



1300 Old Weisgarber Rd
Knoxville, TN 37909
P: 865-584-2146
F: 865-374-2106

Workers' Compensation Information

At MedCare Specialists we strive to provide all injured employees with excellent care as well as knowledge of your rights with any workers' compensation claim.

Things you need to know:

- Insurance Carrier and phone number
- Adjuster name
- Claim number

Until your employer has submitted your claim to the insurance carrier, and there has been a claim number generated, there will be no referrals or physical therapy available. It is very important to obtain this information quickly.

Your claim can be denied and benefits stopped due to non-compliance such as:

- Not showing up for your appointment. This applies to MedCare as well as any physical therapy appointments.
- Not waiting to be seen by the physician.
- Numerous appointments being rescheduled.
- Not following restrictions.

Your adjuster and/or employer will be informed of every appointment that occurs and the outcome of said appointment(s).

Our physician(s) will determine your return to work restrictions(s). It is the employer's responsibility to determine if they can meet these restrictions. Some places of employment offer light/restricted duty while others may not. This is their decision and will need to be discussed with them immediately. MedCare does not know each and every job description and what is required of your position. The physician, based on the injury, will determine your restriction(s).

HIPAA laws involving workers' compensation claims vary from your private insurance claims. For workers' compensation cases in TN, medical records and reports pertaining to your injury, are required to be furnished, upon request, by our office to you the employee, and employee's attorney, a case manager, a third party administrator, the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development, and employer, an insurer, and employer's or insurer's attorney or any other persons or entities involved in the workers' compensation system without the necessity of obtaining the employee's consent to the release of such medical records or reports. (See T.C.A. 50-6-204)

If you have questions or problems relating to a workers' compensation injury, call 1-800-332-2667 (within Tennessee) or online at <http://www.state.tn.us/klabor-wfd/wcomp.html>



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Today's Date: _____

PATIENT INFORMATION					
Name (Last, First, Middle)			SSN #	Birthdate	Sex
Mailing Address			City, State, Zip		
Home Phone		Cell Phone		Email Address	
Marital Status	Student Status ☐ Full-Time ☐ Part Time	Smoker ☐ Yes ☐ No	Veteran ☐ Yes ☐ No	Ethnicity: Hispanic or Non-Hispanic	Primary Care Physician
Race ☐ Africa American ☐ French ☐ Hawaiian ☐ Multi-Racial ☐ Pacific Islander ☐ Alaskan Native ☐ German ☐ Hispanic ☐ Native American Indian ☐ White ☐ Asian ☐ Greek ☐ Indian ☐ German ☐ Other: _____					Preferred Language
Emergency Contact Name		Relationship		Emergency Contact Phone #'s Home: Cell:	
RESPONSIBLE EMPLOYER INFORMATION					
Employer requesting service		Employer Address (City, State, Zip)			Employer Phone Number
Who authorized you to present for treatment at our facility?					Title
WORKERS COMPENSATION ONLY					
Are you here for workers compensation? ☐ Yes ☐ No Date of Injury:					
Type of Injury:					
Was this injury or aggravation suffered in the performance of your duties, while engaged in work-related activities? ☐ Yes ☐ No					
Have you been treated at our facility for this injury, or has any other medical provider treated you for this injury, now or in the past? (Emergency Room, or other medical practices or specialists, etc) ☐ Yes ☐ No If yes, where?					
Do you have a first report of injury DOL Form (C-20)? ☐ Yes ☐ No					
Workman Compensation Insurance Carrier?				Phone #:	
WC Carrier Address (City, State, Zip)					
Were you assigned a case worker? ☐ Yes ☐ No If yes, case workers name: Phone #:					

IN CONSIDERATION OF THIS PHYSICIAN PRACTICE (THE "PRACTICE") FURNISHING SERVICES TO THE PATIENT, PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE, ON PATIENT'S BEHALF) AGREES AS FOLLOWS:

