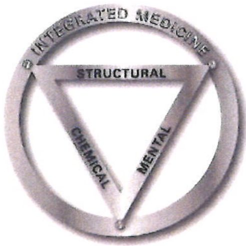

Chattanooga Family & Sports Medicine Center
dba Chattanooga Non-Surgical Orthopedics
Dr. Jeff Hall / Dr. Ethan Kellum
6035 Shallowford Road Ste. 101 Chattanooga, TN 37421
423-499-0003 FAX 423-485-7992
www.cnsorthopedics.com

Patient Intake Information

Date ___________________ **Referred by** ____

Name ____ Gender ____M ____ F

Address ____

City/State ___________________ Zip__________ Cell Phone ______________ Home Phone_____________

****Best Way To Contact You:** □ **Cell Phone** □ **Home Phone** □ **Text**

Date of Birth ______________ Social Security # ____________________

___Married ___Widow ___Single ___Divorced ___Minor

Email ____

Occupation ____

Employer ____ Phone _____________________________

Spouse's name ____ DOB ___________________________

Spouse's Employer ____________________________________ Phone _____________________________

Emergency Contact Name _______________________________ Relationship __________________

Emergency Contact Phone _______________________________

Please SIGN AT THE BOTTOM that you understand the following policies of Chattanooga Non-Surgical Orthopedics.

I am aware that Chattanooga Non-Surgical Orthopedics will file claims with my insurance carrier as a courtesy, but ultimately all charges are my responsibility. I agree to pay for services at the time of my visit. Further, if I am using my insurance, I authorize my insurance company to assign my rights and benefits to CNSO for my care. I authorize release of my records for purpose of insurance claim filing.

I understand that like my own time, the staff's time is valuable. Therefore, I will call and give them 24 hours notice if I need to change or cancel my appointment. Otherwise, I am subject to a $35 cancellation/no-show fee.

I understand that if I fail to pay my bill in a timely manner, I can be turned over for collections and will be responsible for the balance, reasonable fees, interest at a yearly rate of 18%, and all costs of collections, including court costs. I further agree that Hamilton County, Tennessee, is the proper jurisdiction and venue for such collection.

I have reviewed the Privacy Practices. I authorize the staff at CNSO to only speak to the people I have indicated on this form about my care and appointments:

I understand CNSO does not print year end statements of payments made for services rendered. If you need a record other than your credit card receipt, you must request a printout on the day of service.

Patient's Signature ____________________________________ Date ______________________

Authorization for Release of Information (PRIVACY PRACTICES)

Name of Patient ____ Date of Birth _____/_____/_____

Chattanooga Non-Surgical Orthopedics is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released** Check each that can be given to person/entity on the left in the same section.
□ Voice Mail	□ Results of lab tests/x-rays □ Other_________________________
□ Spouse_________________________	□ Financial □ Medical as follows below: _________________________
□ Parent (provide name) _________________________	□ Financial □ Medical as follows below: _________________________
□ Other (provide name) _________________________ _________________________	□ Financial □ Medical as follows below: _________________________

Patient Information:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or discloses as a result of this authorization maybe subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

THIS AUTHORIZATION SHALL IN BE EFFECT UNTILL REVOKED BY PATIENT.

____ **Date** ____/____/____

(Signature of Patient or Personal Representative)

Financial Policy

1. **Payment is due at the time services are provided**. For your convenience, our office accepts cash, checks, Visa, & MasterCard. Future appointments will not be scheduled until your account is current.

2. **As a courtesy, we will file your insurance claims.** We also try to verify your coverage before your visit. **The benefit information given to us is only an abbreviated list and DOES NOT guarantee payment. Any charges billed to your insurance and denied will be the patient's responsibility.** If you need specifics regarding your policy's benefits, exclusions, riders, pre-existing condition clauses, or other information you will need to contact them directly by calling the number listed on the back of your identification card.

3. **All incurred charges are ultimately the responsibility of the patient, regardless of insurance coverage**. We must emphasize that as your health care provider, our relationship is with you, our patient, and not with your insurance company. Your insurance plan is a contract between you, your employer and the insurance company. Our office is not a party to that contract and any possible restrictions.

4. ***PLEASE TAKE NOTE:*** Because of our billing system, we will not be able to give you a year end statement of what you have paid. If you require something other than your credit card slip, you must request it at each visit.

5. **Returned checks will include a $25.00 service fee.**

6. **If your account is turned over for collection, you are responsible for, in addition to your principle balance, reasonable attorney's fees, interest at the yearly rate of 18% and all costs of collection, including court costs. You further agree that the proper jurisdiction and venue for such collection is the General Sessions or Chancery Courts of Hamilton County, Tennessee.**

7. CANCELLATION/NO SHOW POLICY -- We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. As a courtesy, please give us a 24 hour notice.

   If an appointment is not cancelled 24 hours in advance, you will be charged a thirty-five dollar ($35) fee. This will not be covered by your insurance company.

I have had the opportunity to review the above financial policy and understand it and freely and voluntarily agree to abide by such. If the patient is under the age of 18, a legal guardian's signature is required as a guarantee.

Patient's or guardian's signature: ________________________ Date _______________

Guarantor's signature: ______________________________ Date: _____________________

Revised 5/16/2022