UT FAMILY MEDICINE CENTER
294 SUMMAR DRIVE
JACKSON, TN 38301

Patient's Name_____**Chart#**_____
(Please Print)

Assumption of Responsibility: I agree that in consideration of services to be rendered, I obligate myself, assume financial responsibility and agree to pay upon demand to above name practice all charges for such services and incidentals incurred. Should the account be referred to an attorney for collection, I agree to pay reasonable attorney fees and collection expenses. I agree to be fully responsible for paying co-pays of set amounts at the time of services.
Initial_____

Assumption of Referrals: I understand that if I have insurance coverage, which requires a pre-authorization or referral, it must be received in order to receive the maximum benefits from the insurance company. I further understand that it is my responsibility to obtain the pre-authorization/referral. I will be given the opportunity by the above practice to obtain the pre-authorization/referral or reschedule my appointment. I understand that if I refuse to obtain the pre-authorization/referral that I am fully responsible for payment.
Initial_____

Appointment No-Show Procedure: I understand that if I fail to show up for 3 appointments, I may be terminated from the practice with my providers consent.
Initial_____

Assignment of Insurance Benefits and Release of Information: I hereby assign direct payments of any insurance benefits including TNCARE, major medical benefits, insurance disability benefits, or injury benefits payable because of liability of a third party or organization, and so forth, payable to or for the above said patient until account is paid in full. I authorize the release of any medical information necessary to process the claim(s).

Signature_____ **Date**_____

Medicare Lifetime Assignment of Benefits: I request that payment of authorized Medicare benefits be made to me or on my behalf to **UT Family Medicine** (The "Provider") for any services furnished me by the Provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. This assignment is effective until revoked by me in writing.

Signature_____**Date**_____

Medigap (Medicare supplemental insurance) Assignment: I request that payment of authorized Medigap benefits be made either to me or on my behalf to **UT Family Medicine Center** for any services furnished me by that physician/provider/supplier. I authorize any holder of medical information about me to release to the Medigap Insurer listed below any information needed to determine these benefits or the benefits payable for related services.

Medigap Insurance Name_____ **Policy#**_____

Beneficiary
Signature_____D**ate**_____

Consent to Treat: I consent to treatment and/or test provided by University Family Physicians. I reserve the right of consent for procedures until after the risk and benefits have been explained to me. I understand that the UT Family Medicine Center is a residency training program and that my care is being rendered by or under the supervision of a staff physician whose name may appear on my bill. For educational purposes only, I authorize the UT Family Medicine Center to photograph/video and/or view the **clothed-physical examination portion** of my visit. A verbal consent will be requested at the time of visit. I understand these interview sessions and visual materials are fully confidential.

Signature_____ **Date**_____

Acknowledgement of Receipt of Privacy Notice: I acknowledge receiving a copy of Notice of Privacy Practices
Signature_____ **Date**_____