Southern Specialty Physicians
Vascular Surgery

Patient Registration Form

Patient Information

Patient Information:			
Last Name:	First Name: M.I.:		Previous Name (if applicable)
Mailing Address: Apt #			
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐ Voice ☐ Text		If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work	
Family Physician:	Date of Birth:	Sex: ☐ Male ☐ Female ☐ Transgender	
Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Other _____	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:	Relationship to Patient:		

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:		
Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	
Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):		
Email Address:		
Race (please select): ☐ African American/Black ☐ American Indian/ Alaska Native ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	Dialysis Clinic: _____ Treatment Days: _____ Cardiologist: _____	
Preferred Pharmacy Name & Location:		

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name/Policy Number:	Ins. Co. Name/Policy Number:
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Southern Specialty Physicians
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to the information. Please Review It Carefully.

Southern Specialty Physicians, LLC (hereafter referred to as SSP) is required by federal law to maintain the privacy of your individually identifiable health information and to provide you with notice of our legal duties and privacy practices. We will not use, release, or disclose your health information except as specifically described in this Notice of Privacy Practices, unless specifically authorized by you in writing. In providing professional medical services to you, we will create, maintain, and store your protected health information. This Privacy Notice applies to protected health information included as a part of your medical records generated by SSP.

Disclosures for Treatment, Payment and Health Operations:
The following categories describe the ways that we may use, release, and disclose your health information for treatment, payment, and health care operations *without the need* for an additional and specific signed authorization from you.

Personal Information: We store your personal information in our EMR computer system which is in compliance with HIPAA guidelines. We protect your information using physical, technical, and administrative security measures to reduce the risks of loss, misuse, unauthorized access, disclosure and alteration. Some of the safeguards we use are firewalls and data encryption, physical access controls to our data centers, and information access authorization controls.

Treatment: We will use your protected health information in the provision and coordination of your health care. For example, we may disclose all or any portion of your medical record information as part of your care and continued treatment to your attending physician, consulting physician(s), nurses, technicians, and other health care providers who have a *legitimate* need for such information.

Family/Friends: We may release protected health information about you to a friend or a family member *who is involved* in your medical care, unless you object. We may also give information to someone who helps pay for your care.

Payment: SSP may release protected health information about you for the purpose of determining coverage, billing, claims management, medical data processing, and reimbursement. For example, the information may be released to an insurance company, third party payer, or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record, which are *necessary* for the payment of your account.

Routine Healthcare Operations: SSP may use and disclose your protected health information during routine healthcare operations. These operations may include quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities, management and administration of SSP, and education purposes.

Appointment Reminders: SSP may use and disclose protected health information to contact you as a reminder that you have an appointment for treatment, medical care, or follow-up at SSP and may leave a message for you at a number that SSP has listed for you.

Health Related Business, Services, and Treatment Alternatives: SSP may use and disclose your protected health information to tell you of health-related benefits or services provided by SSP that may be of interest to you and your particular medical condition.

Regulatory Agencies: SSP may disclose your medical information to a health oversight agency for activities authorized by law including, but not limited to, licensure, certification, audits, investigations, and inspections.

Law Enforcement/Litigation: SSP may disclose your medical information to a law enforcement official for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Public Health: As required by law, SSP may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Serious Threat to Health or Safety: SSP may use and disclose protected health information when necessary to reduce or prevent a serious threat to your health and safety of another individual or the public. Disclosures will only be made to a person or organization able to prevent the threat.

Military/Veterans/National Security: SSP may disclose your medical information as required by military command authorities if you are a member of the armed forces. In addition, SSP may disclose your medical information to federal officials for intelligence and national security activities authorized by law.

Required by Law: SSP will disclose medical information about you when required to do so by law.

Coroners, Medical Examiners, and Funeral Directors: SSP may release your medical information to a coroner, medical examiner, or to funeral directors as necessary to carry out their duties.

Business Associates: SSP may use and disclose certain medical information about you to business associates of SSP. A business associate is an individual or entity under contract with SSPVM to perform or assist SSP in a function or activity, which requires the use or disclosure of medical information. The law also requires SSP to obtain reasonable, written assurances from its business associates that they will also protect the confidentiality of your medical information.

Research: SSP may use or disclose your medical information for research purposes in certain limited circumstances.

Workers Compensation: SSP may be required under law to release medical information about you for worker's compensation or similar programs.

Inmates: If you are an inmate of a correctional facility or under the custody of a law enforcement officer, SSP may release your medical record information to the correctional facility or law enforcement official.

Your Individual Rights:
You have the following rights concerning your medical information.

Right to Confidential Communications: You have the right to request that SSP communicate with you about your health and related issues in a particular manner or at a certain location. SSP will accommodate *reasonable* requests.

Right to Inspect and Copy: You have the right to inspect and copy your medical information, including patient medical records and billing information. Consistent with federal law, SSP may deny access to certain medical information most notably, psychotherapy notes. A reasonable cost-based charge for copying, labor, mailing, and supplies may be assessed. If a summary of the medical records is requested, a fee may be assessed, as well. In certain limited circumstances, SSP may deny your request to inspect and copy; however, you may request a review of your denial.

Right to Amend: You have the right to amend your medical record information if your believe it to be incorrect, inaccurate, or incomplete as long as the information is created by, kept, and maintained by or for our medical practice. You must request an amendment in writing and include the reasons supporting your request for amendment. SSP, however, may not agree to honor your request for an amendment.

Right to an Accounting: You have the right to obtain a statement or an "accounting" of SSP'S use or disclosure of your protected health information. A request for an accounting must be made in writing.

