Southern Surgical Specialists, LLC

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

I,____,hereby authorize Southern Surgical Specialists, LLC to use and or disclose my health information which specifically identifies me of which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, the physician can refuse to treat me.

I have been informed that Southern Surgical Specialists, LLC has prepared a notice ("Notice") which more full describes the uses and disclosures that can be made of my individually identifiable health information for treatment payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Southern Surgical Specialists, LLC, in writing, but if I revoke my consent, such a revocation will not affect any actions that Southern Surgical Specialists, LLC took before receiving the revocation.

I understand that Southern Surgical Specialists, LLC has the right to change his/her privacy practices and that I can obtain such a changed notice upon request

I understand that I have the right to request that Southern Surgical Specialists, LLC restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Southern Surgical Specialists, LLC does not have to agree with such restrictions, but once such restrictions are agreed to, it must adhere to such restrictions.

____ ________________________

Signature of patient or patient's representative **Date**

(Form MUST be completed before signing.)

________ *Please initial here if you would like to give us permission to speak with someone in your household regarding your care or account status.*

List of person(s): ____

ACKNOWLEDGEMENT OF FINANCIAL POLICY

Please understand that insurance is considered a method of reimbursing the patient for fees paid to a doctor and is not a substitute for payment. It is your responsibility to pay any deductible co-insurance or any other balance not paid by your health plan. For medicare patients, this represents any unmet deductible and the 20% of the allowed amount.

All payments are due at the time of service. All patient-due amounts must be paid within 30 days. If this creates financial hardship for you, please contact our business office. In no case can we extend payments past (4) four months. All past-due accounts are placed with an outside agency for collection.

Checks returned for non-sufficient funds must be paid within five (5) business days from the time we notify you. Uncollected NSF checks are placed with the sheriff's office for collection.

____ ________________________

Signature of patient or patient's representative **Date**

(Form MUST be completed before signing.)

To Be Completed If Patient Is Unable To Sign

____ ________________________

Printed name of patient or patients representative **Relationship to patient**

Patient Information Record

(Please Print)

Physician:____________________________

Patient Information

Patient Name: ______________________________ Marital Status: _______________ Date of Birth: ___ / ___/_____Sex: _______

Full Address: ____
(Street) (City) (State) (Zip)

Home Phone: ________________Social Security No.:__________________________ Driver's License No.: ___________________

Employer: _________________________________ Address: ____
(Street) (City) (State) (Zip)

Occupation: ________________________________

Work Phone: ________________________________ Referring Physician: ____

Spouse Name:______________________________ Spouse's Employer: ____

Spouse's Employer Address:____ Phone: _____________________________
(Street) (City) (State) (Zip)

Emergency Contact:__________________________ Phone: ____

Responsible Party Information (if other than patient)

Were you hurt working? ❑ YES ❑ NO

Person Responsible for Payment: _____________________________Relationship:__________________ Phone: _______________

Full Address: ____ Home Phone: ________________________
(Street) (City) (State) (Zip)

Insurance Information

Primary: ___________________________________ Claims Address:____
(Street) (City) (State) (Zip)

Insured/Member: ____________________________ Relationship_________________ Date of Birth: ___ / ___/_____Sex: _______

Employer: _________________________________ Group No.: _________________ Policy/Member No.: ___________________

Secondary 1: ______________________________ Claims Address:____
(Street) (City) (State) (Zip)

Insured/Member: ____________________________ Relationship_________________ Date of Birth: ___ / ___/_____Sex: _______

Employer: _________________________________ Group No.: _________________ Policy/Member No.: ___________________

Secondary 2: ______________________________ Claims Address:____
(Street) (City) (State) (Zip)

Insured/Member: ____________________________ Relationship_________________ Date of Birth: ___ / ___/_____Sex: _______

Employer: _________________________________ Group No.: _________________ Policy/Member No.: ___________________

Billing Notice and Release of Information

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your healthplan. For Medicare patients, this represents any unmet deductible and 20% of the allowed amount.

I authorize the release of any information to my healthplan and payment directly to my physician for services rendered. For Medicare patients, I request that payment of authorized Medicare benefits be made on my behalf to Southern Surgical Specialists, LLC for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits or the benefits payable for related services.

______________________________________ ______________________________________
Date Patient Signature