Print Patient Name_____Date of Birth_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize ETSU Physicians and Associates, Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. This authorization is valid as long as I am a patient at ETSU Physicians and Associates, Inc.

I am responsible for all financial obligations of health services for this patient; and for reimbursement and payment of claims from my insurance company. If for any reason the account should become delinquent, I agree to pay for all rebilling charges, collection costs and reasonable legal fees.

Signature of Patient or Responsible Party _____

Date_____

MEDICARE PATIENTS

(One time Signature Authorization)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to ETSU Physicians and Associates, Inc. for any services furnished me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services:

Medigap Assignment Authorization

I request that payment of authorized Medigap benefits be made to ETSU Physicians and Associates, Inc. for any services furnished me by the provider. I authorize any holder of medical information about me to release to the medigap carrier any information needed to determine these benefits.

Signature of Patient or Responsible Party_____

Date_____

TEACHING PHYSICIANS

You will be seen by a physician who is a member of the faculty with the Quillen College of Medicine. Physicians, who work in the office as part of their faculty responsibilities, are responsible for teaching medical students and residents (postgraduate trainees). Our mission here is a dual one: caring for patients and teaching students and residents. This is part of the mission of the College of Medicine. We believe this adds to the depth and level of care the patient receives since patients are seen by one or more physicians and discussed in detail.

Several thousand patients receive their medical care through our office and enjoy helping with our teaching programs. "We are pleased with your willingness to participate in our teaching program and your care shall encompass a team approach to health care with involvement of your physician, residents, medical students and other medical trainees."

Signature of Patient or Responsible Party _____

Date_____

ACKNOWLEDGE OF NOTICE OF PRIVACY PRACTICE

I have been given the opportunity to review the ETSU Notice of Privacy Practices and understand that the Notice indicates how my protected health information may be used and disclosed and how I may gain access to this information. I have also been given the opportunity to receive a copy of the ETSU Notice of Privacy Practices for further review. By signing below, I agree to the above mentioned statement:

Signature of Patient _____Date _____