



Patient Information

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ SSN _____

Marital Status _____ Home Phone _____ Cell Phone _____

Primary Care Physician _____ Phone _____

Referring Physician _____ Phone _____

Person Responsible for Account _____

Employer _____ Phone _____

Emergency Contact _____ Phone _____

Pharmacy _____ Phone _____

Insurance Information

Primary Insurance Name _____

Member/Subscriber ID# _____

Policy Holder Name _____

Date of Birth _____ Policy Holder SSN _____

Secondary Insurance Name _____

Member/Subscriber ID# _____

Policy Holder Name _____

Date of Birth _____ Policy Holder SSN _____

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 _____



Authorization to Release Medical Records

Print Patient's Name _____ Social Security Number _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

I request and authorize: Surgical Alliance of Middle Tennessee, PLC
417 NorthCrest Drive
Springfield, TN 37172
Phone: (615) 384-8211
Fax: (615) 384-5859

To Provide to: To Receive from:

Name: _____

Address: _____

Phone: _____ Fax: _____

For the purpose of: Continued medical care Moving Personal use

Method of Delivery: Fax Mail Hold for pick up

Records Requested:

- All available records History and Physicals Medical Imaging
- Operative Reports Hospital Admissions Pathology Reports
- Laboratory Results Other _____

Patient Signature

Date



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 the Surgical Alliance of Middle Tennessee.

Contact Information

Please check all that apply

Home Phone _____

- Leave message with call back information only.
- Okay to leave detailed message.
- Do not contact me at this number.
- Do not leave messages at this number.

Work Phone _____

- Leave message with call back information only.
- Okay to leave detailed message.
- Do not contact me at work.
- Do not messages at the number.

Cell Phone _____

- Leave message with call back information only.
- Okay to leave detailed message.
- Do not contact me on my cell phone.
- Do not leave messages at this number.

Written communication

- Okay to mail sensitive information to my home address.
- Send all written communications to P.O. Box.

Disclosing your health information to other individuals:

- Do not release any information to anyone except me.
- You have my permission to disclose information to the following person(s):

Print Patient Name

Patient/Guardian Signature

Date

Past Medical History: check all the apply

ENDOCRINE

- Diabetes
- Thyroid Disease

CARDIOVASCULAR

- High Blood Pressure
- High Cholesterol
- Congestive Heart Failure
- Coronary Artery Disease
- Ankle Swelling
- Heart Attack (Year ___)
- Deep Vein Thrombosis
- Pulmonary Embolism
- Aneurysm
- Peripheral Vein Disease
- Peripheral Arterial Disease

PULMONARY

- Asthma
- COPD
- Pneumonia
- Sleep Apnea
- CPAP
- Oxygen

GASTROINTESTINAL

- Diverticulitis/Diverticulosis
- GERD (Heartburn)
- Crohn's Disease
- Colitis
- Hiatal Hernia
- Irritable Bowel Disease
- Gastroparesis
- Ulcer
- Difficulty Swallowing

HEPATIC

- Cirrhosis
- Hepatitis A/B/C
- Fatty Liver

UROLOGIC

- Dialysis
- Kidney Disease
- Prostate Disorder

MUSCULOSKELETAL

- Arthritis
- Gout
- Fibromyalgia
- Chronic Back Pain
- Chronic Neck Pain

IMPLANTS

- Medicine Pump
- Other (List)

NEUROVASCULAR

- Neuropathy
- Stroke
- Migraine
- Seizure

HEMATOLOGY

- Clotting Disorder
- Anemia
- Blood Thinner
- Blood Transfusion

CANCER

- Breast
- Thyroid
- Lung
- Colon
- Blood
- Lymph Node
- Prostate
- Ovarian/Uterine
- Radiation Therapy

PSYCHIATRIC

- Depression
- Anxiety
- PTSD
- Dementia

AUTOIMMUNE

- Multiple Sclerosis
- Myasthenia Gravis
- Lupus

INFECTIOUS DISEASE

- HIV/AIDS
- MRSA
- VRE
- Tuberculosis

EARS/NOSE/THROAT

- Sinus Problem
- Blurred Vision/Loss
- Cataracts
- Hearing Loss
- Hoarseness

ANESTHESIA

- Difficult Airway
- Life Threatening

Anesthesia Problem Self/Family

Surgical history: Please add date to surgery

CARDIOVASCULAR

- Aneurysm Repair (AAA)
- Coronary Bypass (CABG)
- Cardiac Stent
- Peripheral Stent
- Fem/Pop Bypass
- Carotid
- Dialysis Access
- Pacemaker/Defibrillator

BREAST

- Mastectomy
- Lumpectomy
- Biopsy

ABDOMINAL

- Appendectomy
- Gallbladder
- Splenectomy
- Colon Resection
- Bariatric
- Ostomy
- Laparoscopy
- Kidney

GYN

- Hysterectomy
- C-section
- Tubal Ligation

HERNIA

- Inguinal R/L
- Abdominal
- Hiatal
- Umbilical

ENDOCRINE

- Thyroid
- Adrenal
- Parathyroid

ENT

- Sinus

MUSCULOSKELETAL

- Spine
- Joint Knee/Shoulder



Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of Surgical Alliance. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. Your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Surgical Alliance Of Middle Tennessee Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may access your personal medical records by logging into the patient portal. In addition, you may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our office. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Contact/Complaints

The name and address of the person you can contact for further information or to file a complaint concerning our privacy practices is:

Practice Manager
Surgical Alliance of Middle Tennessee
417 NorthCrest Dr.
Springfield, TN 37172
Phone: 615-384-8211

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date

This notice is effective on or after **January 1, 2023**.