TENNESSEE VALLEY SURGERY GROUP, P.C.
CONSENT, RELEASE, ASSIGNMENT FORM

CONSENT FOR MEDICAL TREATMENT

I voluntarily present for treatment and consent to my physician and whomever they may designate, associate, treating physician and patient care staff to provide my care. Such care may include, but not be limited to, diagnostic procedures, psychotherapeutic treatment, other treatments and medications, pathologic and radiological evaluations and procedures considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations at Tennessee Valley Surgery Group.

RELEASE AND USE OF PATIENT INFORMATION

I authorize the release of my medical records (including faxing), information, treatment and advice, and specific health information to:

1) **AN EMPLOYER** who requests services (including history, physical, laboratory and diagnostic tests, and screening for the presence of drugs, alcohol or marijuana).

2) **INSURANCE COMPANY** or other third party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility, available benefits and obtaining payment for services provided.

3) **EDUCATIONAL OR SCIENTIFIC INSTITUTIONS** authorized healthcare professionals in training, internal quality improvement, risk management and legal counsel when it is judged that my ongoing medical care, medical research, quality improvement, healthcare education or science will benefit; for any purpose authorized by law.

4) **TREATING PHYSICIANS** on staff at Tennessee Valley Surgery Group, their agents and allied health professional; to another healthcare facility upon direct transfer and to my attending consulting, referring and/or primary care physicians for follow up care. I understand that if I refuse to authorize access to my records for coordination of care, my treatment could be adversely affected.

I understand this information concerning medical care, advise or treatment may include history and physical/diagnosis/laboratory and diagnostic testing/specific information concerning alcohol abuse/mental health/drug abuse/human immune-deficiency virus/hepatitis/or other infectious diseases. I understand that I have the right to revoke this authorization. If my revocation prevents payment or reduces payment for services received, I become responsible for payment.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE

In consideration of services provided by Tennessee Valley Surgery Group, I hereby assign and transfer to Tennessee Valley Surgery Group any and all rights which I have against insurance companies, governmental agencies, or third party payers, for payment of charges for services provided by Tennessee Valley Surgery Group to me or to one of my dependents. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies, governmental agencies or third party payers. In consideration of services to be provided, I agree to pay Tennessee Valley Surgery Group in accordance with the regular rates and terms of Tennessee Valley Surgery Group. I further agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with Tennessee Valley Surgery Group. I authorize said payments to be applied to any unpaid Tennessee Valley Surgery Group balance for which I am responsible. If my account is placed with a collection agency, an additional 25% will be added to my balance.

I give consent, authorize release, and assign benefits to TVSG _____

Patient/Guarantor Signature

RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Tennessee Valley Surgery Group may use and disclose my protected health information. I understand that Tennessee Valley Surgery Group reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

_____ _____

PRINTED PATIENT NAME **DATE**

_____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN

Office Use Only: (To be completed only when patient declines to sign acknowledgement)

_____Check here if patient declined to sign acknowledgement _____Staff Initials_____Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION (VERBAL AND COPIES) TO MEMBERS OF YOUR FAMILY OR OTHER INDIVIDUALS

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996, in order for your physician or the staff of Tennessee Valley Surgery Group to give copies of and/or discuss your condition/exam/procedures/x-rays with members of your family or other individuals that you designate other than your *primary care doctor or specialist,* we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

I authorize Tennessee Valley Surgery Group to release any and all information (including verbal information, copies of x-rays and medical paperwork) concerning my medical care to the following individuals:

_____ _____ _____
Name (please print) Relationship, Phone Number

_____ _____ _____
Name (please print) Relationship, Phone Number

_____ _____ _____
Name (please print) Relationship, Phone Number

_____ _____ _____
Name (please print) Relationship, Phone Number

_____I **DO NOT** authorize Tennessee Valley Surgery Group to release any information concerning my care to any individual.

I authorize Tennessee Valley Surgery Group to leave a detailed message on my;

- Answering machine ___ Cell Phone
- Voice mail
- Work phone.
- E-mail.

I **DO NOT** authorize Tennessee Valley Surgery Group to leave a detailed message on my;

- Answering machine __ Cell Phone Voice Mail
- Voice mail
- Work phone.
- E-mail.

_____ _____
Your Signature and Date

AUTHORIZATION TO DISCUSS FINANCIAL INFORMATION

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996, we must obtain your authorization to discuss financial information with members of your family or other individuals that you designate other than insurance companies or third party payers and their agents.

I authorize Tennessee Valley Surgery Group to verbally discuss financial information with:

_____ _____ _____
Name (please print) Relationship, Phone Number

_____ _____ _____
Name (please print) Relationship, Phone Number

_____ _____ _____

Name (please print) Relationship, Phone Number

_____ _____ _____

Name (please print) Relationship, Phone Number

_____ _____

Your Signature and Date