INDIANA INTERNAL MEDICINE CONSULTANTS

CENTER for RESPIRATORY & SLEEP MEDICINE

701 E. COUNTY LINE ROAD, SUITES 101 & 301
GREENWOOD, IN 46143

PH 317-885-2860 FAX 317-885-2869

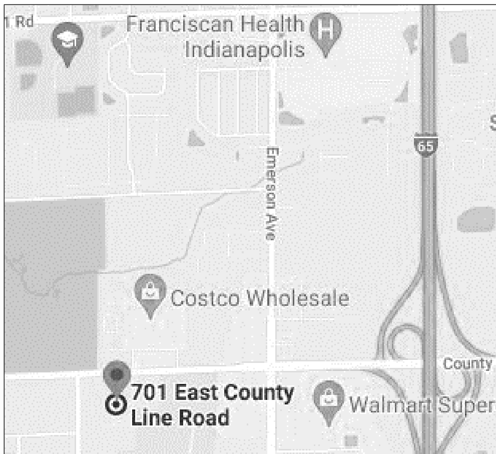
INDIANA PRIMARY CARE ASSOCIATES

INDIANA INFECTIOUS DISEASE CONSULTANTS

Welcome to our practice. Please review the enclosed information and bring your **completed** forms to your scheduled appointment.

Your appointment is confirmed with ____for a New Patient Evaluation on ________________at ______________in _______________________**.** New Patient Evaluations are approximately one hour. Your payment and/or co-pay amount is required for all office services at the time the services are rendered.

If you cannot keep this appointment, you may reschedule by contacting our office between 8 a.m. and 5 p.m., Monday through Friday at (317) 885-2860. Please note: Patients who no show or cancel their office visit less than 24 hours in advance will be charged a $50.00 fee. Also, if you arrive more than 15 minutes late to your scheduled appointment, you may need to be rescheduled to another day.



We are located at 701 E. County Line Road, Greenwood, IN 46143 in the Greenbrooke Medical Pavilion. Visit www.iimconline.com to learn more about our providers and services.

Please bring the following to your appointment:

- A list of all medications and dosages..
- Copy of your medical records.
- Insurance card(s).
- Completed new patient paperwork enclosed with this letter.
- Photo ID
- Any recent results of laboratory tests or X-rays (we do accept electronic files for X-rays). This information is very important to your health evaluation and may decrease the need to repeat tests

As a new primary care patient, your initial appointment may have been scheduled with a nurse practitioner. We offer appointments with nurse practitioners when our patients request this type of provider and when our physicians' schedules are not open for new appointments for more than three months. Our nurse practitioner/physician teams work together to provide you patient-focused, individualized care for all your health care needs.

Thank you for choosing us as your health care provider. Here's to your good health!

Sincerely,

Indiana Internal Medicine Consultants
Indiana Primary Care Associates

Center for Respiratory & Sleep Medicine
Indiana Infectious Disease Consultants

CONFIDENTIAL DATA

INDIANA INTERNAL MEDICINE CONSULTANTS – INDIANA PRIMARY CARE ASSOCIATES
CENTER FOR RESPIRATORY & SLEEP MEDICINE – INDIANA INFECTIOUS DISEASE CONSULTANTS

Date __________ Patient's Date of Birth _____________ Patient's Social Security Number _______________

Legal Name ____
Last First MI Preferred name

Home address ____
Street City State Zip code

Home Phone # ___________________ Cell Phone # __________________ Other Phone # ______________

E-mail address ____ May we contact you by e-mail: □ Yes □ No

Patient Sex: □ Male □ Female Relationship Status: □ Married □ Single □ Widowed □ Divorced □ Other

Race: □ A= Asian □ B= African American Black □ I= Hawaiian or Pacific Islander □ N= American Indian or Ak Nat
□ W= White Caucasian □ O= Other □ P= Declined

Language: □ L= American Sign Language □ A= Arabic □ B= Burmese □ C= Hakha Chin □ E= English □ H= Hindi
□ P= Panjabi □ S=Spanish □ D= Declined □ O=Other

