SWAN SURGICAL
CARDIAC THORACIC VASCULAR

SWAN SURGICAL, PLLC
353 NEW SHACKLE ISLAND RD., SUITE 200A
HENDERSONVILLE, TN 37075

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 the 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. I authorize Swan Surgical to obtain/have access to my medication history.

*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 limited to: co-insurance, co-payments, and deductible. I am financially 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 or Swan Surgical to collect my account, and a service charge of $35.00 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