Insurance Information

(PLEASE GIVE ALL INSURANCE CARDS & COPAYS AT CHECK IN BEFORE YOUR VISIT)

Primary Insurance

Insurance _____

ID# _____

Group# _____DOB:_____

Insured Name _____

Relationship to Patient _____

Secondary Insurance

Insurance _____

ID# _____

Group#_____ DOB: _____

Insured Name _____

Relationship to Patient _____

Insurance Authorization and Assignment Information

I hereby authorize East Tennessee Center for Orthopaedic Excellence to furnish pertinent information to my insurance carrier(s) and referring/consulting physicians concerning my illness, injury, or treatment. I assign payment of benefits directly to the physician for any medical services received by me or by my dependent. I understand that insurance coverages and benefits vary according to the policy and I agree to be responsible. In the event that the services I receive are experimental, investigational, or non-covered services, in or out of network. I understand that I will be held responsible for all physician, facility and ancillary charges, as well as any other related expenses. I understand that I will be responsible for non-covered charges, I will be responsible for timely of payment of service(s), collection fees, attorney fees and any court costs if necessary. THIS AUTHORIZATION IS IN EFFECT FOR ALL FUTURE CLAIMS.

MEDICAL CONSENT RELEASE FORM

I,_____, give East Tennessee Center for Orthopaedic Excellence permission to call my home, cell or work numbers for appointment reminders and leave a message if needed. I will be considerate and call to cancel or reschedule any appointment at least 24 hours before appointment time.

I give my consent to release medical information (verbally or written) to the person listed below.

Name _____ Relationship _____ Phone_____

Name _____ Relationship _____ Phone_____

I HAVE RECEIVED A COPY OF "NOTICE OF PRIVACY PRACTICES AND INIDIVIDUAL RIGHTS"

Signature _____ **Date**_____

Form must be completely filled out