James E. White MD, FACS
Vincent W. Gardner, MD, FACS
Toni B. Ryan, NP-C
Casi White, RDMS

Hamilton Office Park
7446 Shallowford Rd, Suite 205
Chattanooga, TN 37421

423-648-4011 Fax: 423-648-4014

www.advsurgical.com

PLEASE COMPLETE IN BLUE/BLACK INK ONLY – DO NOT USE PENCIL

Patient Name: _____ Date of Birth: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work: _____ Mobile #: _____

Email: _____ (by providing my email address, I agree to receive promotional offers.)

Marital Status: S M D W Sex: M F Social Security: _____

Place of Employment: _____ Occupation: _____

Emergency Contact:_____ Relationship: _____

Emergency Contact Phone: _____

Insurance Guarantor:

Guarantor Name: _____

Guarantor DOB: _____ Guarantor Social Security: _____

Physicians List: Please provide First and Last Name:

Primary Care Physician: _____ Other Physicians: _____

Pharmacy: _____ Location: _____

Allergies: _____

How did you hear about our office: Internet TV Print Friend Relative MD: _____

Consent to Treatment:

I authorize Advanced Surgical Concepts, PLLC; James E. White, MD, Vincent W. Gardner, MD and Toni Ryan, FNP, to administer medical care through visits, testing, lab work, and other surgical procedures.

_____ _____

Patient/Guardian Signature Date

PATIENT HISTORY FORM

Today's Date: _____

Name: _____ Date of Birth:_____

PAST MEDICAL HISTORY: Do you have, or have you had in the past, any of the following conditions: (please circle)

Anxiety	Heart Disease	Lung Disease	
Hepatitis	Seizure Disorder	Rheumatoid Arthritis	Asthma
Blood Pressure	Diabetes	Depression	Stroke High
Thyroid Disease	Kidney Disease	High Cholesterol	GERD
Osteoporosis	STD	Tuberculosis	Heart Attack
Varicose Veins	Chronic Pain-Where: _____	AIDS/HIV	
Cancer- type_____		Other: _____	

Please list any prior injuries and the date of injury:_____

_____

SURGICAL HISTORY: Please list any surgeries you have had with the dates performed:

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Social History:

Do You or have you ever smoked tobacco or used smokeless tobacco? Y N

If yes,? _____ packs/day? How long? _____ Date Stopped: _____

Drink alcohol? Y N If yes, how much? _____

Use any recreational or "street drugs": Y N

ALLERGIES: Have you ever had a reaction to any medication, food, Latex, etc? Please list allergy and reaction: _____

_____

Name: _____ Date of Birth:_____

MEDICATIONS: Please list any prescription or over the counter medications you take (including vitamins and herbs) and the dose:

Medication	Dosage	Frequency Taken	Taken for	Prescribed By

FAMILY HISTORY: Please list any medical conditions family members may have. If deceased, date of death and cause of death. (Are there any illnesses such as cancer, diabetes, heart disease, depression, high cholesterol, Inflammatory Bowel Disease, Lung disease or Varicose Veins)

Relation	Age	Medical History
Mother		
Father		
Siblings		
Siblings		
Grandparents		

Are you Adopted: Y N

Patient Signature: _____

Name: _____ **Date:** _____

Venous Questionnaire

1. Are you consulting for:		Cosmetic purposes		Medical purposes
2. How many years have you had this problem?				
3. When did your problem veins occur?				
Age		Before Pregnancy		
After trauma / injury		During pregnancy		
After estrogen therapy		After birth control		
Other				
4. Have you ever been treated for this problem?				
If so, by whom and when?				
If so, with what method?				
Injection?		Laser (type)?		
Electrocautery?		Surgery		
5. Do you have a **family history** of:		If so, please list family member		
a. Varicose veins				
b. Blood Clots				
c. Leg Ulcers				
6. Have **you** been treated for the following?				
a. Phlebitis (red, hot, hard inflammation of the vein)				
If so, which leg				
Were you hospitalized?				
b. Leg ulcer				
If so, which leg?				
Were you hospitalized?				
c. Deep venous thrombosis (blood clot in leg)				
If so, which leg?				
Were you hospitalized?				
7. If you are currently taking or have you ever taken blood thinning medications, please list:				
8. Have you ever worn compression stockings?				
If so, what length?				
If so, what strength?				

