider my rights and responsibilities as a patient of Appalachian Surgery & Vein, Mountain Family Medicine, and Caudle Cosmetic Surgery, Wellness, & Medical Spa
prior to signing this consent and making healthcare decisions.

ACKNOWLEDGEMENT of HIPPA PRIVACY NOTICE
A written copy of the HIPPA Privacy Notice is also available at the front desk of our offices. If you would like to request a copy, please ask the front desk for a copy.
I have read a copy of the Notice of Privacy Practices which provides a complete description of information uses and disclosures. This clinic reserves the right to make changes to their Privacy Notice and revised copies are available.

By signing below, I acknowledge that I have been afforded the opportunity to consider Appalachian Surgery & Vein, Mountain Family Medicine, and Caudle Cosmetic Surgery, Wellness, & Medical Spa's Notice of Privacy Practices prior to signing this consent and making healthcare decisions.

I also understand and agree to have my digital photo identification taken as part of my electronic health records. I authorize Appalachian Surgery & Vein, Mountain Family Medicine, and Caudle Cosmetic Surgery, Wellness, & Medical Spa to release medical and financial information, including any or all reports, records, bill for services rendered or opinions found in my medical chart, with respect to treatment to any alternative healthcare giver.

Appalachian Surgery & Vein, Mountain Family Medicine, and Caudle Cosmetic Surgery, Wellness, & Medical Spa maintains patient medical records on paper and/or electronic media which may be accessible to any physician or healthcare provider participating in my current or future care. Medical records are disclosed according to applicable TN State and Federal laws, and the provisions of this consent.

HIPAA AUTHORIZATION TO DISCUSS YOUR MEDICAL INFORMATION:

_____ Patient ONLY **OR** You may disclose my medical information to:

Name Relationship Phone: _____

Name Relationship Phone: _____

Patient's Signature Date: _____ _____/_____/_____

OFFICE USE ONLY

Employee's Signature Date: _____ _____/_____/_____

Appalachian Surgery & Vein, Mountain Family Medicine,
and Caudle Cosmetic Surgery, Wellness, & Medical Spa

PATIENT CANCELLATION POLICY & AGREEMENT

Welcome to Our Office! We are pleased to welcome you to our office and are happy you have chosen us for your cosmetic surgery consultation. It is our aim to meet all your cosmetic surgery needs with the highest quality of care in the most welcoming and compassionate environment possible.

PATIENT CANCELLATION POLICY & AGREEMENT: Patient has requested and received an estimated price quotation for surgical procedure(s) to be performed by Scott Caudle, MD; cosmetic and general surgeon.

SURGERY DEPOSIT: Should patient choose to proceed with surgery, a $500.00 (five hundred dollars) or a $1500 (fifteen hundred dollars if conscious sedation or general anesthesia is required) DEPOSIT is required to reserve your surgery date. This deposit is credited towards the surgery fee balance due in the estimated price quotation of your requested surgical procedure(s). The office has the right to change the required deposits without notice.

CANCELLATION POLICY: Upon giving a surgery deposit, you understand that a surgery date has been reserved specifically for you, the patient. This involves the commitment of your surgeon, anesthesia personnel if applicable, surgery center, recovery room team, surgical team and / or necessary surgery equipment & supplies to be reserved for the time period required to perform your surgical procedure(s) on the surgery date you (the patient) have chosen to reserve. As such, you (the patient) acknowledge that any cancellation of the reserved surgery date less than 48 hours prior to scheduled surgery date, is an insufficient period of time within which Scott Caudle, MD, the outpatient surgery center, and anesthesia personnel can reschedule or schedule another patient for surgery to fill the cancelled time slot. *Therefore, any cancellation or postponement initiated by the patient with less than 48 hours' notice prior to the date of surgery will result in patient forfeiting one half of all fees, including the entire deposit. Also, cancellation of your reserved surgical date of less than 2 weeks' notice given will result in the forfeiture of the entire deposit but no other fees (except as described above).

NOTE: If surgical fees paid in full included the cost of implants, a refund for the implant cost will be issued to patient within 30 days if the implant can be used for another patient.

PAYMENT SCHEDULE: After Scott Caudle, MD has received your surgery deposit, 50% of all balances due for the surgical procedure(s) must be PAID IN FULL no later than your scheduled Pre-Operative appointment or 2 weeks prior to your scheduled procedure. The remaining balance for the surgical services requested must be paid by the day of the procedure.

