EAST TENNESSEE SPINE & SPORT PHYSICAL THERAPY

Authorization for Outpatient Treatment

I have been informed of the treatment considered necessary and that the treatment and procedures performed by physical therapists, physical therapist 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 to me is correct and accept full responsibility for all charges. I hereby assign and authorize payment directly to the above -named clinic of all insurance benefits. If my current policy prohibits direct payments to the clinic, I hereby instruct and direct the insurance company to make out the check to me and mail it to East Tennessee Spine & Sport. I authorize East Tennessee Spine & Sport to deposit checks made out to me as a payment to my account. I understand that I am responsible for any balance after insurance payment, including all costs incurred in collecting the balance if the account becomes delinquent; such as court cases, attorney's fees, and/or collection agency commissions or charges.

Medical Records Authorization

East Tennessee Spine & Sport 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 the 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, its intermediaries, or carriers any information needed for these 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 will 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 East Tennessee Spine & Sport's Notice of Privacy Practice.

Print Name	Patient or Guardian Signature	Date

Witness	Date

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Patient Billing & Payment Options

We would like to make the billing and payment process for services as simple as possible. Please read the following information regarding financial policies of this office and initial the source of payment to indicate how you would like our services to be reimbursed.

_____ 1. **Private Insurance and Medicare:** Professional services rendered to you (or your minor child for whom you are responsible) by East Tennessee Spine & Sport are your sole financial responsibility. You further understand that Spine & Sport will bill your insurance as a courtesy, but you are ultimately responsible for payment. You are financially responsible for any and all allowable balances not paid by your insurance (i.e. deductible, copay, coinsurance, and denied charges). You are expected to pay your estimated portion the day of your visit. Any unpaid balance will be reflected in your monthly billing statement. Any unpaid charges on account for 90 days are subject to collection action. On occasion, an insurance company may send a check for the services to you directly. If this occurs, you must reimburse the payment to our office by signing over the check.

_____ 2. **Worker's Compensation:** If you were injured during the course of your employment, please notify the front office so that you may complete the appropriate paperwork. Coverage will be verified and we will bill the worker's compensation carrier directly.

_____ 3. **Personal Injury- No Attorney:** If you were in an accident for which there will be a future settlement and you do not have an attorney, you are expected to make consistent payments as you receive treatment. You may be reimbursed for your payments if your case settles; however, you are responsible for the cost of your entire treatment, regardless of the settlement amount.

_____ 4. **Personal Injury- Attorney:** If you were in an accident and are represented, we must have a lien on file signed by you and your attorney. This will allow you to receive treatment without payment until your case settles. You are ultimately responsible for the cost of your entire treatment, regardless of the settlement amounts.

_____ 5. **Medicare:** If Medicare is your primary insurance we will bill Medicare directly. A Notice of Exclusion from Medicare Benefit will be presented to you if any uncovered services or items are proposed as part of your program. You will be able to make an informed decision regarding acceptance of any non-covered service prior to this occurring or becoming your financial responsibility.

_____6. **Self-Pay/Cash:** If you do not have insurance, you will be expected to pay for treatment at the time of services. The initial evaluation is **$130**. The next seven (7) visits will be **$90** per visit. Any additional visits beyond eight (8) will be **$70** per visit until the end of your treatment.

_____7. **Concierge Package:** Concierge packages are available for purchase at discounted self-pay rates. The evaluation visit fee of **$130** is paid at the time of service, and this amount is applied to the package price. You may select and complete payment for your concierge package (6, 8, or 12 visits) following the completion of your visit. Additional visits may be added to your package for **$75** per visit. Concierge visits are transferable to family and friends, and the recipient is responsible for the full evaluation fee of **$130** at the time of service.

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Patient Signature Witness Date

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Please fill out all information requested below:

- **Patient Name: _____**
- **Height**: _____ ● **Weight**: _____ ● **SSN: _____**
- **Pronouns (Optional):_____**
- **How many falls have you had in the last 12 months? (Circle One): 0 1 >2**
- **Do you currently use tobacco products? (Circle one): YES NO**
- **List all current medications below. If you are taking more than 6 medications, please provide a list to the administrative staff.**

Medication Table

#:	Medication Name:	Dose:	Frequency:	Administration Route:* (circle one)	Type:* (circle one)
				Oral / Topical Other:_____	RX / OTC Other:_____
				Oral / Topical Other:_____	RX / OTC Other:_____
				Oral / Topical Other:_____	RX / OTC Other:_____
				Oral / Topical Other:_____	RX / OTC Other:_____
				Oral / Topical Other:_____	RX / OTC Other:_____
				Oral / Topical Other:_____	RX / OTC Other:_____

**Description*: *Oral= Taken by mouth*
Topical= Applied to skin
RX= Prescribed by medical professional
OTC= Over the counter (ex: Advil)

Emergency Contact: _____ Relation: _____
Contact Number: _____

Patient Signature: _____ Date:_____
Witness: _____