

PARKSIDE INTERNAL MEDICINE
PATIENT REGISTRATION

Office Use Only: Patient # _____ Date: _____

Dr. Michael Baach Dr. Tina Harrison Dr. Almitra Thomas Dr. Ryan Houghton
PATIENT INFORMATION

Name: _____ Social Security #: _____

Address: _____ Apartment: _____

City: _____ State: _____ Zip: _____ Home Telephone #: _____

Marital Status: S M D W Birthday: _____ Age: _____ Sex: M F Cell Phone #: _____

Employer: _____ Occupation: _____ Work Phone #: _____

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

Email: _____ How Did you Hear About Us? Family/Friend Advertisement Other

PERSON RESPONSIBLE FOR PAYMENT

Name: _____ Social Security #: _____ Relationship: _____

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

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Work or Cell Phone #: _____

PRIMARY INSURANCE INFORMATION

Ins Company Name & Address: _____

Policy Holder Name: _____ Relationship: _____ DOB: _____

ID #: _____ Group #: _____ Social Security #: _____

SECONDARY INSURANCE INFORMATION

Ins Company Name & Address: _____

Policy Holder Name: _____ Relationship: _____ DOB: _____

ID #: _____ Group #: _____ Social Security #: _____

THIRD INSURANCE INFORMATION

Ins Company Name & Address: _____

Policy Holder Name: _____ Relationship: _____ DOB: _____

ID #: _____ Group #: _____ Social Security #: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone #: _____ Cell #: _____ Work #: _____

NAME: _____

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as the results or cures have been made to me or relied upon by me.

PARENT/GUARDIAN INITIAL _____ PATIENT INITIAL _____

H.H.S. Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of **NOTICE OF PRIVACY PRACTICES:**

DATE: _____ INITIAL _____

FINANCIAL AGREEMENT: I acknowledge that I have received a copy of Parkside Internal Medicine's Financial Agreement.

PATIENT'S SIGNATURE _____ DATE _____

PARENT/GUARDIAN _____ DATE _____

RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

INITIAL _____

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician who treats me, to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

INITIAL _____

RELEASE OF PROTECTED HEALTH CARE INFORMATION VIA TELEPHONE TO ANSWERING MACHINE OR VOICE MAIL: I give my consent and authorization for the Medical, or Billing Staff of my Physician's Office to leave protected Health Care Information about me or for me on my answering machine or voice mail via the telephone at the number I have listed below. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

PHONE NUMBER _____ INITIAL _____

Have You Appointed a Health Care Representative or Authorization For Release of PHI to Third Party? Yes _____ No _____

I give my consent and authorization for this person or persons I have listed below to act as my Health Care Representative to receive any and all information from my medical records, or discuss any and all aspects of my medical care. I give consent, and authorization for the person, or persons to be notified any time I have an appointment. I also understand that I may revoke this privilege at any time by submitting my request in writing to this office.

Name of Your Health Care Representative or Name of Person(s) Authorized to Receive Information.

Signed By: _____ Date: _____

Witnessed By: _____ Date: _____

ADVANCED DIRECTIVE

1. Do You Have a Living Will? Yes _____ No _____

A copy may be needed for your chart. A copy was received by this office. DATE _____

2. Have You Given Anyone Your Power of Attorney? Yes _____ No _____

A copy may be needed for your chart. A copy was received by this office. DATE _____

Name _____ Relationship _____ Date _____

PARKSIDE INTERNAL MEDICINE FINANCIAL POLICY

Patient Information:

A fully completed, current patient registration will be on file in the patient chart during all times the patient is considered an active patient. Patient registrations will be updated yearly by the patient, and the registration will include where the patient can be reached by telephone. A signature by the responsible party is required.

Insurance Claims:

Primary Insurance: PARKSIDE INTERNAL MEDICINE will file a claim upon patient's submission of proof of insurance (i.e., insurance card indicating coverage, identification number, and group number). In the event the patient has insurance coverage but is unable to provide documentation, payment is due at the time of service. Upon submittal of insurance card, etc., PARKSIDE INTERNAL MEDICINE will submit a health insurance claim form indicating patient payment at time of service.