FAILURE TO PAY BALANCES AS DESCRIBED ABOVE WILL RESULT IN CANCELLATION OR RESCHEDULING OF YOUR RESERVED SURGERY DATE. ACCEPTABLE METHODS OF PAYMENT We accept Cash, Cashier's Checks, Money Orders, and Major Credit Cards. If payment is made by credit card, **we MAY add a 3 percent surcharge to your payment.

A photocopy of this authorization shall be considered as effective as the original.

I HAVE READ AND UNDERSTAND THE OUTLINED PATIENT FINANCIAL POLICY AGREEMENT PROVIDED BY Scott Caudle, MD.

_____ _____/_____/_____

PATIENT SIGNATURE (Parent or guardian signature if patient is a minor) DATE

_____ _____/_____/_____

EMPLOYEE SIGNATURE DATE

Appalachian Surgery & Vein, Mountain Family Medicine, and Caudle Cosmetic Surgery, Wellness, & Medical Spa

NO REFUND - RETURN POLICY AND COLLECTION POLICY

It is the policy of Appalachian Surgery & Vein, Mountain Family Medicine, and Caudle Cosmetic Surgery, Wellness, & Medical Spa to have a Financial / Collection Policy that clearly outlines patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care and minimizing administrative costs. This Policy has been established with these objectives in mind, and to avoid any misunderstanding or disagreement concerning payment for professional services.

NO REFUND OR RETURN POLICY
Please read over your consents carefully and ask any questions before you decide on any service(s), service package(s), gift certificate(s), and/or retail products(s).
Appalachian Surgery & Vein, Mountain Family Medicine, and Caudle Cosmetic Surgery, Wellness, & Medical Spa does not guarantee the outcome of any procedure or product purchased.

By signing below, I am agreeing that any service(s), service package(s), gift certificate(s), and/or retail products(s) I purchase at Appalachian Surgery & Vein, Mountain Family Medicine, and Caudle Cosmetic Surgery, Wellness, & Medical Spa is a final sale. I understand any and all service(s), service package(s), gift certificate(s), and/or retail products(s) purchased will not be refunded or issued a credit. I also understand that if I decided to cancel or postpone any service(s), service package(s), gift certificate(s), and/or retail products(s), I will forfeit all monies paid; including any deposits and/or payments I have already paid.

By signing this No Refund Policy, I understand and agree to all terms and conditions of here said policy. All my questions have been answered concerning the No Refund Policy.

RETURNED CHECK If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient will be responsible for the original check amount in addition to a $25.00 Service Charge. Once notice is received of the returned check, this office will send out a letter to notify the patient of the returned check. If a response is not made within 15 days from the letter date by the patient, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $25.00 Check Service Charge.

AUTHORIZATION AND RELEASE I affirm that the information given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform to office in any changes of address, phones, employment information, and medical status.

I have read all the questionnaires listed above and disclosed my medical history to the best of my knowledge. I understand that this clinic does not accept any medical insurance nor process any medical insurance claim for cosmetic services. I understand that I am financially responsible for all services performed and that the full balance of treatment is due at the time service is rendered. I understand that I am responsible for the full balance, including but not limited to late payment fees, third party collection fees, court fees, filing fees, and attorney fees.

I authorize Appalachian Surgery & Vein, Mountain Family Medicine, and Caudle Cosmetic Surgery, Wellness, & Medical Spa staffs to perform all necessary medical services needed. Like all treatments of the body, there are certain risks, benefits, limitations, and alternatives to treatment and no guarantee of the outcomes or cures will be given. I understand it is difficult to predict any symptoms, if any, I may encounter as a result of treatment.

By signing below, I understand that this will forms a binding agreement between Appalachian Surgery & Vein, Mountain Family Medicine, and Caudle Cosmetic Surgery, Wellness, & Medical Spa and yourself as the patient who is receiving medical services and I agree to accept full financial responsibility as a patient who is receiving medical services.

Cosmetic procedures are not covered by insurance. *Our office participates with numerous insurance companies and managed health care programs. For patients that are members of one of these plans, our insurance / billing department will submit a claim for services rendered.

