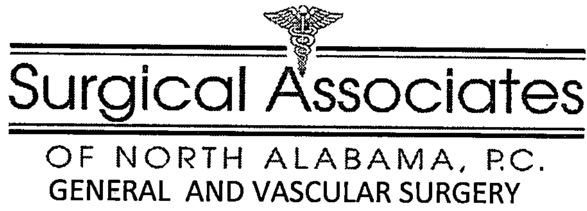

OF NORTH ALABAMA, P.C.
GENERAL AND VASCULAR SURGERY

FOR OFFICE USE ONLY

Chart # ____________

Dr ________________

PATIENT INFORMATION

Date: ________________

Patient's Name: ____
First Middle Maiden Last

Phone No: ______________

Mailing Address: ____

Cell No: ______________

Street Address: ____

Work No: ______________

City, State & Zip: ____

Male: _____ Female: ________

Email: ____

Marital Status: S__ M__ D__ W_

Patient's Employer: ____
(If self employed, state company name or type of business)

Date of Birth__________Age___

Referring Physician: ____

SS No:________________

Race ________________ Ethnicity:☐ Non Hispanic ☐ Hispanic

Language ________________

Other than Spouse
Emergency Contact ________________ Relationship ________________ Phone No ________________

Parent/Guardian if Patient is a Minor: ______________________________ Relationship ________________

Address (if different from above): ____

Spouses Name: ____ Date of Birth: ________________

Spouses Employer: ________________________ Work No:________________ SS No: ________________

Present Your Insurance Card to the Receptionist

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Surgical Associates of North Alabama, P.C. to release or request any medical information from or to another physician or medical institution as necessary for my medical care or for insurance filing purpose.

Date ____________________ Signature______________________________________
PATIENT/GUARDIAN

ASSIGNMENT OF BENEFITS, AGREEMENT, AND GUARANTY:

I/we hereby authorize payment by an insurer directly to Surgical Associates of North Alabama, P.C. for all benefits payable under the terms of any insurance policy for this period of illness. I/we understand that the insurance contract may not cover all charges for medical services, and further understand and agree that I/we are responsible for all charges not covered by the insurance contract. Further, I/we agree to pay reasonable fees if the debt is referred for collection. Any person signing the agreement as "Guarantor" unconditionally agrees to fully pay any charges (and, if appropriate, attorney's fees) owed by the above named patient and remaining unpaid over thirty days after services are rendered by Surgical Associates of North Alabama, P.C.

Date____________________ Signature______________________________________
PATIENT/GUARANTOR(S)

Surgical Associates

OF NORTH ALABAMA, P.C.

Patient Contact Information Sheet

Patient Name: ____

Social Security Number: ____________________________________

Any physician staff, employee or representative of Surgical Associates of North Alabama has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications, appointments or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment. This also includes text messages sent to Surgical Associates of North Alabama physicians, orders, prescriptions, work forms and any other items that need to be picked up by someone other than myself. You do not need to list physicians.

Name	Relationship	Phone

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can revoke this form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s) it may be subject to re-disclosure by the individual(s).

I have received a privacy statement/information from this office. Yes No

In addition, how may we communicate with you? Please circle all that you approve.

Home phone Work Phone Cell phone Mail

May we leave you a message: Yes No

Patient Signature: ______________________________ Date: ____________________