I. CONSENT TO MEDICAL TREATMENT AND RELATED SERVICES: The below-signed individual hereby authorizes the Practice and its associated professionals to furnish medical treatment and services to the patient, including medical treatment and services furnished through telehealth visits, and consents to diagnostic and therapeutic medical care, items, services, and procedures furnished by the Practice, its professionals, and their assistants and designees, including pharmacists and other professionals who are part of the healthcare team. The undersigned acknowledges and agrees treatment at the Practice also may be furnished by a resident physician (a medical school graduate supervised by a physician). The undersigned additionally consents to photographic/video documentation of the patient's medical treatment as the patient's treating professional finds appropriate or medically necessary, as well as any supervising physician's remote video monitoring of resident physicians. There are potential risks and hazards to any medical treatment or service, and there is no guarantee any particular treatment or service furnished by the Practice or its professionals will be successful. It is the Practice physician's responsibility to provide adequate information concerning a proposed treatment or service and to obtain any additional necessary consent before proceeding except as limited by emergency or other time-sensitive circumstances. The Practice's staff may obtain signature for such consent. The patient has the right to question or refuse treatment; however, if a proposed treatment is refused, the undersigned agrees CMG, the Practice, and associated professionals and staff shall be released from any and all liability for failure to provide treatment to the patient.

TELEMEDICINE: The Practice and its associated professionals deliver certain health care services by virtual means, including without limitation, through telehealth (interactive audio, video, and other electronic communications), patient portal communications, and by telephone (collectively, "Virtual Services"). **RISKS AND BENEFITS:** Benefits of Virtual Services include enhanced access to care, patient convenience, reduced risk of exposure to communicable disease, and access to ongoing care and follow-up communication with a health care provider. Medical information is protected to the same extent as in a face-to-face visit, although confidentiality and privacy at the patient's location is not controlled by the Practice. There are risks and limitations to Virtual Services. Virtual Services and care may not be as complete as face-to-face services as a result of a practitioner's potential lack of access to all diagnostic modalities/medical equipment necessary to obtain vital signs, labs, and other pertinent health information to treat the patient, lack of access to complete medical records, and problems with information transmission, including missed information or inaccurate information being transmitted, that could affect a practitioner's medical decision-making. Further, although the Practice uses available encryption and privacy modes for Virtual Services, it is also possible security protocols could fail, causing a breach of privacy of medical information. The alternative is a face-to-face visit, which the patient may request at any time, but an equivalent in-person service may not be available at the same location or time as a Virtual Service. During a Virtual Service, a practitioner may perform a physical exam through the use of technology or a facilitator in the room with the patient. Not all medical conditions can be treated as effectively through a Virtual Service, including emergency conditions. If a practitioner determines a face-to-face evaluation is needed, the patient will be referred to an appropriate location for such evaluation. A practitioner can withdraw from a Virtual Service for any reason, including when, in the practitioner's medical judgment, treatment is not safe, private, or effective. In such event, the practitioner can instruct the patient to seek in-person care and the patient agrees to follow such instruction, including for emergency care. Virtual Services are subject to charges, copayments, and deductibles consistent with this Agreement. While a patient may expect the anticipated benefits from the use of telehealth, no results can be guaranteed. It is the patient's duty to inform his or her physician of electronic interactions that the patient may have with other health care providers. **CONSENT TO TREATMENT VIA VIRTUAL SERVICES:** By electing to proceed with a Virtual Service, the undersigned has been informed of the risk and benefits of Virtual Services, understands and agrees to the above, and consents to medical treatment or consultation by means of a Virtual Service. The undersigned also consents to receiving protected health information via email or SMS text messaging and understands that messages through these communication channels may not be secure.

II. CONSENT TO COMMUNICABLE DISEASE TESTING: The below-signed individual consents for the patient to be tested for hepatitis, human immunodeficiency virus infection, or any other blood-borne infectious disease, as well as for any other communicable disease or condition, if and when another patient, a health care practitioner, or other individual furnishing services to patient at the Practice, a Practice employee, or an emergency aid worker has a potential exposure from the patient. If such testing becomes necessary, it will be performed at no charge.