Name: _____ **Date:** _____

9. Do you ever have the following leg symptoms:

Swelling		Resting pain		Cramping	
Cramping at night		Aching		Throbbing	
Itching		Burning		Stinging	
Tiredness		Heaviness		Numbness	
Restlessness		Warm to touch feeling		Other	

10. Are symptoms worsened by:

Prolonged standing		Prolonged sitting		Prolonged walking	
Heat		Menstrual periods		Other	

11. Are symptoms relieved by:

Elevation of the legs		Walking or exercising		Compression stocking	
Support hose		Medication		Other	

12. Occupation:	
13. Does your work require:	

Prolonged standing		Prolonged sitting	

14. Are you developing new varicose veins?	
15. Are your current varicose veins getting larger?	
16. Do you exercise on a regular basis?	
If so what type of exercise?	
How many days per week and for how long?	
17. Do your symptoms keep you from falling asleep?	
18. Do your symptoms awaken you from sleep?	
19. Other Information:	

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NOTICE OF PRIVACY ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act Of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1) Conduct, plan, and direct my treatment and follow-up among the multiple Healthcare providers who may be involved in that treatment directly and indirectly.

2) Obtain payment from third party payers.

3) Conduct normal healthcare operations such as quality assessments and physician Certifications.

I have received, read and understand that **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices.**

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Patient/Guarantor's Signature: _____ Date: _____

Please list the name and relationship of anyone with whom you authorize us to discuss your care. If no one is listed, you will be the **ONLY** person with access to information regarding you or your account.

Name: _____ Name: _____

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NO SHOW AND CANCELLATION POLICY

Please understand that our appointment times are scheduled to allow us to take care of each individual patient's needs during their visit. Since appointments with Dr. White are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments.

In an effort to decrease unnecessary expenditures and to contain our fees, we have implemented a **No Show/Cancellation Policy** for all our patients. To promote access to Dr. White, we require that any appointment that is no longer needed must be cancelled more than 24 hours in advance. In the event that an appointment is missed or cancelled the same day, a $75 charge will be billed. We understand that circumstances may arise that could result in a missed appointment or canceling the same day. In those instances, please contact our office to inquire about the possibility of waiving the $75 charge. Subsequent missed or same day canceling of an appointment will result in the $75 charge being applied that must be paid before any future appointments can be made. If a third no show or same day cancellation occurs, we reserve the right to terminate the patient-doctor relationship.

Please be assured that we strive to run our office as efficiently as possible in order to provide you the best care; and that this policy is in place to help us achieve that goal. We appreciate your understanding and cooperation in this matter.

_____ _____

Patient/Guarantor Signature Date

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ADVANCED DIRECTIVES

Patient: _____ **Date:** _____

REFERENCE #1008

POLICY:

- It is the policy of this facility that patients will be informed of their rights to formulate an Advance Directive and that they are not required to have an Advance Directive in order to receive treatment at this facility.
- "Do Not Resuscitate" orders are not honored at this facility and in the event of a life-threatening situation, advanced cardiac life support will be instituted in every instance and the patient will be transported to a higher level of care.
- A healthcare power of attorney will be honored.
- If a patient should provide his/her advance directive, a copy will be placed on the patient's medical record and transferred with the patient should a hospital transfer be ordered by his/her physician.
- At all times the patient or his/her representative will be able to obtain any information they need to give informed consent before any treatment or procedure.
- For information and forms regarding Advance Directives, please visit the website: *_health.state.**tn**.us/**advancedirectives**/index.htm*

_____

Patient Signature Date

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Financial Agreement for Insured Patients:

