Assignment and Release

Patient Name _____ **Date of Birth** _____

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.**
- **I authorize the physician to release any medical information required to process this claim.**
- **I authorize my provider's office to contact me by telephone to remind me of my appointments.**
- **I authorize** The Medical Group of Columbia **to obtain and have access to my medication history from outside pharmacy and immunization sources.**
- **I have received a Notice of Privacy Practice, Notice of Patient Rights and Responsibilities.**
- **I hereby consent to treatment by my** The Medical Group of Columbia **providers. I authorize** The Medical Group of Columbia **to release to referring or subsequent healthcare provider, reports of my medical condition that will assist him or her in my continued care and as needed to process claims and for general health care operations, which may include use of an electronic health information exchange.**
- **I authorize the provider to release immunizations to the Tennessee Web Immunization System.**

I understand that once my health information is disclosed to a third party, that party may disclose my information to other parties and any redisclosures of my health information by a third party may no longer be protected under federal or state privacy laws.

I understand that protected health information may include information relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection.

I understand that this consent will remain in effect until I am terminated in writing as a patient of this practice or until I submit a written request to revoke this consent to the Practice. However, any disclosures that occurred prior to the date of revocation will not be affected.

I understand and hereby give consent for this photograph will be stored in the medical practice's electronic record as my photo identification.

By signing this consent, I, or my authorized legal representative, authorize The Medical Group of Columbia and its affiliates to disclose my protected health information to the following individual(s) for the purpose of keeping them informed about my condition and treatment, and I understand that these disclosures

Name of Designated person_____ Relationship _____

Name of Designated person_____ Relationship _____

How may we contact you regarding your protected health information, health status, appointments & results?

☐ Home Phone _____ ☐ Mobile _____ ☐ Other _____

☐ Email _____

May we leave a message regarding your protected health information at the numbers you provided? ☐Yes ☐No

Patient Signature _____ Date _____

The Medical Group of Columbia
Dr. Kennedy and Associates
AdvancedHEALTH

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Registration Form

Date: _____ / _____ / _____ Are you a new patient: ☐ Yes ☐ No

PATIENT INFORMATION (Please Print)

Last Name _____ First Name _____ M.I. _____

Birth Date _____ Gender ☐ M ☐ F SS# _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Marital Status ☐ M ☐ S ☐ D ☐ W Spouse Name _____ DOB _____

Race ☐ Alaskan Native ☐ Native American ☐ Asian ☐ African American ☐ White

Language ☐ English ☐ Spanish ☐ Other **Ethnicity** ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Preferred Pharmacy _____ Location _____ Phone _____

RESPONSIBLE PARTY

Last Name _____ First Name _____ M.I. _____

Relationship to Patient _____ Birth Date _____ SS# _____

Address (if different from Patient) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact Information

Name _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Cell Phone _____

INSURANCE INFORMATION

Primary Insurance Policy Holder (if other than patient)

Last Name _____ First Name _____ M.I. _____

Birth Date _____ Gender ☐ M ☐ F Employer Name _____

Policy Holder Relationship to Patient _____

ID/Certification No. _____ Policy/Group No. _____

Secondary Insurance Policy Holder (if other than patient)

Last Name _____ First Name _____ M.I. _____

Birth Date _____ Gender ☐ M ☐ F Employer Name _____

Policy Holder Relationship to Patient _____

ID/Certification No. _____ Policy/Group No. _____

DELINQUENT ACCOUNTS: We review past due accounts frequently and at every statement cycle. Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing.

If your account becomes sixty (60) days past due, further steps to collect this debt may be taken. If you fail to pay on time and we refer your account (s) to a third party for collection, a collection fee will be assessed and will be due at the time of the referral to the third party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 18 percent. In addition, we reserve the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances.

CONSENT TO CONTACT: I grant permission and consent to Premier Radiology and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and /or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I understand that my refusal to provide the consumer described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

Patient Signature _____ Date _____

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