

PLEASE PRINT

FORM 1001-REV. 12/03

PATIENT INFORMATION

GUARANTOR

INSURANCE

The person seeing the doctor.

Person responsible for all unpaid balances on this account.

List all insurance for which you have a current card. List Medicare or Medicaid first.

Spouse, step-parent, significant other.

TODAY'S DATE		PATIENT REGISTRATION			FORM 1001-REV. 12/03	
PATIENT NUMBER		PLEASE COMPLETE ALL WHITE AREAS				
LAST NAME			FIRST NAME & INITIAL			
ADDRESS LINE 1						
ADDRESS LINE 2						
CITY		STATE	ZIP	E-MAIL ADDRESS		
HOME PHONE		CELL PHONE	PAGER NUMBER			
SEX	MARITAL STATUS (M/S)	DATE OF BIRTH	M.D. REQUESTING YOUR APPOINTMENT			
PATIENT'S S.S. NO.		IF NOT REFERRED BY PHYSICIAN, PLEASE CHECK ONE BOX BELOW <input type="checkbox"/> PATIENT <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> PROVIDER BOOK <input type="checkbox"/> OTHER				
PATIENT'S EMPLOYER						
EMPLOYER ADDRESS						
CITY			STATE	ZIP		
EMPLOYER PHONE			EXT.			
RESP. PARTY LAST NAME			FIRST NAME & INITIAL		RELATIONSHIP	
ADDRESS						
CITY		STATE	ZIP	E-MAIL ADDRESS		
HOME PHONE		CELL PHONE	PAGER NUMBER			
RESP. PARTY DATE OF BIRTH		RESPONSIBLE PARTY S.S. NO.				
RESP. PARTY EMPLOYER			EMPLOYER PHONE	EXT.		
EMPLOYER ADDRESS				EMPLOYER FAX #		
MEDICARE, MEDICAID OR INS. #1 NAME			INS. #1 CODE			
INSURANCE #1 ADDRESS			INS. #1 PHONE			
POLICYHOLDER LAST NAME		FIRST NAME	RELATIONSHIP		SEX	
		DATE OF BIRTH	SS #		M/F	
CERTIFICATE #		GROUP NO.		MEMBER NO.		
INSURANCE #2 NAME			INS. #2 CODE			
INSURANCE #2 ADDRESS			INS. #2 PHONE			
POLICYHOLDER LAST NAME		FIRST NAME	RELATIONSHIP		SEX	
		DATE OF BIRTH	SS #		M/F	
CERTIFICATE #		GROUP NO.		MEMBER NO.		
INSURANCE #3 NAME			INS. #3 CODE			
INSURANCE #3 ADDRESS			INS. #3 PHONE			
POLICYHOLDER LAST NAME		FIRST NAME	RELATIONSHIP		SEX	
		DATE OF BIRTH	SS #		M/F	
CERTIFICATE #		GROUP NO.		MEMBER NO.		
NAME			RELATIONSHIP			
DATE OF BIRTH			S.S. NO.			
EMPLOYER			WORK PHONE			
NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU			RELATIVE/FRIEND PHONE			

YOU MUST READ AND SIGN THE OTHER SIDE OF THIS FORM

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.

INITIAL _____

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INS 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 _____

MEDIGAP AUTHORIZATION (FOR MEDICARE PATIENTS ONLY)

Name of Beneficiary (Patient) _____ Medigap Policy Number _____

I am giving Community Physicians of Indiana, Inc. 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 Community Physicians of Indiana, Inc. 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.

SIGNED _____ DATE _____

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 patients 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 my physician. 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.

INITIAL _____

MISSED APPOINTMENTS:

Unless canceled at least 4 hours in advance, our policy is to charge \$25.00 for missed appointments. Please help us serve you better by keeping scheduled appointments.

INITIAL _____

RETURNED CHECK FEE:

For any check that is returned due to non-sufficient funds, it is our policy to charge a fee of \$25.00.

INITIAL _____

ADVANCED DIRECTIVE		RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received the Notice of Privacy Practices. (If patient did not sign, give reason and initial.) _____ _____
1. Do you have a living will?	Yes ___ No ___	
2. Have you appointed a Health Care Representative?	Yes ___ No ___	
3. Have you given anyone your Power of Attorney?	Yes ___ No ___	
4. Resuscitate?	Yes ___ No ___	

Release of Protected Health Care Information Via Telephone To Answering Machine, Or Voice Mail

I give 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 number I have listed below. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

Number () _____

INITIAL _____

Who May We Leave Test Results With If Unable To Contact Patient Or Parent?

Name _____ Relationship _____ Phone _____

Patient's Signature _____

Date _____

Parent/Guardian _____

Date _____



Community
Physicians of Indiana

Family Practice and Diving Medicine

Ronald K. Andrews, M.D., D.M.O.
740 W. Green Meadows Drive, Suite 110
Greenfield, IN 46140
317-318-7000 (tel)
317-318-7005 (fax)

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have
(please print patient's name)
received the **Community Hospitals of Indiana, Inc. and The
Indiana Heart Hospital Notice of Privacy Practices.**

X _____ (date)
(Patient's or Parent's/Guardian's Signature)

Office use only:
<i>If patient did not sign, please give reason</i> _____
<i>Employee initial</i> _____