Ethnic: □ H= Hispanic or Latino □ N=Not Hispanic or Latino

Referring Physician ____________________________
(First) (Last)
Address _____________________________________

Phone # _____________________________________

Family Physician _______________________________
(First) (Last)
Address _____________________________________

Phone # _____________________________________

Name of Employer ____ Employer Phone ______________________

Name of Spouse __________________________ Spouse Work# _______________ Spouse Cell# _______________

Name & phone number of nearest relative not living with you: Name ___________________ Phone# ______________

IN ORDER FOR US TO FILE WITH YOUR INSURANCE COMPANY, ALL INFORMATION IN THIS SECTION MUST BE COMPLETE & ACCURATE. YOU MUST FILL THIS OUT EVEN THOUGH YOUR INSURANCE CARD HAS BEEN COPIED

Primary Insurance ____________________________

Policy Holder _________________________________
□ Male □ Female

Relationship __________________________________

DOB ____

Employer _____________________________________

Secondary Insurance __________________________

Policy Holder _________________________________
□ Male □ Female

Relationship __________________________________

DOB ____

Employer _____________________________________

Please note: This information is requested for your protection, incorrect information supplied could result in your insurance not paying for services, leaving you responsible for the balance. If you are unsure of any information, we can make a telephone available for you to retrieve information. If you have any questions, please feel free to ask the receptionist.

RELEASE OF INFORMATION

I hereby authorize insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services or items processed as patient responsibility per the insurance. I also authorize the physician to release information required to process claims and agree that a photocopy of this authorization is as valid as the original. If for any reason you request your medical records to be sent to anyone, i.e. yourself, physician, attorney, etc, you **will** be charged a fee, unless **we** refer you to another physician.

Signature ____ **Date** ________________________________

HEALTH QUESTIONNAIRE
Confidential Data

INDIANA INTERNAL MEDICINE CONSULTANTS – INDIANA PRIMARY CARE ASSOCIATES
CENTER FOR RESPIRATORY & SLEEP MEDICINE – INDIANA INFECTIOUS DISEASE CONSULTANTS

Name: DOB: Date:

Reason for visit and symptoms:

LIST OTHER MEDICAL PERSONNEL INVOLVED IN CARE AND THE REASON		
Name	Phone Number	Reason

ALLERGIES/INTOLERANCES			
Allergen Name	Reaction	Intolerance or Allergy	Start Date
		□ Intolerance □ Allergy	
		□ Intolerance □ Allergy	
		□ Intolerance □ Allergy	
		□ Intolerance □ Allergy	

MEDICATIONS – List all prescription medications you currently take				
Medication	Start date	Strength	How often	Reason
SUPPLEMENTS – List all vitamins, hormones, alternative remedies or over the counter medication you use.				
Supplement	Start date	Strength	How often	Reason

PREVENTATIVE CARE – List date of last test or screening	
Test	Date of last test or screening
Colonoscopy	
Gastroscopy	
Dental examination	
DEXA (bone density)	
Eye examination	

MALE PATIENTS	Date of last test	Please (√) check below if applicable
PSA laboratory		□ Urethral discharge
Rectal/prostate examination		□ Urinary: Decreased flow or delayed flow/ejaculation
Testicular examination		□ Problems achieving/maintaining erection
		□ Diminished libido

HEALTH QUESTIONNAIRE
Confidential Data

FEMALE PATIENTS	**Date of last test**	**Menstrual history**
Breast examination		Age of onset:_______ Date of last period:__________ □ regular □ irregular
Mammogram		Flow: □ Heavy □ Mod □ Light □ Pain/cramps w/menstrual flow Days of flow:_______ Length of cycle:_________
Pap smear		
Rectal examination		No. of pregnancies:_______ Live births:________ Miscarriages:_______ Birth control method:_____________ Age of menopausal onset:________
		□ Pain after intercourse □ Bleeding after intercourse □ Flushing/menopause □ Diminished libido □ Infertility/infertility problems □ Problems:____

