Dear Patient,

We at Bristol Surgical Associates are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive health care available today.

In addition we are also dedicated to making top quality care as cost effective as possible. To assist you with your healthcare investment we provide the following:

***Payment Options*:**

- Cash, including money orders
- Debit and Credit Card **(3.99% service charge for any debit/credit card transaction)**
- Check **(not acceptable for surgery payments)**
- Care Credit –An interest free monthly payment plan. We also, offer an extended low interest option with no annual fees; can apply at carecredit.com online or in the office.

Please have the following available upon check in:
Otherwise appointment may be rescheduled

- **Insurance Card**
- **Co-pays and/or deductibles which are due upon check-in. This means if you have a co-insurance that will be collected day of visit**
- **Your current Medication and Allergy List**

In our efforts to reduce your waiting time patient registration information may be faxed to 423-844-6626 **Email to administrative@bristolsurgical.com** at least 48 hours in advance of appointment; please bring original copy to appointment.

If you are more than ***15 minutes late*** for an appointment (without notifying our office) you may be asked to reschedule that appointment.

We require a 24 hour notice of cancellation for appointments or a fee of $25 will be applied; insurance does not cover this and will be patient responsibility.

Our office is located at 1 Medical Park Blvd., 250 West, Bristol, TN 37620, inside Bristol Regional Medical Center; on the second floor, take a right off the elevator and our door is the only one there. If you have any questions or concerns please feel free to contact our office at 423-844-6620, Monday - Friday 9:00 a.m. to 5:00 p.m.

We look forward to seeing you at your scheduled appointment with:

Dr._____ck-in by_____on_____.

Sincerely,
Bristol Surgical Associates

PATIENT INFORMATION

Last Name: _____, First Name: _____, Middle: _____, DOB: _____

Gender: ◻ Male ◻ Female SS#: _____ Race: ◻ White ◻ African American ◻ Other

Marital Status: ◻ Divorced ◻ Married ◻ Single ◻ Widowed Ethnicity: ◻ Hispanic ◻ Non-Hispanic ◻ Other

Mailing Address: _____
City State Zip

Phone: Home: _____, Cell: _____, E-mail Address Required: _____

Pharmacy: _____City:_____State:_____Phone_____

Primary Care Physician: First/Last_____ Referring Physician: _____

Preferred Communications: ◻ Phone ◻ Text ◻ Email ◻ Portal May we leave a message: ◻ Yes ◻ No

Employer: _____, Occupation: _____, Work #:_____

Is the patient under 18 years of age? ☐Yes ◻No If yes, please fill in below:
Ins. Cardholder Name: _____ DOB: _____ SS#: _____

Worker's Compensation? ☐Yes ☐No
Date of Accident: _____Adjuster:_____

I authorize Bristol Surgical Associates to communicate my healthcare, appointment and/or billing information to the following people:

Name: _____ D.O.B.: _____ Relationship to patient: _____ Phone #: _____

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history including, symptoms, examination, test results, diagnoses, treatment, and any plans for further care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which a third party payer can verify that services billed were actually provided, and a tool for routine healthcare operation such as assessing quality and reviewing the competence of healthcare professionals.

I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE UNDERSIGNED PATIENT.

We do not assume responsibility for determining if your insurance carrier requires a second opinion. We do not assume responsibility for motor vehicle / liability claims. We are not participating providers will all insurance carriers, it is the responsibility of the patient to verify insurance participation with Bristol Surgical Associates. Payment is due upon check in; any balance 90 days or older will be subject to a 12% APR. Outstanding accounts will be turned over to collection and the undersigned will be responsible for all collection agency fees, court costs and attorney fee. Effective January 1, 2020 a 3.99% service charge will be applied to any credit card transaction and online credit card transaction will be a flat fee of $4.25.

INFORMATION RELEASE/BENEFIT ASSIGNMENT

I hereby assign and authorize payment directly to the attending physicians / surgeon for services rendered. I further authorize the release of any medical information or medical records for purposes of benefit payment. I hereby authorize Bristol Surgical Associates to obtain my credit report for the sole purpose of obtaining payment. I authorize a representative including but not limited to collection or billing companies of Bristol Surgical Associates to contact me by any and all contact information, including wireless or mobile telephone numbers listed within my medical record. I hereby give my consent to be contacted by any means including but not limited to a dialing service or pre-recorded message listed within my EHR.

The undersigned individual obligates himself to the payment of this account incurred by the patient in accordance with regular rates and terms of this office. The undersigned certifies that he has read, accepts and understands these terms.

No Show Policy for Doctor Appointment

I understand if an appointment is not cancelled at least 24 hours in advance I will be charged $25; this will not be covered by the insurance company and will be patient responsibility.

Patient's Signature: _____ ***Today's Date:*** _____

Responsible Party's Signature: _____ ***Today's Date:*** _____
(Required if patient is under the age of 18)

Patient Update Sheet

Patient Name:_____Date of Birth:_____
Reason for visit:_____:How long have you had this issue:_____
How Severe:__Mild___Moderate___Severe Location of Issue:_____
Primary Care Physician: Full Name_____

Please check if you've had the following since last seen:

__ Bleeding Problems
__ Congestive Heart Failure
__ COPD
__ CPAP
__ Echo
__ Gerd
__ Heart Attack
__ Heart Murmur
__ Hiatal Hernia
__ Sleep Apnea
__ Stress Test
__ Head/Neck Injury

Please check if any blood relative had the following:

__ Anesthesia Issues
__ Bleeding Problems

List any additional surgeries since last seen **___I deny any new surgeries**

_____ _____
_____ _____
_____ _____

Medication Information **___I deny taking medication**

List all MEDICATIONS you are currently taking including "dosage"

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you on a blood thinner (including aspirin) ___Yes **___ I deny taking a blood thinner**

Allergy Information **___I deny any allergies**

List all ALLERGIES (medication, latex, etc) and your "physical reaction"

_____ _____
_____ _____
_____ _____
_____ _____

Latex Allergy ____Yes____No Reaction:_____

Martial Status:Single Married Separated Divorced Widowed Significant Other
Alcohol Use: Never Rarely Moderate Daily, amount per week _____
Tobacco Use: Never Former Smoker Current Age Started_____, Stop_____pks per day___
Smokeless Tobacco:Never Former Smoker Current Age Started_____, Stop_____
Do you wear dentures: Yes No
Patient Signature:_____Date:_____

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