

SWAN SURGICAL CARDIAC THORACIC VASCULAR

Patient Consent Form

I, the undersigned, hereby consent to the following:

- I fully understand that this is given in advance of any specific diagnosis or treatment.
- I intend this consent to be continued in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.
- I, the undersigned, acknowledge that Swan Surgical will use and disclose my information for the purposes of treatment, payment and healthcare operations, as described in the Notice of Privacy Practices.

***TREATMENT** includes, but is not limited to: the administration and performance of all treatments; the administration of any needed anesthetics; the use of prescribed medication; the performance of procedures as may be deemed necessary or advisable in the treatment of this patient; the taking and utilization of cultures and of other medically accepted tests, all of which in the judgement of the attending physician are considered medically necessary.

***PAYMENT:** I hereby authorize payment for services I receive from Swan Surgical to be made directly to Swan Surgical. I acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided. I am financially responsible for charges not covered including, but not limited to: co-insurance, co-payments, and deductibles. I acknowledge that I am also responsible for charges not covered by my insurance plan(s) including, but not limited to: collection fees, court costs, attorney fees, and any other charges incurred by the collections agency of Swan Surgical to collect my account, and a service charge of \$25.00 for any returned check. I understand that Swan Surgical physicians may discontinue care for any patient due to non-payment or accounts sent to collections. I understand it is the policy of Swan Surgical to receive payment before or upon appointment for a patient without insurance/self pay.

***REFERRALS:** I understand that all patients having insurance requiring a referral for surgery services will be required to present the referral before services are provided. Any patient seeking service without a referral must pay for the service in advance or reschedule the appointment.

* A photocopy of this consent shall be considered as valid as the original. This authorization applies to all occasions of service until it is revoked.

Signature of Patient/Guardian

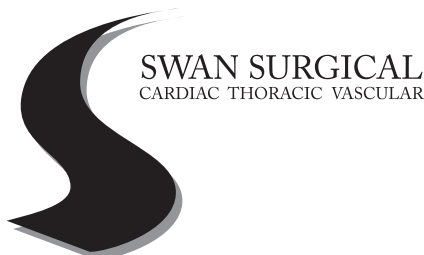
Date

HIPPA Notice of Privacy Practices Acknowledgement Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature of Patient/Guardian

Date



SWAN SURGICAL, PLLC
300 STEAM PLANT ROAD, SUITE 470
GALLATIN, TN 37066
615.206.1700 (OFFICE)
615.451.7708 (FAX)
www.swansurgical.com