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

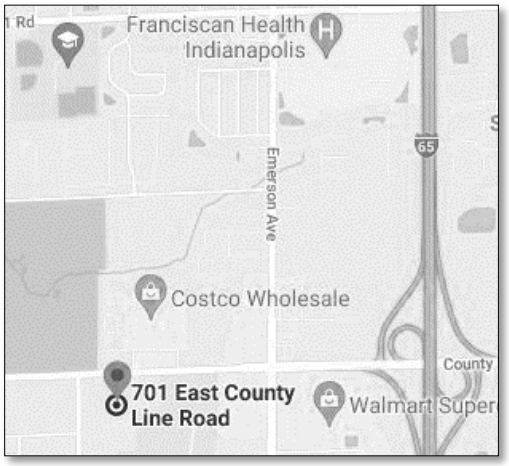
701 E. COUNTY LINE ROAD, SUITES 101 & 301
GREENWOOD, IN 46143

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

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 <u>MUST</u> 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 **<u>will</u>** be charged a fee, unless **<u>we</u>** 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 <u>all</u> prescription medications you currently take				
Medication	Start date	Strength	How often	Reason
SUPPLEMENTS – List <u>all</u> 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
Pap smear		Days of flow:_____ Length of cycle:_____
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 or have you ever had any of the following health conditions?

Please check (√). Space provided below for details or other health conditions not listed

□ 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, LLC

701 E County Line Road;
Greenwood, IN 46143
website: https://iimconline.com
email: privacyofficer@iimconline.com

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Notice Effective Date: 8/8/2022

This Notice of Privacy Practices applies to the following organizations.

Indiana Internal Medicine Consultants, LLC
Indiana Primary Care Associates
Indiana Infectious Disease Consultants
Center for Respiratory and Sleep Medicine

Anita Sears, Privacy Officer
privacyofficer@iimconline.com
317-883-5579

Notice of Privacy Practices, effective August 8, 2022

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 August 8, 2022.

_____ _____
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: □

_____

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 <u>not</u> 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

- 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:**

_____

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

_____
(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: _____