Name: **Patient ID#:** **Physician:**

Is this appointment related to one of the following?

A workman's comp injury ___ **Yes** ___ **No**

If so, please give the date of the injury: _____

Name of the company the patient was working for when the injury occurred: _____

Company address: _____

Workers' comp insurance carrier name and address: _____

A motor vehicle accident ___ **Yes** ___ **No**

[If yes, please describe how and when the accident occurred]

_____

_____

Any other type of injury (such as slip and fall in a store, etc.) ___ **Yes** ___ **No**

[If yes, please describe how and when the accident occurred]

_____

_____

Does your insurance company require prior authorization for outpatient testing and/or admission? ___**Yes** ___**No**

Which hospital does your insurance require you to use? _____

Have you seen one of our Physicians before? ___ **Yes** ___ **No** If yes, who? _____

I request that payment of authorized Medicare/Medicaid and other Health Insurance benefits be made on my behalf to the Physician Members of Semmes-Murphey Clinic for any services furnished to me by that Provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or my designated insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize the release of my medical records from the above Physicians to Semmes-Murphey Clinic.

FINANCIAL RESPONSIBILITY:

I understand that I am financially responsible for all charges whether or not covered by this authorization. I also understand that I am responsible for reasonable costs and / or attorney fees incurred for the collection of this account. Additionally, I agree to the following:

a) If payment is not obtained from my insurance carrier due to incorrect insurance information supplied to this office, I will be financially responsible for all charges incurred, with payment made in a timely manner.

b) If payment is not made in a timely manner by another party who is legally financially responsible for medical fees (i.e. by divorce or court order), I accept financial responsibility for all medical care of myself or the patient.

c) If charges are not covered by my insurance, per the terms of my contract with my insurance carrier, I will be financially responsible for such charges,with payment made in a timely manner.

d) If charges or portions of charges are deemed "patient responsibility or applied to deductible" by my insurance carrier, I will be financially responsible for these amounts due, with payment made in a timely manner.

_____ _____

Patient Date

_____ _____

Guarantor Date