HEALTH HISTORY: Are you being treated for <u>or</u> have you <u>ever</u> had any of the following health conditions?
Please check (√). Space provided below for details or other health conditions not listed

	Condition		Condition		Condition		Condition
	Allergies		Colitis		*Defibrillator*		Nervous system disease
	Alcohol problems		Constipation		*Failure*		Osteoporosis/osteopenia
	Anemia		COPD		*Pacemaker*		Obesity
	Aneurysm		Dementia		*Palpitations*		Peptic ulcer(s)
	Anxiety		Depression		*Stents*		Peripheral vascular disease
	Arthritis:		Diabetes		*Valvular disease*		Pleurisy
	Osteoarthritis		*Last: HgA1 C #_______*		Hemorrhoids		Pneumonia
	Degenerative		*Dilated eye exam_____*		Hepatitis A B C other____		Prostate problems
	Psoriatic		*Urine for microalbumin _____*		High blood pressure		Seizure disorder
	Rheumatoid		Diarrhea		HIV/AIDS		Sexually transmitted disease(s)
	Asthma		Diverticulosis/diverticulitis		Hyperthyroidism		Sleep apnea
	Atrial fibrillation		Eating disorder		Hypothyroidism		Stroke
	Bleeding problem		Emphysema		Irritable bowel		TIA
	Blood clots		Fertility issues		Kidney disease		Tremors
	Blood transfusion		GERD		Kidney failure		Tuberculosis
	Bronchitis		Glaucoma		Kidney stones		Urinary:
	Cancer		Goiter		Low back pain		*Frequency*
	Type ____________		Gout		Lupus (SLE)		*Incontinence*
	CHF		Headaches		Mental illness/mood disorder______		*Infection(s)*
□ *systolic* □ *diastolic*			Heart		MRSA infection(s)		*Retention*
Ejection fraction ______			*Arrhythmia*		Narcolepsy		Varicose veins
	Crohn's disease		*CAD (MI)*		Neuropathy		Weight problems

List additional information and other health conditions not listed above:
____
____

PAST PROCEDURES/SURGERIES – List surgical procedures, reasons for hospitalizations and the year			
Type	Approximate date	Type	Approximate date

HEALTH QUESTIONNAIRE
Confidential Data

IMMUNIZATIONS – List date of last injection and if record is attached					
Injection	Date	Record attached?	Injection	Date	Record attached?
Gardasil		□ Yes □ No	Pneumonia		□ Yes □ No
Hepatitis A		□ Yes □ No	Polio		□ Yes □ No
Hepatitis B		□ Yes □ No	Tetanus		□ Yes □ No
Influenza		□ Yes □ No	Tdap		□ Yes □ No
MMR		□ Yes □ No	Typhoid		□ Yes □ No
Meningitis		□ Yes □ No	Zostavax		□ Yes □ No

SOCIAL HISTORY

Smoking status □ Current every day smoker □ Current someday smoker □ Former smoker □ Never smoker
□ Smoker, current status unknown

If Current or Quit within 12 months □ Cigarettes □ Cigars □ Pipe □ Smokeless Amount?_______ Duration?_______

If Current or Quit within 12 months, Smoking Cessation Counseling? □ Yes □ No If yes, list date of counseling:_______

Preferred language: ________________________________

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Race: □ White □ African-American □ American Indian/Alaskan □ Asian □ Hawaiian/Pacific Islander □ Other______

Relationship status: □ Married □ Single □ Widowed □ Divorced □ Partnered □ Other

How do you identify your sexual orientation? □ Heterosexual (opposite sex partner) □ Gay/lesbian(same sex partner)
□ Bisexual □ Transgender – If transgender, how would you like to be addressed?________________________________

Alcohol? □ Yes □ No □ Rarely Amount________per day/wk/mos. **Caffeine?** □ Yes □ No ____cups per day/wk/mos

Do you/or have you had a problem with drug use? □ Yes □ No If yes, list type_____________frequency_____________

Do you exercise? □ Yes □ No If yes, list type________________________ frequency________________________

