Southern Surgical Associates, P.C.

PATIENT INFORMATION

PATIENT'S NAME (LAST, FIRST, MI)_____

SOCIAL SECURITY_____ BIRTHDATE_____ SEX ☐M ☐F MARITAL STATUS_____

STREET ADDRESS_____ APT#_____

CITY_____ STATE_____ ZIP_____ COUNTY _____

HOME PHONE#_____ CELL PHONE# _____

EMPLOYER NAME_____ PHONE# _____

ADDRESS_____ CITY, ST, ZIP_____

SPOUSE NAME_____ BIRTHDATE_____

SPOUSE EMPLOYER_____ WORK PHONE _____

*REASON FOR VISIT_____ REFERRING PHYSICIAN _____

WHO DO WE NOTIFY IN CASE OF EMERGENCY? NAME_____

HOME_____ CELL_____ WK_____

RELATIONSHIP TO PATIENT_____

INSURANCE INFORMATION (IF OTHER THAN PATIENT)

NAME OF INSURANCE COMPANY_____

POLICY HOLDER (FIRST & LAST NAME) _____

SOCIAL SECURITY#_____ BIRTHDATE_____

HOME PHONE#_____ WORK#_____ CELL# _____

I ATTEST THAT ALL OF THE INFORMATION PROVIDED ABOVE IS ACCURATE AND I UNDERSTAND THAT PROVIDING FALSE INFORMATION IS A CRIME.

I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO SSA, PC FOR SERVICES RENDERED.

I PERMIT A COPY OF MY DATED SIGNATURE TO BE USED AS AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS NECESSARY TO PROCESS ANY CLAIM FOR PROFESSIONAL SERVICES RENDERED.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED TO ME (THE PATIENT), INCLUDING THE BALANCE AFTER PAYMENT OF INSURANCE BENEFITS.

I UNDERSTAND THAT IF MY INSURANCE COMPANY HAS NOT PAID WITHIN 60 DAYS FROM THE DATE OF SERVICE I WILL BE BILLED.

IF MY ACCOUNT IS TURNED OVER TO COLLECTIONS, I WILL BE RESPONSIBLE FOR ALL COSTS AND FEES ASSOCIATED WITH THE COLLECTION OF MY ACCOUNT.

PATIENT'S SIGNATURE_____ DATE_____

GUARDIAN'S SIGNATURE_____ DATE_____
(IF PATIENT IS UNDER 18)

Southern Surgical Associates, P.C.

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I, _____ have been informed that a copy of the Notice of Privacy Practices is posted in the waiting room and that a copy will be furnished to me upon my request.

Signature of Patient _____ Date _____

HIPAA is an acronym for the Health Insurance Portability and Accountability Act of 1996 (a federal law). Of significant concern to healthcare providers is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Privacy regulations over disclosure and use of health information.
- Security regulations over protection of electronic health information.
- Security regulations over electronic transmission of health information.
- Unique Identifiers for health plans, providers, individuals, and employers.

We do not to release confidential information by telephone, voicemail, cell phone, fax or mail.

We do not respond to answering machines if the name and telephone number are not identified.

Information will not be given to unauthorized individuals.

I authorize SSA, PC to release medical information pertaining to my care by the following methods and I assume responsibility to provide updates.

	(PLEASE SELECT)			(PLEASE SELECT)	
HOME TELEPHONE:	☐ YES	☐ NO	FAX:	☐ YES	☐ NO
ANSWERING MACHINE:	☐ YES	☐ NO	CELL PHONE:	☐ YES	☐ NO
MAIL:	☐ YES	☐ NO			

MY CARE MAY BE DISCUSSED WITH THE FOLLOWING INDIVIDUALS:		
	(PLEASE SELECT)	
SPOUSE:	☐ YES	☐ NO
RELATIVE:	☐ YES	☐ NO
OTHER:	☐ YES	☐ NO

SIGNATURE OF PATIENT / GUARDIAN _____ DATE _____

Southern Surgical Associates, P.C.

PATIENT PAYMENT AND REFERRAL RESPONSIBILITES

PAYMENTS, CO-PAYMENTS, DEDUCTIBLES, CO-INSURANCE AND REFERRALS

Office visits, co-payments, and deductibles are to be paid at the time of service.

Referrals are to be received prior to or at time of service.

Co-insurance, deductibles, and professional fees are to be paid prior to surgery.

SOUTHERN SURGICAL ASSOCIATES, P.C. SENDS STATEMENTS VIA EMAIL AND TEXT MESSAGE.

Please check your email and accept the invitation to sign up for the patient portal.

EMAIL ADDRESS _____

SIGNATURE _____ DATE_____

Southern Surgical Associates, P.C.

PAST MEDICAL HISTORY

NAME _____ D.O.B. _____

HEIGHT / WEIGHT _____ PLACE OF BIRTH _____

PRESENT COMPLAINT _____

SURGICAL PROCEDURES:

ILLNESSES:

MEDICATIONS:

ALLERGIES:

	PLEASE SELECT	
HAVE YOU TAKEN CORTISONE?	☐ YES	☐ NO
HAVE YOU HAD A BLOOD TRANSFUSION?	☐ YES	☐ NO
DO YOU CURRENTLY USE TOBACCO?	☐ YES	☐ NO
HAVE YOU USED TOBACCO IN THE PAST?	☐ YES	☐ NO
DO YOU DRINK ALCOHOLIC BEVERAGES?	☐ YES	☐ NO
DO YOU DRINK COFFEE?	☐ YES	☐ NO