Payment in full is expected at the time of service unless prior arrangements have been made with us. Patient may want to call the office and find out how much their first office visit will be prior to coming to the office the first time.

*It is the patient's responsibility to pay any deductible, co-insurance, co-payment, or any portion of the charges as specified by the plan at the time of visit. Any medical services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of visit.

***Payment for professional services can be made with cash, approved check, money order, Cashier's check, medical insurance, or approved third party.** Credit card payments are an option at some locations. If payment is made by a credit card, we may add 3 percent surcharge to your payment.

*If a patient feels that he or she may require financial assistance, notify the Practice Manager before you see the physician.

All patients will receive 1 (one) statement for their portion of their bill. If the patient has not paid or made arrangements to pay the balance of their bill, a delinquent / collection letter will be mailed to the patient. If the patient has still not paid or made arrangements to pay the balance of their bill, this debt may be turned over to a collection agency. After the bill has been turned over to the collection agency, Appalachian Surgery, et al will no longer be able to help with the payment arrangements. All payments will have to be sent to the collection agency. There is $25 late payment fee, $35 administrative processing fee, plus 1.5% interest per month added to all outstanding debt. Any cost of collection including collection agency added costs, court costs, and any legal (e.g. attorney) fees will be added.

***It is the patient's responsibility to provide us with current insurance information and to bring their insurance card to each visit.**

*The billing/insurance clerk is happy to help with insurance questions relating to how a claim was filed, or regarding any additional information the carrier might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company's member service department (number is on the insurance card).

*The adult accompanying a minor, (17 years and younger), and the parents (or guardians of the minor) are responsible for payment at the time of service. For unaccompanied minors, professional services will not be provided.

Appalachian Surgery & Vein, Mountain Family Medicine, and Caudle Cosmetic Surgery, Wellness, & Medical Spa firmly believe that a good physician-provider/patient relationship is based upon understanding and good communications.

Questions about financial arrangements should be directed to our manager: (423) 926-2400. We are here to help you.

A photocopy of this authorization shall be considered as effective as the original.

My signature below verifies that I have read the above disclosure statement, understand my responsibilities, and agree to these terms.

Patient Signature: _____ Date: _____/_____/_____

Employee Signature: _____ Date: _____/_____/_____

ASSIGNMENT AND RELEASE OF INSURANCE

I certify that I (or my dependent) have insurance coverage as provided to Appalachian Surgery & Vein, Mountain Family Medicine, and/or Caudle Cosmetic Surgery, Wellness, & Medical Spa office and assign directly to Appalachian Surgery & Vein, Mountain Family Medicine, and Caudle Cosmetic Surgery, Wellness, & Medical Spa all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the office to release all information per Privacy Practices guidelines necessary to secure payment of benefits. I authorize the use of my signature on all insurance submissions.

Patient Signature: _____ Date: _____/_____/_____

PATIENT REGISTRATION INFORMATION

COMPREHENSIVE MEDICAL HISTORY for COSMETIC PROCEDURES Date: _____/_____/_____

** PLEASE ANSWER ALL QUESTIONS OF THIS FORM AND THEN SIGN**

First Name: _____Middle: _____Last Name: _____
Address:_____

City:_____ State:_____ Zip_____

Home Phone (_____)_____ Work Phone (_____)_____ Cell Phone (_____)_____

Date of Birth: _____/_____/_____ Social Security Number:_____-_____-_____

Best time to contact me is:_____

☐ morning ☐ afternoon ☐ evening **at** ☐ Home ☐ Work ☐ Cell.

☐ Okay to leave voicemail? ☐ Okay to send Text? ☐ Okay to send email? ☐ Sign me up for Specials?

If Student, Name of School_____ City/State_____

Spouse or Parent's Name:_____

Employer_____ Work Phone(_____)_____

Family Doctor: _____.Group Practice Name: _____
Phone # (_____)_____ Family Doctor Address: _____

Emergency contacts:

1. _____ Phone(_____)_____

2. _____ Phone(_____)_____

Provide email & you can access your health records online securely:_____

How did you hear about us?