Secondary Insurance: Secondary insurance will be filed for patient upon patient's submission of proof of secondary insurance. However, if payment is not received in our office within 45 days after filing, the responsibility will be transferred to the patient. Payment will be due upon receipt.

Patient Financial Responsibility:

If no insurance is to be filed by PARKSIDE INTERNAL MEDICINE, or if PARKSIDE INTERNAL MEDICINE is not a participating provider, payment is due at the time of service.

Co-payments, deductibles, co-insurances, and non-covered services are due at the time of service. There will be a \$10 fee applied to the patients account for co-payments not paid at the time of service.

Minors/Dependents:

Children under the age of 18 will require the signature of a responsible adult party on the registration form.

Worker's Compensation:

Worker's compensation will be filed if the patient notifies PARKSIDE INTERNAL MEDICINE upon scheduling an appointment and supplies billing information upon check-in. Details of the accident will be required and a worker's compensation form will be completed.

DOT & CDL Physicals:

Our physicians do perform DOT and CDL physicals. The patient is required to verify with the employer that a specific doctor is not needed to complete the physical.

Certain insurance companies do NOT cover a DOT or CDL physical, in this case the patient would be responsible for payment of the service.

05/06/05 Rev. 2

A \$15.00 charge will be applied for all DOT or CDL paperwork that is filled out during the appointment. This charge is the patient's responsibility, and payment is due at the completion of the appointment (any co-pays that are required by the insurance are also due at that time).

If the office is not notified while the appointment is being scheduled that the physical is for a DOT or CDL physical, an additional appointment will be needed for all testing and paperwork completion.

Method of Payment:

Acceptable methods of payment are cash, check, Visa, Mastercard (including Visa and Mastercard debit cards), and American Express.

Visa, Mastercard, and American Express will be accepted by phone or fax.

Accounts Past Due:

Payment from statement is due upon receipt.

Non-compliance may result in preparation of account for small claims court, credit bureau reporting and possible discharge from the practice.

In the event that 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 of not less than 30% and court costs).

A patient may remit in full for all outstanding charges owed on an account and include amounts previously placed with the collection service. Under these circumstances, a physician may reserve the right to re-establish the patient to active status in the practice.

Missed Appointments:

PARKSIDE INTERNAL MEDICINE request 24 hour notice of appointment cancellations. Appointments missed and not previously cancelled will be charged a "no show" fee of \$25.00. After three no shows in a twelve month period you will be dismissed from the practice.

Physicians are not prepared to discuss financial issues. Our billing staff member at check-in and check-out is trained to discuss your account and make payment arrangements. They will be happy to help you; if you need further assistance, our Billing Manager can be consulted as well.

Medical Records:

Upon your written request, PARKSIDE INTERNAL MEDICINE will copy your medical record for the purpose of transferring your care to another primary care physician, or for your personal use. The fee for copies of you medical record is one dollar (\$1.00) per page for the 1st 10 pages, fifty cents (\$.50) per page for pages 11-50, twenty-five cents (\$.25) per page for pages 51 and higher, (plus postage).

All request for medical records from an attorney, insurance company, or any other outside source will be charged a twenty dollar (\$20.00) labor fee. There will be no charge for the first 10 pages copied. Pages 11-50 will be charged at fifty cents (\$.50) per page. Pages 51 and higher will be charged at twenty-five (\$.25) per page.

PARKSIDE INTERNAL MEDICINE is currently using Health Port as our copy service. You will receive a statement for payment of medical records directly from Health Port.

Miscellaneous Form Completion:

PARKSIDE INTERNAL MEDICINE will fill out any forms that need completed by your primary care physician (i.e., adoption forms, insurance forms, outside paperwork, etc.). A fee in the range of \$15.00 - \$30.00 will be applied. The charge will be based on the complexity of the forms and the amount of time needed for completion. The charge is considered the patient's responsibility, and payment is required upon completion of the paperwork.