Do you have children? □ Yes □ No If yes, how many children?_____ **Seatbelt usage?** List ______% of time worn

Have you been hit or threatened in the past year? □ Yes □ No

Employment history:

Are there cultural or religious beliefs to be considered in your care? □ Yes □ No **If yes, explain**________________________

Potential barrier to learning: □ none □ inability to understand English □ Language (if other than English)___________________
□ blind □ poor vision □ deaf □ decreased hearing □ unable to talk □ unable to read □ memory loss

Learns best by: □ reading □ verbal instruction □ practicing □ talking □ watching □ other

Do you have a: **Durable Power of Attorney** □ Yes □ No **If yes, list person(s)** ____________________________________
Healthcare representative? □ Yes □ No **If yes, list person(s)** ____________________________________
Living will? □ Yes □ No

Did you bring copies of above documents today? □ Yes □ No

Out of hospital Do Not Resuscitate (DNR) □ Yes □ No

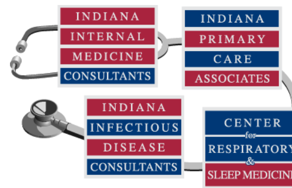
Would you like information on any of the above? □ Yes □ No

FAMILY HISTORY Follow the lines across the page. Mark appropriate box.	**Alive & well**	**Deceased**	**Age at Death**	**Cause of Death**	**High blood pressure**	**Heart disease**	**High cholesterol**	**Diabetes**	**Cancer**	**Asthma/lung disease**	**Tuberculosis**	**Arthritis**	**Kidney disease**	**Glaucoma**	**Stroke**	**Migraine**	**Mental illness**	**Alcoholism**	**Bleeds easily**	**Anemia**	**Gout**	**Seizures**	**Other**
FATHER																							
□ GF □ GM																							
MOTHER																							
□ GF □ GM																							
□ BRO □ SIS																							
□ BRO □ SIS																							
□ BRO □ SIS																							
□ BRO □ SIS																							
□ Spouse																							

Additional Comments or Information: ____
____

Person completing form Signature Date

Indiana Internal Medicine Consultants



Notice of Privacy Practices

This Notice of Privacy Practices and Policies outlines our practices, policies and legal duties to maintain confidentiality and protect against prohibited disclosures of protected health information **("PHI")** under the privacy regulations mandated by the Health Insurance Portability and Accountability Act ("HIPAA") and further expanded by the Health Information Technology for Economic Clinical Health Act ("HITECH").

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully***. This Notice of Privacy Practices describes how we may use and disclose your protected health information ("PHI") to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected health information" ("PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. Your PHI may be maintained by us electronically and/or on paper. We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices.

Uses and Disclosures of Protected Health Information

Your protected health information ("PHI") may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. Following are examples of the types of uses and disclosures of your PHI that the physician's office is permitted to make. These examples are not meant to be exhaustive, but do describe the types of uses and disclosures that may be made by our office.

- **Treatment:** We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your PHI. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. We will also disclose PHI to other physicians who may be treating you when we have the necessary permission from you to disclose your

protected health information. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

- **Payment:** Your PHI will be used, as needed to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

- **Healthcare Operations:** We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI to contact you to remind you of your appointment. This contact may include, but is not limited to, leaving voicemail messages, e-mail messages or messages with other members of your household. You may request that we not use any or all of these methods to contact you. We will share your PHI with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI. We may use or disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your PHI for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our HIPAA Privacy Officer to request that these materials not be sent to you.

- **Uses and Disclosures of PHI Based upon Your Written Authorization**: Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

- **Other Permitted and Required Uses and Disclosures that May be made with Your Consent Authorization or Opportunity to Object:** We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of PHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

- **Others Involved in Your Healthcare:** Upon your verbal authorization, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that is directly related to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made without Your Consent, Authorization or Opportunity to Object

- **Required by Law:** We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements by the law. You will be notified, as required by law, of any such uses or disclosures.

