COOKEVILLE REGIONAL MEDICAL GROUP
It's the Way WeCARE

Cookeville Regional Medical Group
www.crmedgroup.org

PATIENT INFORMATION

Last Name

First Name Middle Initial

SSN:_____--_____--_____ DOB:_____

Age:_____ Gender: ❑ M ❑ F

Address: _____

City:_____

State:_____Zip Code:_____

Home Phone: ( ) _____

Cell Phone: ( ) _____

Marital Status: ❑ S ❑ M ❑ D ❑ W

Race/Ethnicity: _____

Preferred Language:_____

Employer: _____

Occupation: _____

Work Phone: ( ) _____

Spouse Name (Parent, if child): _____

Spouse/Parent SSN:_____--_____--_____

Spouse/Parent DOB:_____

Spouse/Parent Employer:_____

Spouse/Parent Employer Phone: ( ) _____

Referring Physician: _____

DO YOU HAVE A:

❑ Living Will

❑ Power of Attorney for Healthcare

❑ Power of Attorney for Financial Affairs

PATIENT PORTAL

Please list your email address to enroll in our patient portal.

❑ I do not want to sign up for the patient portal.

MR # _____

EMERGENCY CONTACT INFORMATION

Last Name

First Name

Phone: ( ) _____

Relationship

INSURANCE INFORMATION

PLEASE GIVE ALL INSURANCE CARDS TO RECEPTIONIST

RESPONSIBLE PARTY INFORMATION

❑ **SAME AS PATIENT**

Last Name

First Name Middle Initial

SSN:_____--_____--_____DOB: _____

Address: _____

City:_____

State:_____ Zip Code: _____

Home Phone: ( ) _____

Cell Phone: ( ) _____

Employer: _____

Work Phone: ( ) _____

Please list any person that health information may be released to:

NAME	RELATIONSHIP	PHONE

HOW DID YOU HEAR ABOUT US

***Please complete the next page also ➔**

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Patient Financial Policy

Name (print):_____ Date of Birth: _____ :

ASSIGNMENT OF BENEFITS: I hereby assign all medical and surgical benefits, to which I am entitled, to Cookeville Regional Medical Group. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to Cookeville Regional Medical Group for medical services rendered to myself and/or my dependents.

RESPONSIBILITY OF PAYMENT: I understand that I am responsible for any amount not covered by insurance. If my account is placed with an outside collection agency, I will be responsible for any collection agency fees, court costs, and legal fees.

RELEASE OF INFORMATION: I authorize the release of any medical or other information necessary by Cookeville Regional Medical Group for the purpose of processing this or any related claim. I also authorize Cookeville Regional Medical Group to release requested documentation for this claim or any related claim to myself and/or other health care providers involved in the treatment of my condition.

NOTICE OF PRIVACY PRACTICES: I have received a copy of Cookeville Regional Medical Group's Notice of Privacy Practices which describes how my medical information may be used and disclosed.

PHONE NOTIFICATIONS: I consent to receive calls from Cookeville Regional Medical Group, or its agents, for purposes including, but not limited to, appointment reminders, results communication, patient surveys, and debt collection at the phone numbers I have listed on the reverse, including my wireless number provided. I understand I may be charged for such calls or text by my wireless carrier and that such calls may be generated by an automated dialing system. I understand messages such as appointment reminders may be left for me at the phone numbers I have listed.

PARTICIPATING INSURANCE PLANS: We participate in most major health plans. We have contracts with many commercial insurance companies and governmental plans, including traditional Medicare and TennCare.

Copayments must be paid at the time of service. We will submit a claim to your plan for all services rendered. After your insurance processes your claim, any additional outstanding patient balance will be billed to you.

Please bring your insurance information with you to each visit so that we can verify that our information is accurate.

NON-PARTICIPATING PLANS AND SELF PAY: If you have insurance that we do not participate in, we will be happy to file the claim to your carrier; however, payment in full is expected at time of service.

If you do not have medical insurance, payment for all services is expected at the time of your visit.

We will collect a pre-service deposit at check-in, and any remaining balance will be calculated and due when you check-out. If paid in full at the time of service, we will offer a 20% prompt pay discount on the day of your visit. If you are not able to pay the remaining balance in full, our staff will work with you to arrange a payment plan.

PAYMENT OPTIONS: We accept cash, check, Visa, MasterCard, and Discover. You also have the option of assigning a credit card on file with our secure payment processor. This option can be used to charge balances as they accrue or to set up automatic monthly payment plans. There is a $25.00 charge for any returned checks.

PATIENT BALANCES: Statements are mailed for any outstanding patient balance. Payments are accepted by mail, phone, or in person, or can be made through our QuickPay website as noted on your statement. Additionally, automated reminder calls will be made 15 days after each statement if no payment is received, and payment can be made by connecting to a live operator at that time. If you are unable to make payment, please contact our Business Office at 931-783-5857 to discuss payment arrangements. In the event your account is not paid within 60 days, it may be placed with a collection agency, and you will be responsible for the collection fees (up to 35% of balance), court costs, and legal fees.

Please feel free to ask our front office staff if you have any questions about our policies or your responsibilities. You may also contact our Business Office at 931-783-5857.

I have read and understand the CRMG Patient Financial Policy.

_____ _____

Patient Signature Date