TENNESSEE VALLEY INTERNAL MEDICINE, P.C.

PATIENT INFORMATION:

First _____ MI ____ Last_____ Sex: [ ] Male [ ] Female

Address: _____ Date of Birth: _____

City, State &Zip: _____ Social Security#: _____

Phone: _____ [ ] Home [ ] Cell [ ]Work Driver License #: _____ Exp: _____

Phone: _____ [ ] Home [ ] Cell [ ]Work Email: _____

Preferred Pharmacy: Name & Phone:_____

Address: _____

TENNESSEE VALLEY INTERNAL MEDICINE has permission to discuss my medical & billing info with the following persons:

_____ [ ] Spouse [ ] Other

_____ [ ] Relative [ ] Other

EMPLOYMENT: [ ] Employed [ ]Unemployed [ ] Retired

Employer's Name: _____

Employer's Address: _____

Employer's Phone: _____

INSURANCE POLICY AND GUARANTOR INFORMATION:

Primary Insurance Co: _____	**Secondary** Insurance Co: _____
Address: _____	Address: _____
Policy or Contract # _____	Policy or Contract # _____
Group Number: _____	Group Number: _____
Name of Policy Holder:_____	Name of Policy Holder: _____
Social Security # _____Date of Birth: _____	Social Security # _____ Date of Birth: _____
Phone: _____ [ ] Home [ ] Cell [ ]Work	Phone: _____ [ ] Home [ ] Cell [ ]Work
Employer: _____	Employer: _____

ASSIGNMENTS OF BENEFITS AND/OR GUARANTEE OF ACCOUNT:
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO TENNESSEE VALLEY INTERNAL MEDICINE FOR THE BENEFITS PAYABLE UNDER THE TERMS OF MY POLICY FOR MY ILLNESSES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY MY INSURANCE INCLUDING ALL COST OF COLLECTION AND REASONABLE ATTORNEY'S FEES.

RELEASE OF INFORMATION:
I HEREBY AUTHORIZE TENNESSEE VALLEY INTERNAL MEDICINE TO RELEASE TO MY INSURER FULL INFORMATION INCLUDING COPIES OF THE RECORDS RELATIVE TO MY ILLNESS.

SIGNATURE: _____ DATE: _____

PRINT

PAYMENT IS DUE AT TIME OF SERVICE

CLEAR