☐ Our Website ☐ Friend ☐ Facebook ☐ Google ☐ Bing ☐ Radio ☐ Billboard ☐ TV
☐ Walk-in ☐ Phone book ☐ Newspaper / Print ☐ Digital Advertising ☐ Different Website _____

Reason for visit including areas of concern: Please list when condition (s) started, is it better or worse now? What tests/ treatments have been done? Any Medications started? _____

_____

_____

Current diet and exercise plan: _____

What role has diet and exercise played? _____

Has your weight remained stable in the last 10 years? Y N. Max Weight = _____ Minimum Weight = _____

Please explain weight changes: _____

_____

Past Surgical History (please check all that apply & add date of surgery) □ **No Prior Surgery**

__Abdominoplasty (Tummy Tuck)
__Aortic Aneurysm
__Appendectomy
__Breast Reduction
__Breast Lift
__Breast Augmentation (implants)
__Breast Fat Transfer
__Carotid Surgery, R or L
__Cataract/Eye
__Carpal Tunnel
__Colonoscopy
__Colon surgery
__C-Section
__D & C
__Endometrial Ablation
__Facelift
__Foot Surgery
__Gallbladder
__Gastroscopy
__Gastric Bypass
__Gastric Sleeve
__Heart Bypass
__Heart Angioplasty/Stents
__Hernia
__Hip Surgery
__Hysterectomy
__Knee Surgery
__Laparoscopy, Diagnostic
__Liposuction
__Lumbar (Disc) Surgery

__Lung Surgery	__Shoulder Surgery	__Tonsillectomy
__Neck surgery	__Splenectomy (↑DVT, PE)	__Ovarian Tubal Ligation
__Pacemaker	__Stomach Surgery	__Vascular Surgery, R or L
__Prostate Surgery	__Thyroid Surgery	__Vein Surgery, R or L

__Urinary Bladder Any Other Surgeries _____

Any prior Transfusions? Y N. Any problems with anesthesia? Y N. Explain _____

Past Medical History (please **check** all that apply) (please circle **Active** for all that are currently being treated)

__Abnormal Healing`	Active	__Heart Attack	Active	__PCOS-Polycystic Ovarian	Active
__Acid Reflux (GERD)	Active	__Hepatitis	Active	__Recreational drugs	Active
__Anemia	Active	__Hernia	Active	__Scarring/Keloids	Active
__Anorexia	Active	__High Blood Pressure	Active	__Seizures	Active
__Arthritis	Active	__HIV	Active	__Shortness of breath	Active
__Asthma	Active	__Insomnia	Active	__Sinus problems	Active
__Bladder Infections	Active	__Irregular Heart	Active	__Sleep Apnea	Active
__Blood Disorder	Active	__Kidney disease	Active	__Stroke/TIA	Active
__Bronchitis	Active	__Liver Disease	Active	__Thyroid disease	Active
__Cancer	Active	__Lymphedema	Active	__TMJ syndrome	Active
__Chest pain (angina)	Active	__Malignant Hyperthermia		__Tuberculosis	Active
__Cold sores	Active	__Motion sickness	Active	__Ulcers, stomach	Active
__Dentures	Active	__Nausea/Vomiting	Active	__Varicose veins	Active
__Depression	Active	__Neuropathy	Active	__Vision Problems	Active
__Diabetes	Active	__Oxygen use	Active	Other_____	
__Fibromyalgia	Active	__Palpitations	Active	Other_____	
__Gout	Active	__Pancreatitis	Active	Other_____	

Review of Systems (Please underline or circle all that apply)

