Highlands Healthcare

Authorization for Treatment

I hereby consent to treatment by the attending medical staff for all local anesthetics, test, surgical and other medical procedures as deemed necessary by myself and the medical staff.

Authorization for Assignment of Benefits

I hereby assign to the above-named office; those benefits otherwise payable to me by any third party as reimbursement of expenses and fees in connection with treatment rendered. I request that payment of authorized benefits be made directly to the medical provider named above on my behalf.

I fully understand that I am financially responsible for any and all amounts not otherwise paid by my insurance carrier. I certify that the information on this form given by me for payment under title XVIII (Medicare) is correct and complete. I authorize the holder of medical or related information about me to be released to the Health Care Finance Administration or other health care coverage entity, any information needed for this or any related health care claim in writing or verbally. I further understand and agree to pay for services or co-payment amounts, and charges denied as not covered by my insurance program or deemed medically unnecessary. I understand that well care is not covered by Medicare or many other health insurance programs.

Authorization for Release of Information

I hereby authorize the release of my medical records as needed for subsequent medical care. If someone other than the patient is signing this form, please state relationship with patient and the reason patient is unable to sign.

I certify that I have given Highlands Health Care all of my valid insurance cards and acknowledge that if not I may be held responsible for cost.

Notice of Privacy Practices

I have been made aware of and/or received a copy of Highlands HealthCare's privacy practice notice.

Signature: _____ Date: _____

Printed Name: _____ Date: _____

Relationship/Responsible Party: □ Patient □ Parent □ Guardian □ Other

HIGHLANDS HEALTHCARE
315 N. Washington, Suite 175
Cookeville, TN 38501
Phone 931-528-3300
Fax 931-372-2102

Please list the numbers below that we can call if we need to leave you a message regarding your appointment.

Phone #'s: _____

_____

Is it okay to leave a voice mail regarding your appointment times (please check yes or no)

Yes_____

No_____

If you would like to designate a personal representative(s) that can discuss or request your medical records, please list them below:

Name of Person	Relationship to Patient

Date: _____

Patient Information

First Name: _____ **MI:** _____ **Last Name:** _____

Date of Birth: _____ **Social Security #:** _____

Gender (Please Circle): M F **Primary Language:** _____

Ethnicity (Please Circle): Hispanic Not Hispanic

Race (Please Circle): White Black American Indian Other Prefer not to answer

Mailing Address:

Street: _____

City: _____ State: _____ Zip Code: _____

Cell Phone #: ( ) _____ - _____

Home Phone #: ( ) _____ - _____

*Do you prefer to be contacted on your Cell or Home phone? (Please Circle): Cell Home

Email Address: _____

Employer: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone #: ( ) _____ - _____

Pharmacy Name: _____ Phone #: ( ) _____ - _____

Insurance Information:

Primary Insurance: _____

Subscriber #: _____ Group #: _____

***If you are not the policy holder for your insurance please fill out the following information:**

Policy Holder Name: _____ Birthday: _____

Employer: _____ Social Security #: _____

Relationship to Patient: _____

Secondary Insurance: _____

Subscriber #: _____ Group #: _____

***If you are not the policy holder for your insurance please fill out the following information:**

Policy Holder Name: _____ Birthday: _____

Employer: _____ Social Security #: _____

Relationship to Patient: _____

***If patient is a **MINOR** (under 18 years of age) please fill out the following:

Mother's/Guardian's Name: _____

Cell Phone #: ( ) _____ - _____

Home Phone #: ( ) _____ - _____

Social Security #: _____

Employer: _____

Father's/Guardian's Name: _____

Cell Phone #: ( ) _____ - _____

Home Phone #: ( ) _____ - _____

Social Security #: _____

Employer: _____