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your medical information. SSP may not agree to honor your request for restrictions; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

Right to Receive Copy of this Notice: You have the right to receive a paper copy of this Notice, upon request.

Right to Revoke Authorization: You have the right to revoke any authorization allowing SSP to use or disclose your medical information except to the extent that action has already been taken by SSP in reliance upon that authorization.

Please note that to exercise any of the privacy rights described herein, you must complete a written request and send it to Privacy Officer at Southern Specialty Physicians Vascular Surgery. SSP will carefully review each patient request and respond within thirty (30) days.

If you have problem or would like to request more information, you may contact SSP AT (334) 246-4774.

If you believe your privacy rights have been violated, you may file a complaint with SSP or with the Office of Civil Rights.

To file a complaint with SSP, please contact:
Southern Specialty Physicians Attn: Office Manager
7085 Sydney Curve
Montgomery, AL 36117

For complaints involving covered entities located in Alabama:
Region IV, Office for Civil Rights
US Department of Health and Human Services Atlanta Federal Center, Suite 3B70
61 Forsyth Street SW Atlanta, GA 30303-8909
Voice Phone: (404) 562-7886
Fax: (404) 562-7881
TDD: (404) 331-2867

All complaints must be submitted in writing.

There will be NO retaliation for filing a complaint or expressing a concern.

Changes to this Notice: SSP will abide by the terms of the Notice currently in effect. SSP reserves the right to change the terms of its Privacy Notice and to make the new Notice provisions effective for all individually identifiable health information that it maintains. SSP will provide a copy of the revised Notice via the patient's email address on file and a paper copy of the Notice will be provided to the patient during the next office appointment.

Privacy Notice Effective Date: The effective date of the Privacy Notice is October 5, 2022.

Southern Specialty Physicians Payment Policy

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 to ensure 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 may 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. Please call (334) 246-4774 to cancel or reschedule an appointment.

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 information 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.

Southern Specialty Physicians Patient Responsibility Policy

Compliance

I understand that SSP will strive to provide me with the best possible care but that it is my responsibility to participate in my healthcare by attending scheduled appointments and following through with the provider's plan. I understand that I need to promptly notify the provider if their plan of care cannot be followed. It is very important to SSP that I receive the best care possible.

Updated Information

I understand that it is my responsibility to provide SSP with up-to-date insurance information, contact information (including telephone, email, and address), medications and prescriptions, and health information (including hospitalizations, new diagnosis, changes in my health, etc.).

Authorized Representative

If I am not capable of participating in my own healthcare, an authorized representative will need to be present at all appointments.

Timely Payment

I understand that it is my responsibility to pay all payments and bills timely. I will work with a billing representative to setup a payment plan if I cannot pay my bills in full. A payment arrangement can be made for a balance of $50.00 or higher.

SSP Staff and Patients

As a patient of SSP, I understand that I and/or my caregiver need to respect all staff members and other patients I may encounter during my time of care. This includes phone calls, telehealth appointments, or other means of communication.

Dismissal

I understand that SSP cannot provide me the best care if I am not compliant with my responsibilities. Non-compliance may result in dismissal from SSP. Missed appointments without cancellation and/or rescheduling prevent SSP from providing me with the care I need and can negatively affect my health. I understand that SSP may dismiss me from the practice if I: a) do not attend one or more appointment(s) without the proper 48-hour cancellation notification and b) do not timely reschedule the appointment(s). Should SSP dismiss me from the practice, I understand that it is important to seek care with another physician. SSP will help aid in transferring my records to another provider.

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.

Consent to Contact by Phone/Cell Phone/Electronic Mail

I give SSP employees and/or SSP 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 to my photograph being taken during office visits with SSP. I understand that I will not receive any payment from any party as a result of this consent. I understand that photographs publicly disseminated by SSP will not contain identifying information such as my name; however, I also understand that it is possible that someone may recognize me.

Consent to Treatment

I consent to Southern Specialty Physicians, LLC providing me with medical consultation, evaluation, and treatment.

Southern Specialty Physicians, LLC
Patient Acknowledgments

Please **INITIAL** the following statements:

_____ Received and agree to the ***Notice of Privacy Practices***

_____ Received and agree to the ***Payment Policy*** (including broken appointment potential fees)

_____ Received and agree to the ***Patient Responsibility Policy***

_____ Received and agree to the ***Authorization to Release Medical Records***

_____ Received and agree to ***Consent to Contact by Phone/Cellphone or E-Mail*** (when applicable)

Unless we have your written permission to do so, we will not:

- Leave messages with anyone except the patient or legal guardian
- Leave information on an answering machine or voicemail

I _____ give SSP my permission to leave phone messages regarding my medical care and test results. I fully understand that this consent will remain in effect until revoked in writing.

☐ I do NOT want messages regarding my healthcare left with anyone other than the individuals authorized below.

☐ I do NOT want my information left on an answering machine or voicemail.

Received and **AGREE** to ***Consent for Photography*** (initial all that apply)

_____ For use in my medical record

_____ For use on our website

_____ For demonstration purposes

_____ In advertisements and/or professional journals

_____ I **DO NOT** agree to ***Consent for Photography***

_____ Received and agree to ***Consent for Medical Treatment***

_____ ***Consent to Release Medical Information***

My medical care may be discussed with the following:

Name _____ Relationship _____

Name _____ Relationship _____

_____ Reviewed ***Contact and Insurance Information***

Patient/Guardian Signature _____ **Date** _____

Southern Specialty Physicians
Vascular Surgery

To: _____ (Name and Address of Provider)

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.