I understand that my insurance will be filled as a courtesy and that I am responsible for any and all balances not covered by my insurance. I also understand that if my insurance has an office Co-payment, that co-payment amount is due and payable at the time of service. I understand that if my insurance has not paid their portion within 60 days of being properly billed, the balance will become due and payable from me. I understand that I am responsible for any and all deductible amounts, co-insurance amounts, and amounts denied as non-covered by my insurance company. I understand that I am ultimately responsible for timely payments on my account and that if I fail to honor this agreement, my account may be referred to an outside source for collections. I also understand that I will be held responsible for any and all attorney fees, court costs, and/or collection fees incurred as a result of agency referral. Appointments not canceled with 24 hours notice will be charged a $75.00 Fee. A service fee of $30.00 will be charged on any returned check. There is a $25.00 processing fee for any patient records to be transferred to another Medical facility.

_____ _____

Patient/Guardian Signature Date

Insurance Payment Authorization (non Medicare):

I authorize the payment of any and all insurance benefits paid for services rendered on my behalf by Advanced Surgical Concepts, PLLC to be paid directly to them. I authorize the release of any medical information requested by the insurance company in order to process my claim(s) for benefits.

_____ _____

Patient/Guardian Signature Date

Assignment of Medicare Benefits:

I authorize payment of Medicare benefits to be made directly to Advanced Surgical Concepts, PLLC for medical services provided. I authorize the release of any medical information by Medicare for the processing of claims. I understand that Advanced Surgical Concepts, PLLC may bill me for any deductible or co-insurance amount represented by Medicare in the patient responsibility field of the Medicare Explanation of Benefits (EOB). I also understand that I may also be billed for any Medicare non-covered items requested by Medicare as patient responsibility.

_____ _____

Patient/Guardian Signature Date

Financial Agreement for Private Pay Patients (no insurance):

I understand that payment in full is expected at the time of service unless prior arrangements have been made PRIOR to this appointment. I understand that if I fail to honor this agreement and my account becomes past due, my account may be referred to an outside source for collections. If this occurs, I will be held responsible for the balance on my account as well as any attorney fees, court costs, and/or collection fees. Appointments not canceled with 24 hours notice will be charged a $75.00 Fee. A service fee of $30.00 will be charged on any returned check. There is a $25.00 processing fee for any patient records to be transferred to another Medical facility.

_____ _____

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SUBJECT: Patient Rights and Responsibility Policy

POLICY NUMBER:

EFFECTIVE DATE: 1-2011

NUMBER OF PAGES: 2

PURPOSE: To set forth and inform staff and the patient of guidelines regarding the patient's rights and responsibilities.

Upon arrival of the patient's first visit to Advanced Surgical Concepts they are presented with a copy of the patient's rights and responsibilities for them to sign. The signed copy is then scanned into the patient's electronic medical records and the original is given to the patient to carry with them.

The policy is as follows:

- You have the right to prompt and adequate response to reasonable request and needs for treatment or services, within our capacity.
- You have the right to choose a healthcare provider who can give you high quality health care when you need it or to refuse examination or care by a specific healthcare professional. You have the right to refuse to participate in experimental research.
- You have the right to accurate and easily understood information about your health plan, healthcare professionals, and health care facilities. If you speak another language, have a physical or mental disability, or just don't understand something, help will be provided so you can make informed health care decisions.
- You have the right to information regarding services available at Advanced Surgical Concepts and the cost of these services.
- You have the right to know your treatment options and to take part in decisions about your care. Parents, guardians, family members, or others that you select can represent you if you cannot make your own decisions.
- You have a right to considerate, respectful care from your doctors, health plan representatives, and other health care providers that does not discriminate against you.
- You have the right to talk privately with health care providers and to have your health care information protected. You also have the right to a copy your own

