Robert A. Crook D.O.

Notifications and Releases

Listed below are several notices. ***Please read them carefully and sign where indicated that you have read each statement.***

****General Consent for Treatment**

We look forward to treating you as a patient, however, we need your consent for Dr. Crook to provide treatment or services. Also, certify that no guarantee or assurance has been made regarding the result that may be obtained.

I hereby grant consent to treatment or services.

_____ Date: _____

Patient/Patient's representative

**** Financial Policy/Assignment of Benefits**

As a courtesy to our patients, Dr. Crook accepts assignment from most major insurance plans. We will file your insurance claim for you. However, insurance is a contract between you and your insurance company. Therefore, we ask that you acknowledge your responsibility for the payment of our services. Payment for self pay, coinsurance % and any deductibles for the office visits, injections, and other charges are to be paid at time of service. We accept payment by Cash, Check, Money Order, Visa, Master card.

We contract with: Blue Cross Blue Shield, United Health Care, Aetna, and several other plans.

We **DO NOT** accept: Medicare, Cigna, TENN CARE, Workers Compensation, or Car Accidents under Litigation!

A 24-hour notification is required for cancelled/rescheduled appointments, or you will be subject to a fee. _____ (Patient Initial)

If the insurance denies coverage, disallows a service, or otherwise does not pay the claim, you are still responsible for the fees. In addition, if the fees for our services are not paid, we may turn the account to a collection agency. Attorney's fees and court costs will also be added to the outstanding balance if it becomes necessary to take legal action to collect past due amounts. Also, your insurance company may ask us to provide information concerning your treatment before they will pay for the services.

I authorize payment of benefits to be made on my behalf to Dr. Crook; Healthplus for medical services provided.

I acknowledge it is my responsibility to ensure payment of fees for services provided by Dr. Crook and authorize Healthplus to release any medical information, if necessary, to my insurance company.

_____ Date: _____

Patient/Patient's representative

****Privacy Policy**

Federal regulations require physician practices to keep your medical information private. Healthplus guards the privacy of our patients. We only share medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues.

I acknowledge that I have been informed about the privacy of my medical records.

_____ Date: _____

Patient/Patient's representative