- **Public Health:** We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Communicable Diseases:** We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- **Health Oversight:** We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- **Abuse or Neglect:** We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- **Food and Drug Administration:** We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

- **Legal Proceedings:** We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement:** We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required law; (2) limited information requests for identification and location purposes; (3) pertaining to victims of a crime; (4) suspicion that death has occurred as a result of criminal conduct; (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

- **Coroners, Funeral Directors, and Organ Donation:** We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable

anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

- **Research:** We may disclose your PHI information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

- **Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services by the President or others legally authorized.

- **Workers' Compensation:** Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

- **Inmates:** We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.

- **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

Your Rights Regarding Medical Information about You

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Copies may be made available either

in paper or electronic format. Usually, this includes medical and billing records, but does not include psychotherapy.

To inspect and copy medical information that may be used to make medical decisions about you, you must submit your request in writing to the IIMC Health Information Management Department. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for IIMC.

  To request an amendment, your request must be made in writing and submitted to the IIMC HIPAA Privacy Officer. In addition, you must provide a reason that supports your requests. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
  - Is not part of the medical information kept by or for the practice
  - Is not part of the information which you would be permitted to inspect and copy
  - Is accurate and complete

- **Right to Accounting of Disclosures:** You have the right to request an "Accounting of Disclosures". This is a list of the disclosures we made of medical information about you. Your "Accounting of Disclosures" will not, however, list certain uses and disclosures that are exempted from the accounting requirement by federal or state law. To request this list of accounting of disclosures, you must submit your request in writing to the IIMC HIPAA Privacy Officer. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional list, we may charge you for the cost of providing the list. We will notify you of the cost involved and may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Receive Notice of Breach.** We are required by law to maintain the privacy of PHI, to provide you with notice of our legal duties and privacy practices with respect to your medical information, and notify you following a breach of your unsecured medical information. We will give you written notice in the event we learn of any unauthorized acquisition, use or disclosure of your PHI that has not otherwise been properly secured

as required by HIPAA. We will notify you without unreasonable delay, but no later than sixty (60) days after the breach has been discovered.

- **Right to Request Restrictions:** You have the right to request a restriction or limitation on how we use and disclose your medical information. For example, you also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. Additionally, if you pay for a particular service in full, out of pocket, on the date of service, you may ask us not to disclose any related medical information to your health plan.

  With the exception of disclosures to health plans for purposes of payment or health care operations that are not otherwise required by law for items or services paid in full, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

  To request restrictions, you must make your request in writing to the IIMC HIPAA Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you must make your request in writing to the IIMC HIPAA Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

  Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain another copy of this notice at our website, at www.iimconline.com.

  To obtain a paper copy of this notice, you may request a copy of the Notice of Privacy Practices from any Front Office Staff member, Health Information Management Department, or the IIMC HIPAA Privacy Officer.

Changes to this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post our current Notice of Privacy Practices at each office where we provide direct treatment to our patients and on our website at: www.iimconline.com. The effective date of the Notice will be listed below.

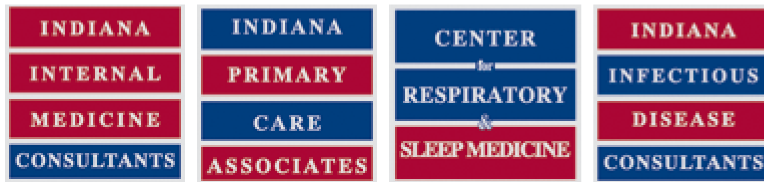
Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Practice or to the Secretary of Health and Human Services. You may file a complaint with us by notifying our HIPAA Privacy Officer of your complaint. **We will not retaliate against you for filing a complaint.**

You may contact our HIPAA Privacy Officer by e-mail at privacyofficer@iimconline.com, or by phone at (317) 885-2860 for further information about the complaint process. You can also write to us at:

701 East County Line Road
Suite 101
Greenwood, IN 46143
ATTN: HIPAA Privacy Officer

This notice was published and become effective on April 14, 2003 and was revised October 6, 2017.