III. CALCULATION AND PAYMENT OF CHARGES: The patient is liable and individually obligated for payment of the Practice's charges on the patient's account and the undersigned individual understands and agrees to the following: (1) The Practice's charges are set out in a chargemaster, the relevant portions of which may be examined for purposes of verifying the patient's account during regular business hours in our billing office. The Practice reserves the right to change the rates in the chargemaster. Charges on the patient's account are calculated based on chargemaster rates in effect as of the date charges for items or services are accrued. (2) The patient is liable for the uninsured portion of the Practice bill, which is due in full when services are rendered. Any amount not paid in full by insurance, for any reason, is the responsibility of the patient. (3) The Practice has both an uninsured patient discount policy and an indigent care policy. If the patient is uninsured, the patient is automatically entitled to a discount on chargemaster rates in accordance with the Practice's uninsured patient discount policy. In addition, if the patient is uninsured and meets certain criteria set forth in the Practice's indigent care policy (including, without limitation, income criteria), the patient may be entitled to further discounts to chargemaster rates. Please contact the Practice's financial counselors in our office or the CMG billing office at 865-374-5200 for more information. (4) The amount of the patient's Practice charges may differ from amounts other patients are obligated to pay based upon each patient's insurance coverage, Medicare/Medicaid coverage, or lack of insurance coverage. The amount of any discount from charges varies based on the circumstances applicable to each individual under the Practice's policies. (5) After reasonable notice, delinquent accounts may be turned over to a collection agency and/or attorney for collection. The patient agrees to pay the costs of collection, including court costs, reasonable attorney fees, collections charges, and reasonable interest charges, associated with Practice's efforts to collect amounts due. The undersigned hereby authorizes CMG, the Practice, and all health care professionals providing care to patient at the Practice, together with any billing service, collection agency, attorney, or other individual or entity working on their behalf, to contact the patient and patient's representatives by cellular and home telephone using prerecorded or artificial voice messages, automatic telephone dialing systems or other computer-assisted technology, text messages, and other forms of electronic communication.

IV. MEDICARE/MEDICAID PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFITS: The undersigned individual certifies that the information provided in applying for payment or reimbursement under Titles XVIII and XIX of the Social Security Act is true and correct. Further, the undersigned certifies that correct and complete information has been provided regarding the patient's insurance, HMO, health plan, workers' compensation, or other coverage for services and items furnished to the patient by the Practice, and the undersigned consents to CMG's/the

**Covenant Medical Group, Inc. ("CMG") Physician
Practice Patient Registration Agreement**

practice's billing such payers for items and services furnished by the Practice to patient. The undersigned hereby irrevocably assigns to CMG (or, if Practice professionals are not CMG employees, to Practice) all rights, title, and interest in compensation or payments otherwise payable to the patient, or received by or on behalf of the patient, for Practice items or services from any source or payer on file for the patient's account, including Medicare/Medicaid/TennCare, insurance companies, HMOs, and any other third-party payer or financially responsible person, not to exceed charges for services or items rendered. The undersigned further assigns to CMG, Practice, and any of its parent entities, affiliates, subsidiaries, or assigns any and all rights and benefits the patient has or may become entitled to under any policy of Insurance, any type of health plan under the Employee Retirement Income Security Act (ERISA), whether self-funded or otherwise, indemnity agreement, or from any other collateral source or third-party payor of any kind or nature, including all the rights to collect benefits directly from any insurance company, indemnity agreement, health plan covered by ERISA, or from any other collateral source or third-party payor of any kind or nature, and any and all right to proceed against the same in any action, including legal suit, if for any reason any of the same should fail to make payment of benefits due. It is patient's intent to assign to the fullest extent possible any and all rights patient has under ERISA to CMG and any of its parent entities, affiliates, subsidiaries or assigns without limitation. The patient further assigns to CMG and any of its parent entities, affiliates, subsidiaries or assigns, the right to the proceeds to pay the chargemaster rate for patient's bill from any claim and/or any action at law or equity for personal injuries which patient may have to the extent allowed by law. Any person, corporation, or government entity having notice of this assignment is authorized and directed to pay directly to CMG (or, if Practice professionals are not CMG employees, to Practice) all amounts due for health care items and services provided to the patient by the Practice. Except as provided in Section III or by law, the patient is financially responsible to the Practice for the charges not covered by these authorizations. The undersigned understands there are certain items and services for which payers, including Medicare and TRICARE/CHAMPUS/CHAMPVA, do not pay. Any sums not paid by a third-party payer are the patient's obligation. The patient is responsible for all health insurance or health plan deductibles and co-insurance, as well as noncovered or excluded items or services. If it is later determined the patient has an HMO or other health plan primary to Medicare and failed to inform the Practice prior to service of such election, the patient shall be responsible for paying the account. In the case of series services furnished to the patient by Practice, this Agreement shall remain in full force and effect for all such series services until specifically revoked in writing. The undersigned agrees to sign such further documents as may be reasonably requested to confirm and substantiate the Practice's or CMG's rights hereunder. The undersigned further agrees that a copy of this assignment may be used in place of the original copy.

