

East Tennessee Spine & Sport
ONLINE VERSION

Authorization for Outpatient Treatment

I have been informed of the treatment considered necessary and that the treatment and procedures will be performed by physical therapists, physical therapy assistants, athletic trainers, and exercise physiologists employed by East Tennessee Spine & Sport. Authorization is hereby granted for such treatment and procedures.

I certify that the information given by me is correct and accept full responsibility for all charges. I hereby assign and authorize payment directly to the above names clinic of all insurance benefits. If my current policy prohibits direct payment to the clinic, I hereby instruct and direct the insurance company to make out the check to me and mail to East Tennessee Spine & Sport. I authorize East Tennessee Spine & Sport to deposit checks made out to me as payment to my account. I understand that I am responsible for any balance after insurance after insurance payment, including all costs incurred in collecting the balance if the account becomes delinquent, such as court case, attorney's fees, and/or collection agency commissions or charges.

Medical Record Authorization

The clinic is authorized to release information pertinent to my treatment to any doctor, insurer, compensation carrier, attorney, or welfare agency involved in this case.

Medicare Patients

I certify that the information given to me in applying for payment under the Title XVII of Social Security is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf. I authorize the therapist to initiate a complaint to the insurance Commissioner for any reason on my behalf. A photocopy of this assignment shall be considered as effective and valid as an original.

Acknowledgement of Receipt of Privacy Practices

By signing below, I acknowledge that I have received a copy of Spine & Sport's Notice of Privacy Practice.

Print Name

Patient (or Guardian) Signature

Date

Witness

Date