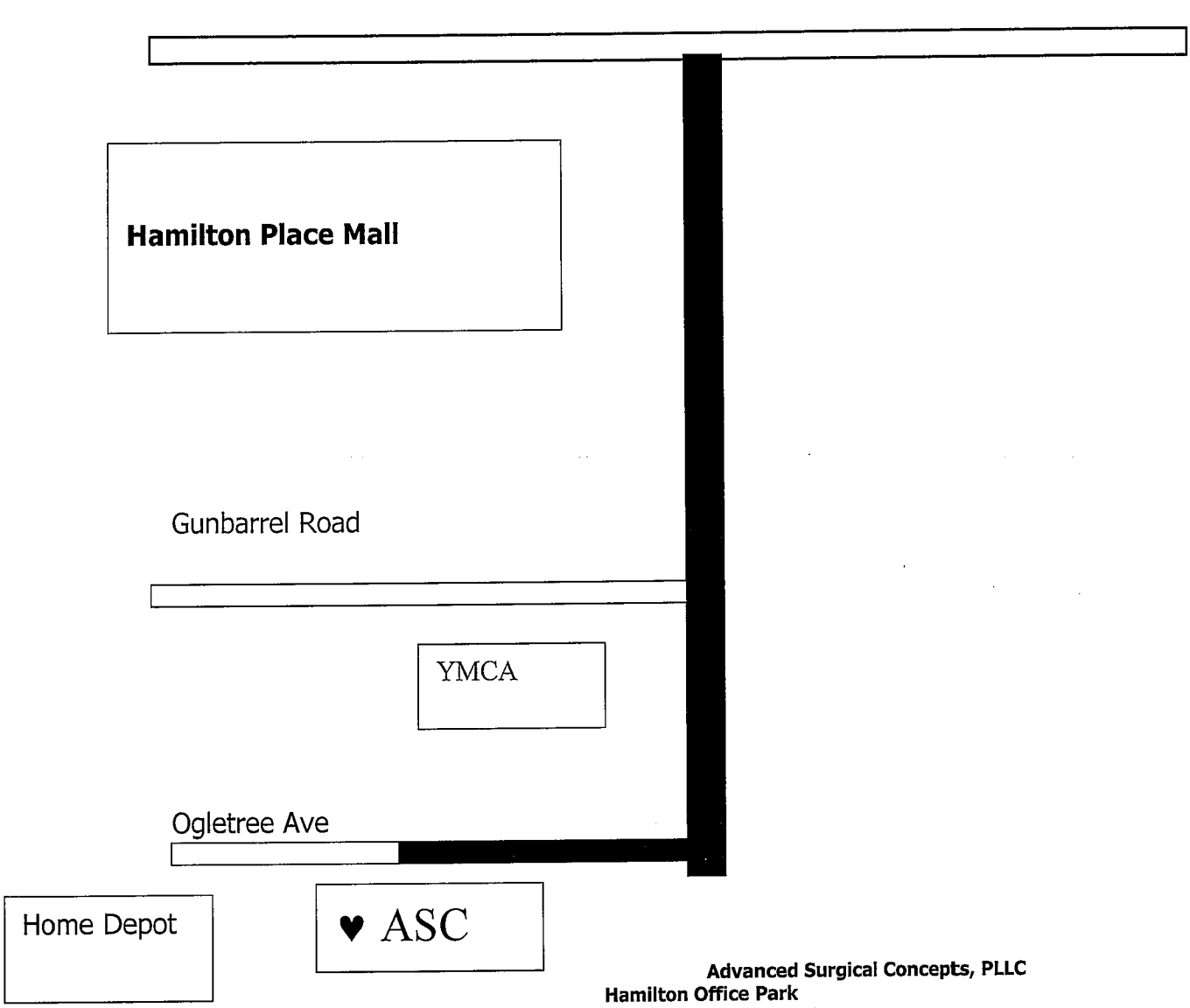
medical record. You have the right to ask that your doctor document in your records any corrections to inaccurate, irrelevant, or incomplete information.

- You have a right to a fair, fast, and objective review of any complaint you have against your health plan, doctors, hospitals or other health care personnel. This includes complaints about waiting times, operating hours, the actions of health care personnel, and the adequacy of the health care facility.
- You have the right upon request to receive a copy of any itemized bill or statement of your charges.
- You have the right to afterhours contact numbers. You may contact a provider after hours at 423-648-4011. If a medical emergency arises always dial 911 first.
- You have a right to our payment policy for all services rendered.
- You have a right to all credentials for the facility and for healthcare professionals.

