SURGICAL ASSOCIATES
of Cleveland, P.C.
General and Vascular Surgery
Vein Treatment Center

2253 Chambliss Ave. NW, Suite 100
P.O. Box 3295
Cleveland, TN 37320-3295
Office (423) 472-5423 • Fax (423) 476-5523

Patient's Name _____ Social Security # _____

Address _____ Date of Birth _____ Age _____

City _____ State _____ Zip _____

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

Email _____ Spouse's Name & DOB _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Life Partner

Who referred you to our office? _____ Who is your family doctor? _____

Pharmacy Name & Location _____

Patient's Employer _____ City _____ State ____ Zip _____

Next three items are requested by the government for reporting purposes:

Language Best Served In: ❑ English ❑ Spanish ❑ Other

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander ❑ White

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino

Emergency Contacts Name _____ Relationship _____ Home or Cell _____ Work _____

❑ Child * - please give both parent's names, cell #s, and employers

Father's Name _____ Cell# _____ Employer _____

Social Security # _____ Date of Birth _____

Mother's Name _____ Cell # _____ Employer _____

Social Security # _____ Date of Birth _____

* Divorced Parents, we are not bound by your divorce decree. Financial responsibility is with you.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

INITIAL I authorize treatment of the person named above and agree to pay all fees for such charges. I agree to pay promptly and according to the arrangements set by both myself and this office. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims unless agreed by both myself and this office. **I agree to a collection fee if my account is placed for collection because of non-payment. The collection fee could be 20% of the balance owed or higher if court costs are involved. Co-pays not paid at time of service will incur a $10.00 billing charge.**

INITIAL **MEDICAL RECORDS RELEASE:** I authorize the release of any medical information necessary to process any and all claims on my behalf. I request payment of any medical benefits (including Medigap) be made to the physicians or suppliers for services given. I also authorize the mailing or faxing of any pertinent records to my referring physician, primary care physician and any other party deemed necessary by my physician in treating me.

INITIAL **HIPAA:** I have had the opportunity to read a Notice of Privacy Practices for Protected Health Information and have been given a privacy number for accessing my medical information from Surgical Associates of Cleveland.

MEDICARE PATIENTS:

INITIAL I request that payment of authorized Medicare benefits be made either to me or on my behalf to Surgical Associates of Cleveland, P.C. for any services furnished to 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 needed to determine these benefits or the benefits payable for related services.

INITIAL **APPOINTMENT REMINDERS:** As a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls that may be place using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

INITIAL **COLLECTIONS AND PHONE CALLS:** I, the above named patient, acknowledge and agree that if my account is placed for collection I may be contacted by my phone numbers listed in my patient information. I also know that I may be called by a dialing service or prerecorded message. I will also keep Surgical Associates updated should my address or phone number changes.

_____ / _____
Signature: Patient/Parent/Guardian Date