V. RECEIPT OF NOTICES OF PRIVACY PRACTICES AND NONDISCRIMINATION; CONSENT TO USE AND DISCLOSE HEALTH INFORMATION:

The undersigned acknowledges receipt of the Practice's Notice of Privacy Practices (NPP), which is provided at <https://www.covenanthealth.com/privacy-notice/> and incorporated into this Agreement by reference, and consents to use and disclosure of the patient's protected health information and other patient records (a) consistent with the NPP, including without limitation, for purposes of the treatment, payment, and health care operations functions described in the NPP, whether through electronic health information exchange or otherwise; and (b) as authorized or permitted by federal or state law. Consistent with the above, the undersigned agrees to the Practice's disclosure of all or part of the patient's medical record for treatment purposes and to any person, corporation, or agency that is or may be liable for charges incurred at the Practice or for determining the necessity, appropriateness, amount, or other matter related to such services or charges, including, without limitation, insurance companies, HMOs, PPOs, workers compensation carriers, welfare funds, governmental health plans, the Social Security Administration, the Centers for Medicare & Medicaid Services, or any contractors of the same. The undersigned also consents to release by the patient's health plan or other insurance carrier to the Practice and CMG of any eligibility, utilization, or plan data concerning the patient's coverage that may be required. The undersigned additionally acknowledges receipt of the Practice's Notice of Nondiscrimination.

VI. PATIENT IDENTIFICATION; PERSONAL VALUABLES: The undersigned consents to photographic documentation of the patient for purposes of identification and registration. Further, the undersigned agrees that Practice is not responsible for loss of or damage to any money, jewelry, eyeglasses, clothing, hearing aids, or other personal property.

VII. HEALTH PLAN NOTIFICATION/AUTHORIZATION; APPOINTMENT: If the patient's health plan, insurer, or other coverage requires notification/authorization as a condition of payment for services, the patient must provide such notification and obtain such authorization. The patient hereby assumes full financial responsibility for charges incurred as a result of failure to comply with prior notification/authorization requirements. Notwithstanding the foregoing, the undersigned hereby appoints Practice as patient's agent for purposes of requesting prior authorization for services Practice professionals order at a Covenant Health hospital (e.g., lab services) and agrees Practice may delegate such appointment to such hospital. The undersigned acknowledges there is no guarantee or assurance authorization will be obtained.

VIII. AMENDMENTS: Revisions to the Agreement are not effective or enforceable unless accepted in writing by a CMG corporate officer.

IX. ADVANCE CARE PLAN/HEALTH CARE DECISIONMAKER.

Is the patient providing a copy of an advance care plan to include in the patient's medical record today (e.g., living will)?

☐ Yes* ☐ No

**if yes, provide patient's health care provider with a copy of advance care plan so it can be included in the patient's medical record*

Does the patient want to name a surrogate health care decision maker?

☐ Yes* ☐ No

**If yes, name of surrogate health care decision maker: _____ and relationship to patient: _____*

X. CONTACTING PATIENT. Patient may be contacted at the following number: _____. In addition, please check one:

☐ Practice may contact or leave messages regarding appointments and lab/test results with the following:

Name: _____ Relation to patient: _____ Phone: _____

Name: _____ Relation to patient: _____ Phone: _____

☐ Practice may not leave messages regarding appointments and lab/test results with anyone other than the patient.



