

NORTHCREST PHYSICIAN SERVICES

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, upon request, I can receive a copy of 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. HEALTH INFORMATION EXCHANGE

Northcrest Physician Services is participating in a Health Information Exchange with Vanderbilt and other facilities throughout the area. We will send your health care information to the Vanderbilt Health Affiliated Network (VHAN) Health Information Exchange (HIE). VHAN HIE is a secure electronic system through which your health care Providers participating in the VHAN HIE may view certain records of your care for purposes of treatment, payment and health care operations. You have two options with respect to the VHAN HIE: (1) you may permit authorized individuals at this and your other health care providers who also participate in the VHAN HIE to access your electronic health information through the HIE. If you choose this option, you need not take any further action; or (2) you may restrict access to all of your information that is sent to the VHAN HIE (except as required by law). This is called "opting-out". You cannot restrict access to certain information only. If you choose to "opt out" please check here: Opt Out

V. 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.

VI. 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 co-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.

VII. MEDICARE PATIENT CERTIFICATION

I certify that the information given by me in applying to 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.

VIII. 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.

Signature of Patient / Parent / Guardian / Conservator

Date