SURGICAL ALLIANCE PRIVACY POLICY

AND

CONTACT INFORMATION SIGNATURE SHEET

Notice of Privacy Practices

By signing below I indicate that I have been given the opportunity to review and receive a copy of the Privacy Practice Policy of Surgical Alliance of Middle Tennessee.

Contact Information

Patient Name: _____

Email Address: _____

Home telephone # _____

- ☐ Leave message with call back information ***ONLY***.
- ☐ Okay to leave detailed message.
- ☐ Do not leave messages at this number.

Work telephone # _____

- ☐ Leave message with call back information ***ONLY***.
- ☐ Okay to leave detailed message.
- ☐ Do not leave messages at this number.

Cell telephone # _____

- ☐ Leave message with call back information ***ONLY***.
- ☐ Okay to leave detailed message by voice or text.
- ☐ Do not leave messages at this number.

Written communication

- ☐ Okay to mail sensitive information to my house.
- ☐ Okay to E-mail sensitive information.
- ☐ Send all written communications to my P. O. Box.

Disclosing your health information to other individuals:

- ☐ DO NOT release any information to anyone except me. (This includes your spouse, parent, etc.)
- ☐ You have my permission to disclose information to the following person(s):

_____ _____

_____ _____

Patient/Guardian Signature: _____ Date: _____

Surgical Alliance of Middle Tennessee

PATIENT INFORMATION

NAME _____ DATE _____

ADDRESS _____ CITY _____ STATE ____ ZIP_____

DATE OF BIRTH _____ AGE _____ GENDER M / F MARITAL STATUS ____

SSN _____ HOME PHONE _____ CELL PHONE_____

EMAIL ADDRESS _____

REFERRING PHYSICIAN _____ PHONE _____

PERSON RESPONSIBLE FOR ACCOUNT _____

EMPLOYER _____ WORK PHONE _____

NEAREST RELATIVE _____ RELATIVE'S PHONE _____

DO YOU HAVE A LIVING WILL? _____ PHARMACY/ PHONE# _____

INSURANCE INFORMATION

DO YOU HAVE INSURANCE COVERAGE YES NO ***SPECIALIST*** CO-PAY AMOUNT_____

PRIMARY INS _____ INSURED'S NAME_____

POLICY HOLDER _____ DOB _____ SSN _____

POLICY HOLDERS ADDRESS (if different than above) _____

CITY _____ STATE____ ZIP _____ PHONE _____

INSURANCE ID # _____ GROUP _____

SECONDARY INS _____ INSURED'S NAME_____

POLICY HOLDER _____ DOB _____ SSN _____

POLICY HOLDERS ADDRESS (if different than above) _____

CITY _____ STATE____ ZIP _____ PHONE _____

INSURANCE ID # _____ GROUP _____

BY SIGNING BELOW, I AGREE TO ALLOW SURGICAL ALLIANCE OF MIDDLE TENNESSEE TO RELEASE ANY INFORMATION TO MY INSURANCE CARRIER TO FILE MY INSURANCE. I ALSO AGREE TO PAY MY CO-PAYMENTS AND ALL AMOUNTS APPLIED TO DEDUCTIBLE/ COINSURANCE. IF MY ACCOUNT IS SENT TO COLLECTIONS, I ALSO AGREE TO PAY FOR COLLECTION CHARGES AND ASSOCIATED FEES INCLUDING ATTORNEY AND COLLECTION AGENCY FEES.

PATIENT SIGNATURE _____ DATE_____

What Pharmacy do you use: _____ Pharmacy Phone # _____

Who is your primary care physician? _____ Who referred you to see us? _____

Please list **ALL** (Both prescription and OTC) medications, supplements, herbals, vitamins:

Name of Medication	Dosage	How often

Allergies: Please check all that apply

○ None ○ Codeine ○ Penicillin ○ Morphine ○ Novocaine ○ Iodine ○ Latex ○ Adhesive/Tape

○ Demerol ○ Sulfa ○ Aspirin ○ Local Anesthetics ○ Seafood ○ Foods _____

○ Other _____

Please list **ALL** surgeries:

_____

_____

_____

_____

Surgical Alliance of Middle TN

Name: _____ **Date of Birth:** _____

Reason For Visit

What is the reason for your visit today? _____

When did you first notice this problem? _____

Location of problem? _____

Is the problem painful? oYes oNo If so, what is the intensity? 0 being no pain: 0 1 2 3 4 5 6 7 8 9 10

Is the pain: o Sharp o Dull o Constant o Intermittent

Does it interfere with regular activities? o Yes o No

What makes it worse? _____

What makes it better? _____

Have you had this problem before? o Yes o No When? _____

If so, did you receive treatment? o Yes o No What physician did you see? _____

Do you have any dizziness or fainting spells in the last year? o Yes o No

Do you experience leg pain, aching or swelling? o Yes o No

Have you ever had shortness of breath or chest pain that was unexplained? o Yes o No

Social History

Do you smoke? o Yes o No How many packs per day? _____

Do you drink alcohol? o Yes o No How much per day? _____

Do you use street drugs? o Yes o No What kind and how often? _____

Past Medical History

Do you have or have you ever had any of the following:

o High Blood Pressure	o Heart Failure	o Heart Attack	o Stroke
o Thyroid Problems	o Diabetes	o HIV	o Hepatitis
o DVT/ PE	o Emphysema/COPD/Asthma		o Arthritis
o Hemorrhoids	o Painful or frequent Urination		o Joint or back pain
o Kidney Disease/Failure	o Cancer: What type?_____		o Prostate Problems

o Other medical problems_____