PATIENT RESPONSIBILTY

- You are responsible for providing complete and accurate information to the best of your ability about your health, any medications, including over the counter products and dietary supplements, present complaints, past illnesses, hospitalizations, advanced directives, power of attorney, or other directive that could affect your care, any allergies or sensitivities, and other matters relevant to health or care.
- You are responsible for keeping all appointments or contacting the office 24 hours prior to your appointment to cancel.
- You are responsible to inform Advanced Surgical Concepts promptly if you do not understand any matter relating to your care and treatment or instructions with which you cannot comply.
- You are responsible to follow the treatment plan prescribed by your provider.
- You are responsible to be considerate to other patients and to see that any person with you is considerate, particularly with reference to noise.
- You are responsible for providing a responsible driver to transport you home and remain with you for 24 hours if required by your physician.
- You are responsible to observe the smoke-free policy at our office.
- You must accept personal financial responsibility for any charges for services rendered at Advanced Surgical Concepts and for any charges not covered by insurance if insurance is filed.
- You are responsible to provide necessary information regarding coverage of your charges.
- You must be respectful to all the health care providers and staff.
- You are responsible for your actions if you refuse treatment or do not follow your provider's instructions.
- You are responsible for all products purchased at Advanced Surgical Concepts and understand that these may be prescription products, which are by state law nonrefundable.

Patient Signature Date



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Appointment :	*** If unable to keep this appointment, please notify our office as soon as possible. If we are unable to confirm appointment due to phone disconnection or returned mail, your appointment will be cancelled.

- **Your Copay and/or Deductible are due at time of service. We accept the following form of payment: Visa, MasterCard, American Express, and Discover. Cash or Cashier Check.**
- Please bring all paperwork completed with you to your appointment, incomplete forms may cause a delay in being seen or your appointment to be rescheduled. **ALL PAPERWORK SHOULD BE COMPLETED USING BLUE OR BLACK INK.**
- Due to Allergies of the staff of Advanced Surgical Concepts and other patients, please do not wear any perfume/cologne to appointment.
- If you are being seen for treatment of your face, please **DO NOT WEAR** any make-up or sunscreen prior to your appointment.

******Grandview Medical Center (Medical Building, 4thfloor, Suite 408)**

Directions:

- From Nashville: Take I-24 East toward Chattanooga. Take Exit 155. Turn right onto Highway 28 South for 1/10 of a mile until it ends at the Grandview entrance.
- From Dunlap: Take Highway 28 South until it ends at the Grandview entrance.
- From Chattanooga: Take I-24 West to Exit 155. Turn left onto Highway 28 South and continue until it ends at the Grandview entrance.
- From Bridgeport/Stevenson, AL: Take Highway 72 East, Merge onto I-24 East, Take Exit 155. Turn right onto Highway 28 South for 1/10 of a mile until it ends at the Grandview entrance.

******Copper Basin Medical Center: 144 Medical Center Dr Copperhill, TN 37317 – Office Bldg D.**

Directions:

- From Cleveland, TN: Take TN-40/US-64E to Exit TN-68 S. Turn right onto Medical Center Drive.
- From Murphy, NC: Head southwest on Hiawassee St/Valley River Ave. Turn right onto US-64 W/US-74 W. Exit on the left onto TN-68 S. Turn right onto Medical Center Drive.

******Advanced Surgical Concepts (Chattanooga Office)**

Directions:

- From Cleveland, TN: Take I-75 S to Exit 5 Shallowford Rd. Turn Left onto Shallowford RD. Turn Right onto Ogletree Drive. First drive on the left. Our office faces the YMCA playground.
- From Dalton, GA: Take I-75 N to Exit 5 Shallowford Rd. Turn Right onto Shallowford RD. Turn Right onto Ogletree Drive. First drive on the left. Our office faces the YMCA playground.
- From Nashville, TN: Take I-24 E to I-75 N Exit 5 Shallowford Rd. Turn Right onto Shallowford RD. Turn Right onto Ogletree Drive. First drive on the left. Our office faces the YMCA playground.