I have received a copy of the PARKSIDE INTERNAL MEDICINE financial policy (Revision 8)

Signature

Date



PARKSIDE INTERNAL MEDICINE
13050 PARKSIDE DR. SUITE 210
FISHERS, IN 46038
OFFICE 588-2233 FAX# 588-2244

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ SS#: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Telephone: _____

- I agree to the release of health records and/or information as stated below.
I understand that I may refuse to sign this form and that not signing this form will not affect my services, treatment or payment for services; unless the services are only to create a record for someone else, such as physical exam or drug testing for an employer or insurance company; or if the services are research-related and your signature is required so that your results can be used for the research.
I understand that I may see and copy the information described in this form if I ask for it.
Unless limited below, I understand that this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR Part 2) or State Law (IC 16-39-2) concerning hospitalization or treatment, including but not limited to, information regarding alcohol abuse, substance abuse, communicable disease documentation, human immunodeficiency virus (HIV,) or mental health treatment or counseling.

I authorize _____ (practice name) to release information to:

Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____

I authorize _____ (practice name) to obtain information from:

Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____

The purpose or need for the disclosure: At the request of the individual Other (Specify:) _____

Date(s) of information to be disclosed: (please circle one) past year, past 2 years, past 3 years, past 4 years, past 5 years, All Records, Other _____ (list) _____

Information to be disclosed:

Office Notes X-Ray report All Records
Labs Emergency Room Other _____

I understand that this authorization is voluntary and that I have the right to revoke it at any time prior to its expiration date by written notification to _____ (name of releasing entity). This revocation will not have any effect on the information released pursuant to this Authorization before the revocation. I understand that the information released may be subject to redisclosure by any recipient and no longer protected by federal privacy laws.

The expiration Date for this release is 60 days from the signature date.

Information to be released: Verbally Photocopy Faxed Other _____

Signature _____ Date _____ Parent/Guardian/Representative Signature _____ Date _____
Witness _____ Date _____ Legal Authority of Representative _____

Released by _____ Date _____ Correspondence Section
Copy of Auth. provided to Individual by: _____ Date _____



COMMUNITY HEALTH NETWORK, INC. NOTICE OF PRIVACY PRACTICES

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 describes privacy practices of Community Hospitals of Indiana, Inc.; The Indiana Heart Hospital; Community Hospital South; Indiana Surgery Centers; Indianapolis Endoscopy Center, LLC; Community Home Health Services; and their affiliates, including: any employees; volunteers; health care professionals authorized to enter information into your health/medical records; and medical staff members (hereinafter referred to as Community Health Network or Network).

I. Our Duty to Safeguard Your Protected Health Information:

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for your health care is considered "Protected Health Information" ("PHI"). We understand that medical information about you and your health is personal and we are committed to protecting medical information about you. We are required by law to make sure that your PHI is kept private and to give you this Notice about our legal duties and privacy practices, that explains how, when and why we may use or disclose your PHI. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

We must follow the privacy practices described in this Notice, though we reserve the right to change the terms of this Notice at any time. We reserve the right to make new Notice provisions effective for all PHI we currently maintain or that we receive in the future. If we change this Notice, we will post a new Notice in patient registration and/or patient waiting areas. You may request a copy of the new notice from the Patient Access Department and it will also be posted on our website at www.eCommunity.com. We will also make available a copy of the Notice in effect each time you are admitted to the hospital as an inpatient or outpatient, or receive health care services from other health care providers within the Community Health Network, listed above.

II. How We May Use and Disclose Your Protected Health Information:

We use and disclose PHI for a variety of reasons. For certain uses/disclosures, we must get your written authorization. However, the law provides that we may make some uses/disclosures without your authorization. The following section offers more description and examples of our potential uses/disclosures of your PHI.

“ **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.** Since we are an integrated system, we may share your PHI with designated staff within the Community Health Network, for treatment, payment or operations purposes. Generally, we may use/disclose your PHI:

- **For treatment:** We may disclose your PHI to doctors, nurses, and other health care personnel who are involved in providing your health care. For example, your PHI will be shared among members of your treatment team, our central pharmacy staff, or with a specialist to whom you have been referred. If you are an inpatient, your name may be posted outside the door of your room.
- **To obtain payment:** We may use/disclose your PHI in order to bill and collect payment for your health care services. For example, we may release portions of your PHI to Medicare/Medicaid, a private insurer or group health plan to get paid for services that we delivered to you. Release of your PHI to the state Medicaid agency might also be necessary to determine your eligibility for publicly funded services.
- **For health care operations:** We may use/disclose your PHI in the course of our operations. For example, we may use your PHI or your answers to a patient satisfaction survey in evaluating the quality of services provided by our staff, or disclose your PHI to our auditors or attorneys for audit or legal purposes. We may also share PHI with health care provider licensing bodies like the Indiana State Department of Health.
- **Appointment reminders:** Unless you provide us with alternative instructions, we may send appointment reminders and other similar materials to your home. We may also call your home and leave a message on your answering machine or voice mail. (See Section III about confidential communication.)
- **Treatment alternatives:** We may contact you about possible treatment options or alternatives, or other health-related benefits or services that may interest you.
- **Fundraising:** We or our Foundation may contact you to raise money for the Network and its operations, unless you tell us in writing not to contact you for this purpose.

“ **Uses and Disclosures Requiring Authorization:** For uses and disclosures other than treatment, payment and health care operations purposes, we are required to have your written authorization, unless the use or disclosure falls within one of the exceptions described below. You may revoke an authorization, in writing, any time to stop **future** uses/disclosures. If you revoke your authorization, we will stop using/disclosing your PHI for the purposes or reasons covered by your written authorization. You understand that we are unable to take back disclosures we have already made with your permission. (See Section VI for instructions for revoking an authorization.) We cannot refuse to treat you if you refuse to sign an authorization to release PHI, **unless** services provided are solely to create health records for a third party, such as physical and drug testing for an employer or insurance company; or if treatment provided is research-related and authorization is required for the use of health information for research purposes. We will not use or disclose your PHI for marketing purposes without your authorization.

“ **Uses and Disclosures Not Requiring Authorization:** The law provides that we may use/disclose your PHI without your authorization in the following circumstances:

- **When required by law:** We may disclose PHI when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, for FDA-

regulated products or activities, or in response to a court order. We must also disclose PHI to authorities that monitor compliance with these privacy requirements.

- **For public health activities:** We may disclose PHI when we are required to collect information about disease or injury, or to report vital statistics to the public health authority, such as reports of tuberculosis cases or births and deaths.

- **For health oversight activities:** We may disclose PHI to the Indiana State Department of Health or other agencies responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

- **Relating to decedents:** We may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

- **For research purposes:** In certain circumstances, and under supervision of our Institutional Review Board, we may disclose PHI in order to assist medical research, such as comparing the health and recovery of all patients who received one medicine to those who received another. Generally, we will ask you for your specific permission if the researcher will have access to your name, address and other PHI, or will be involved in your care.

- **To avert threat to health or safety:** In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

- **Law enforcement:** We may disclose PHI to a law enforcement official in circumstances such as: in response to a court order; to identify a suspect, witness or missing person; about crime victims; about a death that we may suspect is the result of criminal conduct; or criminal conduct at the hospital or health care facility.

- **For specific government functions:** We may disclose PHI of military personnel and veterans in certain situations; to correctional facilities in certain situations; and for national security and intelligence reasons, such as protection of the President.

- **Workers' Compensation:** We may disclose your PHI to your employer for Workers' Compensation or similar programs that provide benefits for work-related illness or injuries.

- **Inmates:** An inmate of a correctional institution does not have the rights listed in this Notice of Privacy Practices.

•• **Uses and Disclosures Requiring You to Have an Opportunity to Object:** In the following situations, we may disclose your PHI if we tell you about the disclosure in advance and you have the opportunity to agree to, prohibit, or restrict the disclosure. However, if there is an emergency situation and you cannot be given the opportunity to agree or object, we may disclose your PHI if it is consistent with any prior expressed wishes and the disclosure is determined to be in your best interests. You must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.

- **Patient Directories:** If you are hospitalized, your name, location, general condition, and religious affiliation may be put into our patient directory for use by callers or visitors who ask for you by name and by clergy. If you ask to be a "No Information" patient, volunteers, employees and telephone operators will not tell anyone that you are in the facility and flowers, mail, phone calls and visitors will be turned away and not accepted if your room number is not provided.

