900 Goodyear Avenue
Suite B
Gadsden, AL 35903

Phone (256) 492-0020
Fax (256) 492-0029
SurgicalAssociatesGadsden.com

Surgical Associates of Gadsden

Patient Information

(*SAG Use Only*) Entered by: _____

NAME OF PERSON SEEING DOCTOR (Please Print)

Patient Name: (First, Middle, Last) _____ Sex: M or F

Marital Status: S, M, W, D or Sep Date of Birth _____ Social Security # _____

Mailing/Billing Address _____

City _____ State_____ Zip_____

Email Address _____

Primary Phone _____ Secondary Phone _____ Work Phone _____

Race: _____ American Indian _____ Asian _____ Black/African Am. _____ White Caucasian _____Other

Ethnicity: _____ Hispanic/Latino _____ Not Hispanic/Latino

Patient's Employer (Circle if Student, Retired, Disabled or Unemployed) _____
Is this a work related injury (circle one) ? Yes or No

Spouse Name _____ Date of Birth _____ Spouse Contact # _____

Emergency Contact (Relative or Friend not at patient's address) _____

Home Phone _____ Cell Phone _____

RESPONSIBLE PARTY IF DIFFERENT FROM PATIENT/PARENT INFORMATION IF PATIENT IS A MINOR

Parent/Guardian _____ Date of Birth _____ Social Security # _____

Street Address _____ City and State _____ Zip _____

Primary Phone _____ Secondary Phone _____ Work Phone_____

I agree to pay any costs that my insurance does not cover; which includes the office visit, surgical procedures, or any other costs incurred, including any pre-existing clause in my insurance contract to Surgical Associates of Gadsden, P.C..

Should I decide to have surgery, I hereby grant permission to Dr. Alberto Echeverri or Dr. Ken Davenport to perform my surgery.

IF YOU DO NOT HAVE INSURANCE PLEASE LET THE STAFF KNOW SO ARRANGEMENTS CAN BE MADE.

I UNDERSTAND THAT PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED. I AGREE TO PAY ALL COSTS AND COLLECTION FEES INCURRED BY ME; SHOULD COLLECTION PROCEEDINGS BECOME NECESSARY; INCLUDING AN ATTORNEY'S FEE, I WAIVE ALL RIGHTS OF EXEMPTION UNDER THE CONSTITUTION AND THE LAWS OF THE STATE OF ALABAMA OR ANY OTHER STATE. I HEREBY ASSIGN TO AND AUTHORIZE PAYMENT DIRECTLY TO SURGICAL ASSOCIATES OF GADSDEN, P.C. ALL BENEFITS PAYABLE UNDER THE TERMS OF ANY INSURANCE POLICY LISTED. I UNDERSTAND THAT MY INSURANCE MAY NOT PAY THE BILL IN FULL; THEREFORE, I AGREE TO PAY THE REMAINING BALANCE, OR THE ENTIRE BILL IF NECESSARY. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY MEDICAL CLAIMS OR TO CONTINUE MY MEDICAL CARE.

_____ _____

Signature *of Patient, Personal Representative or Legal Guardian* **Date**