Southern Specialty Physicians
Vascular Surgery

I hereby authorize Southern Specialty Physicians to obtain the following records for further work up and treatment.

_____ Complete Medical Records

_____ Hospital Records

_____ Procedure Reports

_____ Imaging Study Reports

_____ Graft Scan Reports

_____ Other _____

Patient name:_____ Date of Birth:_____

Patient Signature:_____

Please fax record to (833) 963-2439.

7085 Sydney Curve, Montgomery, AL 36117 Telephone: (334) 246-4774 Fax: (833) 963-2439 www.southern-vascular.com

Southern Specialty Physicians

Patient Responsibilities

As a medical practice, our goal is to provide you with the best possible medical care. As a small business, we strive to be patient friendly and cost effective. This payment policy represents our effort in this area

Personal Information

For the protection of our patients, to reduce medical identity theft, all patients are required to present valid insurance card and driver's license (or valid photo id) at every visit. The patient is responsible to make sure that SSP has their updated address, phone, and email information.

Payments Due at Time of Service

We bill participating insurance companies as a courtesy to you. It is the patient's responsibility that all insurance information is correct and is given at the time of service. Please remember that insurance is a contract between you and the insurance. All co-payments and deductibles are set by your insurance company and are due at time of service. If your insurance company does not pay the practice within a reasonable period, you will be billed. SSP is not responsible for collecting insurance information after the date of service.

Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. If you are unsure, contact your insurance company to go over your benefits.

Methods of Payment

Credit cards (VISA, Mastercard, AMEX, Discover), Cash and Checks are accepted. For returned checks, a $35.00 insufficient fund fee will be charged to your account and due prior to visit.

Private Pay

Non-Insured Patients/Self-Pay patients of Southern Specialty Physicians, LLC, requires full payment at the time of service unless prior arrangements have been made with our billing department. Billing department number is 334-373-1677.

Scheduled Appointments

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. A 48-hour notice must be given for a cancelled appointment. A missed or cancelled appointment without notice may be subject to the following fees.

Office Visits: $25
Ultrasound and Other Office Testing: $100
Vein Procedures: $150
Office Based Procedures: $250

Additionally, arriving 15 minutes late may result into a rescheduled appointment. Excessive abuse of scheduled appointments may result in discharge from the practice.

Authorization To Release Medical Records

I authorize Southern Specialty Physicians, LLC (SSP) to release all medical records and pertinent medical information to any insurer, governmental agencies providing benefits, or to anyone liable for charges. I also authorize release of said information to my referring physician and to other medical providers who are or may become involved in my treatment.

Prior Consent to Contact By Phone/Cell Phone

I , the undersigned, give SSP its employees and/or agents consent to contact me by telephone at any number associated with my account, including wireless telephone numbers, which could result in charges to me, for the purpose of treatment, insurance and/or payment. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I authorize messages to be left on my answering machine and/or voicemail.

Consent for Photography

I consent for medical photographs to be taken during my visit. By consenting to these medical photographers, I understand that I will not receive payment from any party. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. (Please initial indicating YES or NO below)

_____ YES _____ NO For use in my medical record.
_____ YES _____ NO For use on our website.
_____ YES _____ NO For demonstration purpose.
_____ YES _____ NO In advertisements and/or professional journals.

I have read the above payment policy and understand my financial responsibility to Southern Specialty Physicians, LLC. If I have additional questions, I understand that I may speak with a billing representative prior to my appointment. I hereby authorize and direct Southern Specialty Physicians, LLC, to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment. I authorize and direct my insurance carrier(s), including Medicare, Medicaid, Tricare, private insurance and any other health/medical plan, to issue payment check(s) directly to Southern Specialty Physicians for medical services to myself and/or my dependents regardless of my insurance benefits, if any.

By signing this form below, I confirm that above information has been explained to me in terms which I understand.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY_____

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY_____

DATE_____