CHART # ______________

DOCTOR ______________

LIFETIME AUTHORIZATION TO FILE MEDICARE

I request that payment of Medicare benefits be made to Kellett, Brophy & Lovell Neurosurgical Clinic for any services furnished to me by that provider. I authorize any holder of medical information about me to release to KBL and its agencies any information needed to determine these benefits or the benefits payable for related services.

Signature ____ Date: ________________
Patient or Guardian

ACKNOWLEDGEMENT/DENIAL OF TENNCARE/BLUECARE

Please read and initial the statement that applies:

1) _____ I do not have TennCare (Blue Care, TennCare Select) insurance. I have not tried to get TennCare insurance.

2) _____ I have BlueCare or TennCare Select insurance. I understand my insurance may not pay for these services and that I will be responsible for the balance not paid by my insurance.

Signature ____ Date: ________________
Patient or Guardian

CONSENT FOR CARE

I hereby give my consent for treatment to Kellett, Brophy & Lovell Neurosurgical Clinic treatment or services and which may include but not limited to laboratory procedures, examination, medical treatment or procedures rendered for me under the general and specific instruction of the patient's physician.

Signature ____ Date: ________________
Patient or Guardian

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

I authorize Kellett, Brophy & Lovell Neurosurgical Clinic or any person designated by them to obtain/release copies of my medical records to any physician or institution for the purpose of evaluation and/or comparison with examination and testing being performed on me.

Signature ____ Date: ________________
Patient or Guardian

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I authorize payment to Kellett, Brophy & Lovell Neurosurgical Clinic for services rendered to me. I also authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for any balance not covered by insurance and any collection costs and/or legal fees incurred in any attempts to collect said balance.

Signature ____ Date: ________________
Patient or Guardian

CHART # ____________

DOCTOR ____________

NOTICE OF NO SHOW/LATE CANCELLATION FEES/RETURNED CHECK FEES

I understand that it is the policy of this clinic to charge $25.00 for cancellations made less than 24 hours of my appointment time. I also understand that this clinic charges $50 for failure to show for my appointment without 24 hour notice. It is also the policy of this clinic to charge $25 for returned checks.

Signature ____ Date: ________________

Patient or Guardian

AUTHORIZATION TO LEAVE MESSAGE

I hereby authorize Kellett, Brophy & Lovell neurosurgical Clinic to leave a message regarding pending appointments. You may notify me of lab/test results, matters relating to prescription, my physician or a Work Comp Carrier by leaving a message (check all that apply):

____ on my answering machine/home voice mail;
____ with my spouse
____ family member (please specify name of family member ____________________)

Signature ____ Date: ________________

Patient or Guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, outlining my rights regarding my health information.

Signature ____ Date: ________________

Patient or Guardian