Notice of Privacy Practices, effective April 14, 2003, revised October 6, 2017

WRITTEN ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

Patient's Name: ____

Last **First** **Middle initial**

Date of Birth: ______________________

I hereby acknowledge that I have received the Notice of Privacy Practices of Indiana Internal Medicine Consultants dated April 14, 2003, revised October 6, 2017.

______________________________ ______________________
Signature of patient (or healthcare representative) Date

____
Printed name of healthcare representative

____
Relationship to patient

PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION TO THOSE INVOLVED IN THE PATIENT'S CARE AND FOR NOTIFICATION PURPOSES

I, ______________________________, request that Indiana Internal Medicine Consultants disclose to the follow family members or friends my protected health information that is directly relevant to such person's involvement with my care or payment related to my care. Indiana Internal Medicine Consultants may also use or disclose this information as necessary to notify the following individuals of my general condition, location or death.

______________________________ ______________ ______________
Printed name Relationship to patient Contact Number

______________________________ ______________ ______________
Printed name Relationship to patient Contact Number

______________________________ ______________ ______________
Printed name Relationship to patient Contact Number

______________________________ ______________________
Signature of patient (or healthcare representative) Date

If patient is unable to sign, but circumstances are such that it can be reasonably inferred that the patient intends to consent to such disclosure, so note by checking and initialing here: □

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A copy of this written acknowledgement shall be placed in the medical record.

INDIANA INTERNAL MEDICINE CONSULTANTS
PATIENT FINANCIAL POLICY

Indiana Internal Medicine Consultants, St Francis Medical Group and Indiana Sleep Center thanks you for putting your trust in us as your health care provider. Our objectives are to provide you with the highest quality health care in the most cost-effective manner and to have a successful physician-patient relationship with you and your family. However, the ability to achieve these objectives depends greatly on your understanding of our financial policy.

Insurance Billing

- As a courtesy, we will verify your eligibility and file insurance claims on your behalf if you provide us with proof of insurance to include your insurance card indicating coverage, identification number and group number. In the event you have insurance coverage, but cannot provide documentation, payment is due at the time of service. You will then have 30 days to provide our office with the proper insurance information in order to file your claim(s). You will not receive a refund until your insurance company processes the claim(s).
- Secondary insurance claims will be filed with secondary insurance if adequate information is received at the time of service. However, if secondary insurance payment is not received in our office within 45 days after filing, the responsibility will be transferred to the patient and due upon receipt.
- If no insurance is to be filed by us, or if we are not a participating provider in your insurance plan, full payment is expected at time of service. Payment arrangements can be made for certain procedures only upon approval of the Business Office and a signed payment agreement.
- Children under the age of 18 will require the signature of a responsible party on the registration form unless they can show proof of emancipation.
- At your initial visit and annually thereafter, you will be asked to complete/update a patient information form. A Signature by the responsible party is required.
- Please bring your insurance card(s) with you to every visit. We want to help you receive the maximum allowable benefits from your insurer. In order to do so, we must have accurate and complete insurance information on file for you.
- It is your responsibility to understand what services are covered under your policy, and which providers participate in the plan or network you have chosen.
- Our practice will not bill auto insurance companies, attorneys, or any third-party liabilities for any medical services you receive. You will need to pay for services at the time of your visit or we will file with your medical insurance. If at any time your medical insurance would not pay for these services or take their money back due to it being an auto accident, you will be responsible for the bill in full. You may phone our billing office to get an Itemized receipt that you may present to the auto insurance company or attorney to get reimbursed if needed.
- Payment in full of your co-pay is required at time of service. If you cannot pay your co-pay, you may be asked to reschedule the appointment.
- Many Managed Care plans require you to obtain a referral prior to seeing a specialist. It is your responsibility to obtain this referral if required. Without a referral, your appointment may be rescheduled.
- A waiver stating you accept financial responsibility for your account balance must be signed if your insurance company cannot verify coverage of a specific service or if you do not have the necessary referral from your insurance company.
- As a participating provider of Medicare Part B (Physician Services), our office will only bill you for your Medicare coinsurance, deductible, and any services rendered but not covered by Medicare. All other services will be billed directly to Medicare. If you have Medicare Part A only, then the services you receive from our practice will not be covered by Medicare. We will not file with Medicare and the charges will be your responsibility unless you have other insurance coverage.

