

Patient Name: _____ Date of Birth: _____ Physician: _____
 Please Print MM/DD/YY

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 to the results or cures have been made to me or relied upon by me.

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INS BENEFITS: I authorize my physician to release information from my medical records to my insurance carrier(s) or governments 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.

FINANCIAL AGREEMENT:

- I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. My physician will assist in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to the physician. Current insurance cards must be presented at each visit. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs. Collection fees will equal 50% of the amount turned over for collection. Reasonable attorney fees incurred to effect collection of this account or future outstanding accounts will be the responsibility of the patient. We do require 100% of co-pays and deductibles to be paid at the time of service. A \$15 service charge will be added to the account if the co-pay is not paid at the time of service or within 10 day grace period.
- Unless canceled at least 4 hours in advance, our policy is to charge \$25 for missed appointments and \$50 for missed physicals and new patients.
- For any check that is returned due to non-sufficient funds, it is our policy to charge a fee of \$25.00.

INITIAL _____

RELEASE OF PROTECTED HEALTH CARE INFORMATION VIA TELEPHONE

- I give consent and authorization for my physician or the 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 number listed below.
 Phone() _____
- If Unable to Contact Patient or Parent, test results may be left with:
 Name: _____ Relationship _____ Phone _____
- I understand I may revoke these privileges at any time by submitting my request in writing to this office.

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII of 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 _____

MEDIGAP AUTHORIZATION (FOR MEDICARE PATIENTS ONLY)

Name of Beneficiary (Patient) _____ Medigap Policy Number _____

I am giving Anderson Family Health Specialists permission to ask for Medigap Payments for my medical care. I understand that _____ (Name of Medigap Insurer) needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to _____ (Name of Insurer.)

I request that payment authorized by Medigap benefits be made either to me or on my behalf to Anderson Family Health Specialists for any services furnished to me by that physician/supplier. I authorize any holder of medical information to release to _____ (name of Medigap Insurer) any information needed to determine benefits payable for related services.

PATIENT SIGNATURE _____ DATE _____

ADVANCED DIRECTIVE

- | | |
|--|--|
| Do you have a living will? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Have you appointed a Health Care Representative? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Have you given anyone your Power of Attorney? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Resuscitate? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

NEW PATIENTS ONLY

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I _____ acknowledge that I have received the Community Hospitals of Indiana, Inc. Notice of Privacy (If patient did not sign, give reason and initial.) _____

Patients Signature _____ Date _____

Parent/Guardian _____ Date _____