

# EAST TENNESSEE COLON & RECTAL SURGICAL ASSOCIATES

## PLEASE READ

All charges are due at the time of service. If hospitalization or surgery is indicated, we will file your claim directly to your insurance company. Please remember that most insurance companies do not pay the full amount, and therefore you are responsible for the balance. If there is a problem paying the balance in full, please let us know and we will be happy to work with you.

## FINANCIAL RESPONSIBILITY

I understand if I have not secured the appropriate referrals and authorizations and otherwise followed the terms of my health plan benefits, there may be a decrease in my coverage or no coverage at all for some or all of the services which I am about to receive, and that I will be financially responsible for the services not covered, including co-payments, co-insurance and deductibles. If I have no insurance, I understand that I will be financially responsible for all services provided.

Patient or Guardian's Signature \_\_\_\_\_

## INSURANCE AUTHORIZATION AND RELEASE

I request that payment of authorized benefits (including Medicare, and any other government sponsored program, private insurance, and any other health plans) be made to **East Tennessee Colon & Rectal Surgical Associates, P.C.** for any services furnished by that provider. I authorize any holder of medical information about me to release to those persons or companies presenting a legitimate request for such information needed to determine these benefits or the benefits payable for related services. I authorize **East Tennessee Colon & Rectal Surgical Associates, P.C.** to act as my agent to help me obtain any required precertification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give **East Tennessee Colon & Rectal Surgical Associates, P.C.** any information they require to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

## MEDICAL RECORDS RELEASE

I hereby authorize East Tennessee Colon & Rectal Surgical Associates, P.C. to release any information in my chart to any practitioner, doctor, hospital, medical institution to whom I may be referred to assist in my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital or medical institution to assist in my care.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

## OFFICE EXAMINATION

I Consent to have an examination by Dr. Baker or Dr. Young. This may include an anorectal exam, proctoscopy and/or flexible sigmoidoscopy. I understand that the Physician will discuss this with me including the possibility of pain, cramping, bleeding and the remote possibility of perforation, which would require surgery.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

## FOR MEDICARE SUPPLEMENT POLICIES ONLY ONE-TIME MEDIGAP ASSIGNMENT AND RELEASE

\_\_\_\_\_  
NAME

\_\_\_\_\_  
MEDICARE NUMBER

\_\_\_\_\_  
MEDIGAP POLICY NAME

\_\_\_\_\_  
MEDIGAP POLICY NUMBER

I request that payment of authorized Medigap benefits be made on my behalf to **East Tennessee Colon & Rectal Surgical Associates, P.C.** for services furnished me by them. I authorize any holder of medical information about me to release to  
(name of policy)

Any information needed to determine these benefits payable for related services. This will remain in effect until revoked in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_