- Note: You will be informed of services not covered by Medicare prior to these services being rendered. Your signature upon the appropriate Medicare Waiver (ABN) form represents your authorization for the physician to perform these services and your acceptance of the financial responsibility for these services.
- In the event your insurance company inadvertently mails payment for our services to you instead of our office, we would expect that you would endorse the check and return it to our office for processing of the payment and credit to your account immediately.
- Our practice files all claims with your (legal name) and date of birth that were provided to us. In the event that your insurance company denies claims for these reasons it is your responsibility to have this corrected with your insurance. Until the correction(s) are made and we are paid for our services you will be billed the unpaid balances.

Self-Pay

- If no insurance information is provided at the time of service, your account will be considered self-pay and payment is due on that service date. We require all new patients, who do not have insurance, to pay by cash, credit card, or money order for their first and subsequent visits. A discount is offered for same day payments.

Workers' Compensation

- If you are being seen for a work-related injury, we will need documentation from your employer to confirm they want the visit to be considered under worker's compensation with instructions and how to bill for your services. If we do not receive this, you will be responsible for payment at the time services are rendered. We must have your caseworker's name, phone and fax numbers and authorization for specified visit (s) prior to your appointment.

No Show Appointments and Other Fees

- Effective January 1st 2017, Patients who do not show up for their office appointment without a call to cancel that appointment will be considered as **NO SHOW**. We understand that situations arise in which you cannot make it to your scheduled appointment. It is therefore requested that if you must cancel your appointment, you provide more than 24-hour notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24-hour notice, we are unable to offer that slot to other people. Patients who No-Show two (2) or more times in a 12-month period, may be dismissed from the practice thus they could be denied any future appointments. Patients may be charged **a $50.00 fee for an office appointment No Show.** The No Show fees are the sole responsibility of the patient and must be paid in full before the patient’s next appointment.

- Forms**:** The fee for completing Family Medical Leave or Disability forms is $25. This fee is per patient, per form.

Payment Options

- Acceptable methods of payment include cash, check, MasterCard, Visa and Discover. Credit card payments may be accepted by phone. Our practice does not keep credit card information on file.
- Your health insurance benefit is a contract between you and your insurance carrier. Therefore, the obligation to ensure payment is with you. As such, you are contractually obligated to pay your co-pay at the time of your office visit.
- You should receive a response from your insurance company within 30 to 45 days. This will be in the form of an EOB letter (Explanation of Benefits) sent to you at the address your insurance company has on file for you. If you do not receive this in a timely manner, we encourage you to contact your insurance company for the status of the claim. Doing so will help ensure your claim(s) are paid timely and will help you avoid problems with your account.

INDIANA INTERNAL MEDICINE CONSULTANTS
PATIENT FINANCIAL POLICY (cont.)

- Your insurance company may contact you directly by mail for additional information prior to your claim being paid. It is your responsibility to provide the information in a timely manner. Failure on your part to comply with your insurance company's request for additional information will result in denial of your claim(s) getting paid and can cause your account to become delinquent and could result in collection proceedings against you.
- You may contact our billing department at 317-885-2870 if you have questions or need assistance.
- In the event of an overpayment of your coinsurance or deductible, a refund will be processed.
- Patient statements are mailed on a monthly basis. If you do not receive a statement, please call the billing department.
- Services not covered by insurance or balances remaining after the insurance has processed the claim are the responsibility of the patient and are due immediately.
- Accounts with past due balances greater than 90 days old from the date of service are at risk for collection proceedings. We value our patients and make every attempt to work with them. However, when a patient makes no attempt at payment or communication with us, we have no alternative but to initiate collection proceedings. This may include one or all of the following: forward the past due account to an attorney, proceed to small claims *court,* garnishment of wages, reports filed with the three major credit bureaus. The options mentioned above can significantly and adversely impact your credit rating. Sending your account to collections, could also result in your being dismissed from the practice.
- If you find that you are unable to meet your financial obligation to Indiana Internal Medicine Consultants**.** Please contact our billing office ASAP to make payment arrangements. You can call 317-885-2870, to make these arrangements or to arrange a credit/debit card payment by phone.
- Co-pays will be collected at the time of the visit
- For your information the cost for a new patient consultation or office visit generally ranges from $84 - $305, if you are uninsured, you might be responsible. Diagnostic tests such as X-Rays, laboratory, EKG, injections, pulmonary tests are not included in the consultation or office visit fee

