Covenant Medical Group, Inc. ("CMG")
Physician Practice Patient Registration Agreement
P82750001 (Rev. 4/14) Page 1 of 2

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 SERVICES: The below-signed individual hereby authorizes the Practice and its associated professionals to furnish medical treatment and services to the patient and consents to diagnostic and therapeutic medical care, items, services, and procedures furnished by the Practice, its professionals, and their assistants and designees. Such consent includes consent to photographic/video documentation of the patient's medical treatment as the patient's treating professional finds medically necessary. 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 and refuse treatment; however, if a proposed treatment is refused, the undersigned agrees CMG, the Practice, and their associated professionals and staff shall be released from any and all liability for failure to provide treatment to the patient.
- **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 to the patient.
- 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.
- 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 the 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 thirdparty payer or financially responsible person, not to exceed charges for services or items rendered. 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 coinsurance, 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

Physic	nant Medical Grou cian Practice Patio 50001 (Rev. 4/14)	up, Inc. ("CMG") ent Registration Agreement Page 2 of 2		
remair sign si	n in full force and end uch further document	account. In the case of series services ffect for all such series services until series as may be reasonably requested to ed further agrees that a copy of this ass	specifically revoked in writing o confirm and substantiate the	The undersigned agrees to Practice's or CMG's rights
incorp inform treatm inform unders any pe necess insuran Securi also co	RECEIPT OF NOTICE OF PRIVACY PRACTICES; CONSENT TO USE AND DISCLOSE HEALTH AFORMATION: The undersigned acknowledges receipt of the Practice's Notice of Privacy Practices, which is corporated into this Agreement by reference, and consents to use and disclosure of the patient's protected health formation and other patient records (a) consistent with such Notice, including without limitation, for purposes of the eatment, payment, and health care operations functions described in such Notice, whether through electronic health formation exchange or otherwise; and (b) as authorized or permitted by federal or state law. Consistent with the above, the indersigned agrees to the Practice's disclosure of all or part of the patient's medical record for treatment purposes and to make a proportion, or agency that is or may be liable for charges incurred at the Practice or for determining the excessity, appropriateness, amount, or other matter related to such services or charges, including, without limitation, surance companies, HMOs, PPOs, workers compensation carriers, welfare funds, governmental health plans, the Social ecurity Administration, the Centers for Medicare & Medicaid Services, or any contractors of the same. The undersigned so consents to release by the patient's health plan or other insurance carrier to the Practice and CMG of any eligibility, ilization, or plan data concerning the patient's coverage that may be required.			
docum	PATIENT IDENTIFICATION; PERSONAL VALUABLES: The undersigned consents to photographic cumentation of the patient for purposes of identification and registration. Further, the undersigned agrees that Practice is t responsible for loss of or damage to any money, jewelry, eyeglasses, clothing, hearing aids, or other personal property.			
or other notific result unders profess	er coverage requires eation and obtain suc of failure to com- signed hereby appoint sionals order at a Co	COTIFICATION/AUTHORIZATION is notification/authorization as a condition authorization as a condition authorization. The patient hereby assumply with prior notification/authorizations Practice as patient's agent for purpovenant Health hospital (e.g., lab servicing and acknowledges there is no guarantee.	on of payment for services, the sumes full financial responsibilition requirements. Notwiths oses of requesting prior authorizes) and agrees Practice may of	ne patient must provide such lity for charges incurred as a tanding the foregoing, the rization for services Practice lelegate such appointment to
	AMENDMENTS: corporate officer.	Revisions to this Agreement are no	t effective or enforceable unle	ess accepted in writing by a
	CONTACTING PA	TIENT. Patient may be contacted at a <i>llowing</i> :	the following number:	In addition,
	Practice may con	tact or leave messages regarding appoir	ntments and lab/test results wit	h the following:
	Name:	Relation to patient: Relation to patient:	Phone:	
		leave messages regarding appointments		
AGRI CERT NECE	EE TO ITS TERM TIFIES THAT HI ESSARY LEGAL A URE: PATIENT (OR	UNDERSTAND THIS REGISTRA IS. IF THE UNDERSIGNED IS N E/SHE IS THE PATIENT'S AU AUTHORITY TO ENTER INTO THE R PATIENT'S LEGALLY AUTHORIZE	NOT THE PATIENT, SUCH THORIZED REPRESENT IS AGREEMENT ON THE D D REPRESENTATIVE)	I INDIVIDUAL HEREBY ATIVE AND HAS ALL
SIGNED _			PRINTED NAME	
PATIENT NAME		RELATIONSHIP TO PATIENT		

TIME

A copy of this agreement will be provided on request.

AM/PM

DATE