

# NORTHCREST PHYSICIAN SERVICES

Care Center at NorthCrest  
430 NorthCrest Drive • Springfield, TN 37172  
Telephone: (615) 382-7284

NorthCrest Orthopaedics  
417 NorthCrest Drive • Springfield, TN 37172  
Telephone: (615) 382-5204

NorthCrest Medical Care in White House  
121 Highway 76 • White House, TN 37188  
Telephone: (615) 672-5575

## CONDITIONS OF ADMISSION AND AUTHORIZATION FOR MEDICAL TREATMENT

### I. CONSENT FOR MEDICAL PROCEDURES AND TREATMENT

*Medical Consent for Treatment:* Permission is hereby granted to NorthCrest Physician Services, Inc. for medical treatment as may be deemed necessary by my physician and/or his or her designee. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me as to the results of treatments, or examinations.

### II. NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given the NorthCrest Physician Services' Notice of Privacy Practices. I understand that if I have questions or complaints, I may contact the Practice Manager of NorthCrest Physician Services at (615) 382-5851.

### III. RELEASE OF INFORMATION

I authorize NorthCrest Physician Services physicians involved in my care to release medical information and supporting documentation of same as compiled in my medical records to any organization which is or may be liable or responsible for payment of charges associated with my care and for all other purposes of benefit payment. If my injury is work related, I authorize NorthCrest Physician Services to release any information from my medical records to my employer and/or its designee. I acknowledge that data from my patient records will be accessible to all health care providers participating in my care or treatment, including but not limited to physicians, nurses, and technicians at the hospital, home health agencies, physical therapy centers and such other health care agencies involved with my care.

### IV. Assignment of Benefits

This assignment of benefits allows NorthCrest Physician Services Physicians to be paid directly by my health insurance carrier or other health benefit plan for the services NorthCrest Physician Services Physicians provide to me, my minor child, or other person entitled to health care benefits for this office visit.

### V. Financial Agreement

In consideration of the services to be rendered to the patient, the undersigned (as parent, guardian, spouse, guarantor, agent or as the patient) individually promises to pay the patient's account at the rates stated in NorthCrest Physician Services' price list (known as the "Charge Master") effective on the date of service. In the event that NorthCrest Physician Services has to engage an attorney or collection agency to collect any unpaid balances that arise from the treatment consented herein, the undersigned agrees to pay the reasonable attorney's fees and collection expenses incurred by NorthCrest Physician Services.

It is the responsibility of the patient, the undersigned (as parent, guardian, spouse, guarantor, and agent or as the patient) to let the physician's office know at the time of service if your insurance has changed. All co-payments and deductibles are expected to be paid at the time of service. I understand that if I have a cop-payment according to my insurance policy, I am responsible for making this payment at the time of each visit to the office. I further understand that failure to make this payment at time of service will result in my visit being rescheduled.

### VI. Medicare Patient Certification

I certify that the information given by me in applying of payment under Title XVIII and Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf.

### VII. TOBACCO USE POLICY

NorthCrest Physician Services is a tobacco free facility. I understand that while I am a patient at NorthCrest Physician Services I may not use tobacco products.

**I hereby certify and state that I have read, and that I fully and completely understand the above Conditions of Admission and Authorization for Medical Treatment, and that I have signed this Conditions of Admission and Authorization for Medical Treatment knowingly, freely, and voluntarily.**

<ESIG:DESC=Patient or Other>

\_\_\_\_\_  
Signature of Patient / Parent / Guardian / Conservator

\_\_\_\_\_  
Date