Monthly Statements

- We will send you a statement of balances not paid by insurance monthly. The statement is generated after we have received an explanation of benefits from your insurance company. The payment of this balance is due 15 days from the statement's date.
- Payment can be made by cash, check, money order, MasterCard, Visa or Discover

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- Delinquent accounts may be referred to a collection agency. Lack of payment may result in dismissal from the practice.
- In the event an account is turned over for collection, the person financially responsible for the account will be responsible for all collection costs including reasonable attorney fees and court costs.

Signature requested here to indicate that you have read, understand and accept the terms of the financial policy and you agree to authorize assignment of your insurance rights and benefits directly to the provider for services rendered. You fully understand you are solely responsible for any balance not paid by your insurance company. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I hereby designate Indiana Internal Medicine Consultants and its employees and agents to act as my representative to file grievances with my insurance company and to represent me with regards to claims, benefits, and other matters that may arise in accordance with the Indiana Code, Title 27, Chapters 8, and 13. I fully understand I am solely responsible for any balance not paid by my insurance company.

Patient/Guarantor Signature Date

Signature requested here to give consent to wireless telephone calls and/or email contact: "If at any time I provide a wireless telephone number and/or email address at which I may be contacted, I consent to receive calls, text messages and/or emails including but not restricted to communications regarding billing and payment for items and services, unless I notify the facility to the contrary in writing. Calls, text messages and other forms of electronic communication include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from this facility and our associated affiliates," in accordance with the Federal Code 47 U.S. Code 227. Thank you

Patient/Guarantor Signature Date

NOTE: Please sign both lines and return only the signed page to be included in your medical record.

Thank you

INDIANA INTERNAL MEDICINE CONSULTANTS – INDIANA PRIMARY CARE ASSOCIATES
CENTER FOR RESPIRATORY & SLEEP MEDICINE – INDIANA INFECTIOUS DISEASE CONSULTANTS

AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

PATIENT'S INFORMATION: (Please print)

Patient's name (Last, First, MI)	Date of Birth	Social Security #
Patient's Address (Street, Apt#, City, State & Zip Code)		

(PLEASE CHECK THE ONE THAT APPLIES):

☐ **I hereby request that my medical records be released to:**

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INDIANA INTERNAL MEDICINE CONSULTANTS
701 E. County Line Road, #101 & #301
Greenwood, IN 46143 317-885-2860 Fax: 317-885-2869

☐ **I hereby authorize Indiana Internal Medicine to release my records to:**

TO: ____
(Physician/Facility)

____
(Address) (City) (State) (Zip)

Purpose of Release

☐ Personal use ☐ Changing physicians ☐ Insurance ☐ Attorney ☐ Other

Unless limited below, I understand that this release pertains to medical records concerning treatment, including but not limited to information regarding treatment for alcohol/substance abuse, human immunodeficiency virus (HIV), or for psychiatric treatment or counseling.

Limitations: ____

I understand that this authorization is subject to written revocation at any time except to the extent that the action has been taken based upon it. I also understand that this authorization will expire in 60 days from the date signed unless I specify otherwise.

We provide up to two years of medical records at no cost. Please contact our office if you need medical records beyond two years. Medical Records: 317-885-2860, ext. 4978

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(Patient/Guardian Signature)

______________________________________ _________________________
(Relationship to patient, if other than patient) (Date)

REDISCLOSURE IS PROHIBITED WITHOUT SPECIFIED WRITTEN AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS.

For Office Use Only:

Released by: ________________________________ Date: _____________________