If & only if you have ANY form of Medicare Insurance you MUST answer the questions in the box:
****(If this does not apply to you please skip this part and sign & date the bottom of this page)****

1) Are you entitled to Medicare based on ___ age ___ disability ___ESRD (End Stage Renal Disease/Dialysis)
2) Are you currently employed? ____ yes ____ no if no, date of retirement: _____
   If yes, name & address of employer: _____
   _____
3) Is your spouse currently employed? ____ yes ____ no if no, date of retirement: _____
   If yes, name and address of employer: _____
   _____
4) Do you have group health coverage based on your or your spouse's employment?
   ____ yes ____ no (for exp: BCBS, United Healthcare, Cigna, etc.)
5) Does the employer that sponsors your group health coverage employ 100 or more employees?
   ____ yes (group health is primary) ____ no (Medicare is primary)
6) Was illness/injury due to a non-work related accident? ____ yes ____ no Date of accident: _____
7) If this visit is related to an accident, was it automobile related? ____ yes ____ no
   If yes, name & address of no-fault liability insurer: _____
   _____
8) Are you currently receiving treatment from a home health agency? ____ yes _____ no
   If yes, name/address/phone no: _____
   _____
9) Are you currently under hospice care? ____ yes ____ no
   If yes, name & phone number of hospice provider: _____
   _____
10) Do you currently reside in a nursing home? ____ yes ____ no
    If yes, name/address/phone no: _____
    _____

Policies, Assignments, and Releases

I, the undersigned, am requesting treatment by one or more of the following: Dr. Frank Thomas, Dr. Henry Barnard, Dr. Bobby Prince, Dr. Tony Davis, Dr. Michael Fussell, Sheri Smith, PA-C, T Barrett Chaffin FNP-C, Leslie Mashburn, PA-C, Suzanne Wilson, PT, Brock Simmons, PT, Glenn Hamby, PT, Jason Martin, PT, Cathy Durland, PT, who are employees of Regional Health Group, Inc. I understand that while this is a practice offering orthopedic and physical therapy, no doctor desires to disrupt any current doctor patient relationship I may have, and I am free to choose my own orthopedist or physical therapist should any doctor here recommend such a referral. I further certify that I (or my dependent) have insurance with the company(s) or agency(s) provided, and I assign directly to Regional Health Group, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I also understand that I am financially responsible for all charges whether or not they are paid by insurance. I hereby authorize my doctor(s) to release any information necessary to secure the payment of benefits or as needed to coordinate my care with other healthcare professionals. I authorize the use of this signature on all insurance claim submissions. I also hereby authorize the release of any information necessary to secure the payment of benefits or any other information needed to settle my account, including verification of employment.

Please Sign Here: _____ Date: _____