Covenant Medical Group, Inc. ("CMG") Physician
Practice Patient Registration Agreement

I HAVE READ AND UNDERSTAND THIS REGISTRATION AGREEMENT AND BY SIGNING BELOW, AGREE TO ITS TERMS. IF THE UNDERSIGNED IS NOT THE PATIENT, SUCH INDIVIDUAL HEREBY CERTIFIES THAT HE/SHE IS THE PATIENT'S AUTHORIZED REPRESENTATIVE AND HAS ALL NECESSARY LEGAL AUTHORITY TO ENTER INTO THIS AGREEMENT ON THE PATIENT'S BEHALF. A COPY OF THIS AGREEMENT WILL BE PROVIDED ON REQUEST.

SIGNATURE: PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE)

SIGNED _____

Printed Name _____

Patient Name _____

Relationship to Patient _____

Date and Time _____

Rev 05/25

MM82750001 (05/25)



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AUTHORIZATION TO RELEASE HEALTH INFORMATION

PROVIDER AUTHORIZED TO RELEASE HEALTH INFORMATION: MedCare Specialists

Patient Name: _____

Date of Birth: ____/____/____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

The information is to be disclosed to the following persons or organizations (Patient's Employer):

Name/Title: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Purpose: **Employment and/or Department of Transportation use**

INFORMATION TO BE DISCLOSED IS ALL RECORDS FOR ANY DATES ASSOCIATED WITH OCCUPATIONAL HEALTH SERVICES

I understand that this information may include, but is not limited to, information related to Acquired Immune Deficiency/HIV, psychiatric or psychological treatment, and treatment for drug and/or alcohol use. My medical history and any medication use or prescriptions may be included.

EXPIRATION: I understand that unless I revoke the authorization earlier, this authorization will automatically expire one year following the release of care or transfer to another provider.

I understand I may revoke this authorization at any time by sending a written notice to each provider marked above. Revocation will not affect any uses or disclosures provider(s) may have made before receiving revocation. I understand information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be re-disclosed by the receiving party. I understand I may refuse to sign this authorization and that provider(s) will not condition treatment, enrollment, or eligibility for benefits on whether I sign this Authorization. I understand that there may be a reasonable copying fee, as permitted by applicable law.

SIGNATURE: _____ DATE: ____/____/____ TIME: _____

If signed by patient's legal Representative please complete the following and attach appropriate documentation.

Printed Name: _____ Relationship: _____

FOR PROVIDER USE ONLY

How was identity verified? _____ Copy made? YES NO

How was authority verified? _____ Copy made? YES NO

By: _____ Title: _____ Date: _____

☐ Picked up Mailed ☐ Faxed Date: ____/____/____ Released by: _____



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MEDICAL WAIVER AND CONSENT

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

THIS MEDICAL AUTHORIZATION FORM ONLY PERMITS THE EMPLOYER OR THE DIVISION OF WORKERS' COMPENSATION TO OBTAIN MEDICAL INFORMATION THROUGH ORAL OR WRITTEN COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, CHARTS, FILES, RECORDS, AND REPORTS IN THE POSSESSION OF A MEDICAL PROVIDER AUTHORIZED BY THE EMPLOYER PURSUANT TO T.C.A. 50-6-204 AND A MEDICAL PROVIDER THAT IS REIMBURSED BY THE EMPLOYER FOR THE EMPLOYEE'S TREATMENT.

I, _____, having filed a claim for workers' compensation benefits, do hereby authorize FamilyCare Specialists to furnish my employer or my employer's representative, and/or the Division of Workers' Compensation any information or written material reasonably related to my work-related injury for which I am claiming compensation. If my worker's compensation claim is denied, I authorize FamilyCare Specialists to file my private health insurance and I agree to pay any unpaid balance. If I do not have private insurance, I agree to pay the entire balance.

I further authorize the release of the same information to my attorney or me. _____
Initials

The authorization includes, but is not restricted to, a right to review and obtain copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

A photocopy of the authorization may be accepted in lieu of the original.

Dated: _____, 20_____

Patient

Witness