- **Constitutional:** Fever, chills, night sweats, trouble swallowing, weight loss/gain _____lbs.. Insomnia.
- **Skin:** Ulcers, Rash, Itching, Cellulitis, Melanoma, Skin Cancer, Eczema, Psoriasis
- **Eyes:** Temporary loss of vision in one eye, Blurred Vision, Cataracts, Glasses, Macular Degeneration.
- **ENT:** Dentures, Ear Problems, Hearing Aid, Nose Bleeds, Congestion, Swallowing Problems
- **Cardiac:** Chest Pain, Angina, Chest pain with exertion, Palpitations, Leg swelling, Ankle swelling, Leg pain, leg pain at rest, leg pain with activity, last stress test _____, Echocardiogram _____
- **Respiratory:** Short of breath (SOB), Wheezing, SOB when lying flat, Cough, change in voice/hoarseness.
- **GI:** Nausea, Vomiting, Diarrhea (stool per day_____), Constipation (On average, stool every day _____), Abdominal pain, Blood in stool, black stool , Heartburn, acid Reflux, Colon Polyps
- **Nutrition:** Generally I eat 'junk food'. Low or Hi carbohydrate diet. <1or >1 8oz soft drink/day, high or low <u>fiber</u> diet, high or low <u>fat</u> diet.
- **GU:** Burning when urinate, frequency, urgency, Prostate problems, Kidney disease, Genital Warts, Herpes
- **GYN:** # of Pregnancies _____, # of Births _____, # of miscarriages/abortions _____.
  Last menstrual period ___/___/_____. Painful intercourse. __Irregular, __light, __ medium __heavy menstrual periods.
  Approximate age at menopause _____. Last pelvic ____/____/_____ Last Pap smear ____/____/_____
- **Breast: Last mammogram:** ____/_____ Breast lumps: Yes No. Nipple discharge: Yes No. Bloody: Yes No. Breast infections: Yes No, Breast pain: Yes No. Breast fed: Yes No.
- **Musculoskeletal:** Pain legs/calf with walking, Sciatica, back pain, back disc disease, joint pain, neck pain.
- **Neurologic:** Dizzy, lightheaded, weak or numb one side- arm/leg/face, headache, passing out.
- **Psych:** Depression, Anxiety, Psychosis, rehab for drug or alcohol abuse, Dementia, Bipolar
- **Endocrine:** Excessive thirst or urination, Thyroid disease
- **Heme/Immune:** HIV/AIDS, Hepatitis A, B, C, easy bruising, clotting disorder, bleeding problems in past.
- **Trouble with Leg Swelling / Leg Edema?** _____
- **Any history of Radiation:** No Yes When & Where: _____
- **Any prior history of cancer?**-Explain: _____

Medications: List all medications, dosages, frequency, and include all natural supplements: _____

_____

_____

Any History of 'Panic' or 'Anxiety' attacks? Yes No Last attack? _____
Any history of Staph or MRSA infections? Yes No Last episode? _____
Any bleeding problems? Yes No
Explain: _____
Use of any Diet Pills: (phentermine) Yes No Last time: _____
Latex Allergy: Yes No Explain: _____
Xylocaine "caine" any local anesthetic Allergy: Yes No
Drug Allergies: _____
Environmental Allergies: _____
Social History: Check all that apply: Alcohol: Yes No. How much _____Tobacco/ **Smoke:** Yes No Dip ____ Chew ____ eCig ____ Cigars. How much & how long? _____
If you quit, when? _____

1. Do you understand that the use of alcohol, drug abuse, and especially tobacco, E-cig, and/or marijuana within a month prior and up to 2 months after any surgical procedure will increase your risks of wound complications including skin necrosis, poor healing, infections, and poor results? Yes No

2. Do you understand that the surgical procedure may not be done or may be done in a less aggressive fashion to potentially avoid possible complications due to tobacco /marijuana /ecig use? Yes No

3. There is no guarantee from complications? Yes No

History of Substance / Drug Abuse or Alcohol Abuse? No If Yes Explain: _____

_____

Live Alone ____. Employed ____. Disabled ____. Retired ____. Student ____. Homemaker ____. Married ____. Divorced ____. Widowed ____. Single never married____.

Family History: Please specify which family member (s): □ Cancer □ Bleeding Disorder □ Diabetes □ Hypertensions □ Heart Problems □ Aneurysm □ Stroke □ Varicose Veins Explain: _____

_____

Other Information by Patient _____

_____

Patient Signature: _____ Date: _____/_____/_____

Physician Reviewed- Signature: _____ Date: _____/_____/_____

Appalachian Surgery & Vein, Mountain Family Medicine, and Caudle Cosmetic Surgery, Wellness, & Medical Spa

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, this is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered will be determined by submission to arbitration as provided by Tennessee law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceeding. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s), of the patient in relation to all claims, including loss of consortium. This agreement is intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptor ship interns who now or in the future treat the patient while employed by, working or associated with or serving as back-up for the health care provider including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within 30 days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties with in thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here _____. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this Arbitration Agreement.

By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient's Signature & Date: _____ _____/_____/_____

OFFICE USE ONLY

Employee's Signature & Date: _____ _____/_____/_____