- **To families, friends or others involved in your care:** We may share with these people information directly related to your family's, friend's or other person's involvement in your care, or payment for

your care. We may also share PHI with these people to notify them about your location, general condition, or your death.

- **Disaster relief:** We may release your PHI to a public or private relief agency for purposes of coordinating notifying your family and friends of your location, condition or death in the event of a disaster.

III. Your Rights Regarding Your Protected Health Information:

You have the following rights relating to your protected health information:

To request restrictions on uses/disclosures: You have the right to ask that we limit how we use or disclose your PHI. You must make your request in writing. We will consider your request, but are not legally bound to agree to the restriction. To the extent that we do agree to any restrictions on our use/disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. If agreed upon, these restrictions will only apply to the Community Health Network affiliates listed in the beginning of this Notice. You understand that we are not able to take back disclosures already made. We cannot agree to limit uses/disclosures that are required by law.

To request confidential communication: You have the right to ask that we send you information at an alternative address or by an alternative means, such as contacting you only at work. You must make your request in writing. We must agree to your request as long as it is reasonably easy for us to do so.

To inspect and copy your PHI: Unless your access is restricted for clear and documented treatment reasons, you have a right to see your protected health information if you put your request in writing. We will respond to your request within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed. You have a right to choose what portions of your information you want copied and to have information on the cost of copying in advance.

To request amendment of your PHI: If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. Written requests must include a reason that supports your request. We will respond within 60 days of receiving your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We may also deny your request if we determine that the PHI is: (1) correct and complete; (2) not created by us and/or not part of our records, or; (3) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial reviewed, along with any statement in response that you provide, added to your PHI. If we approve the request for amendment, we will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

To find out what disclosures have been made: You have a right to get a list of when, to whom, for what purpose, and what content of your PHI has been released other than instances of disclosure for which you gave your written authorization. (This is called an accounting of disclosures.) Your request can relate to disclosures going as far back as six years. The list will not include any disclosures made: before April 14, 2003; for national security purposes; for treatment, payment or health care

operations purposes; through a facility directory; or to law enforcement officials or correctional facilities. Your request must be in writing. We will respond to your written request for such a list within 60 days of receiving it. There will be no charge for the first list requested each year. There may be a charge for subsequent requests.

To receive a paper copy of this Notice: You have a right to receive a paper copy of this Notice and/or an electronic copy by email upon request. To obtain a copy of this Notice, contact: one of the individuals identified in Section V. below.

IV. How to Complain About Our Privacy Practices:

If you think we may have violated your privacy rights, or if you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section V. below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. **You will not be penalized if you file a complaint.**

V. Contact Persons for Information or to Submit a Complaint:

If you have questions about this Notice or complaints about our privacy practices, please contact: Marti A. Baker, Network Privacy & Compliance Consultant, 8180 Clearvista Pkwy., Suite 101 Indianapolis, IN 46256, 317/621-7321, mabaker@eCommunity.com; Mary Gamache, Privacy Official, The Indiana Heart Hospital, 8075 N. Shadeland Ave., Indianapolis, IN 46250, 317/621-8057, mgamache@eCommunity.com; Gail Mahoney, Privacy Official, Community Home Health Services, 9894 E. 121st St., Fishers, IN 46038, 800/404-4852, gamahoney@eCommunity.com; or Jackie Smith, Network Privacy & Compliance Officer, Clearvista Pkwy., Suite 101 Indianapolis, IN 46256, 317/621-7324, jackie.smith@eCommunity.com

VI. Instructions for Revoking an Authorization:

You may revoke an authorization to use or disclose your PHI, in writing, **except:** 1) to the extent that action has been taken in reliance on the authorization, or 2) if the authorization was obtained as a condition of obtaining insurance coverage and other law provides the insurer with the right to contest a claim under the policy. Your written revocation must include the date of the authorization, the name of the person or organization authorized to receive the PHI, your signature and the date you signed the revocation, addressed to the contact person listed on your original authorization.

VII. Effective Date:

This Notice was effective on 4/14/03; updated on 10/15/04; updated on 1/1/05; updated on 1/21/05; updated on 3/30/07.