PATIENT INFORMATION FORM
PUTNAM PEDIATRIC & INTERNAL MEDICINE

PATIENT INFORMATION DATE:_____

Last Name: _____ First: _____ M.I. _____

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

Social Security #: _____ Date of Birth: _____ Sex: _____ Martial status: _____

Race: *(please select at least one)* ☐ white ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Refuse to Report

Language Best Served: _____ Veteran: ☐ Yes ☐ No

Ethnicity: *(please select only one)* ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Refuse to Report

Please indicate the preferred method for us to contact you. ☐ by phone ☐ by mail ☐ by web portal

Home Phone # _____ Email address: _____
(IN ORDER TO ACCESS WEB PORTAL EMAIL IS REQUIRED)

Cell Phone#: _____ Work Phone: _____

Employer: _____ Full time / part time Student: ☐ Yes ☐ No

Family Physician: _____ Phone: _____ Referring Physician: _____ Phone: _____

Spouse Name: _____ Spouse Employer: _____ Date of Birth: _____

PHARMACY OF CHOICE: _____ CITY: _____

IN CASE OF EMERGENCY: _____ PHONE: _____

RESPONSIBLE PARTY INFORMATION *(if patient is child, who do they reside with)* Relationship to Patient ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Step-Father ☐ Step-Mother ☐ Other

Full Name: _____ Phone #: _____

Mailing Address: _____ City: _____ State: ___ Zip: _____

IS THIS PATIENT COVERED BY INSURANCE? ☐ Yes ☐ No

PRIMARY INSURANCE: Policy Holder?: ☐ Patient ☐ Spouse ☐ Father ☐ Mother ☐ Step-Father ☐ Step-Mother ☐ Other

Name of Insurance Company: _____ Employer: _____

Policy Holder's full name: _____ SS#: _____ Date of Birth: _____

SECONDARY INSURANCE: Policy Holder?: ☐ Patient ☐ Spouse ☐ Father ☐ Mother ☐ Step-Father ☐ Step-Mother ☐ Other

Name of Insurance Company: _____ Employer: _____

Policy Holder's full name: _____ SS#: _____ Date of Birth: _____

Signature:

_____ Relationship to patient: _____
(My signature confirms that the information I have reported above is correct)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Due to HIPPA regulations, the office must have the patient's consent to speak with any other individual(s) regarding personal records, no matter the relationship to the patient. Please list individuals and relationship to those individuals that we may speak with regarding your medical records or when leaving a telephone message.
Patient records available both electronically and in a hard copy format within 3 days upon request.

PERSONS TO CONTACT AND WHOM INFORMATION MAY BE DISCLOSED
Please include full name and phone number of anyone authorized to talk to on your behalf

PRIMARY/EMERGENCY CONTACT

NAME: ______________________

PHONE: ______________________

RELATIONSHIP: ______________________

Please indicate the information covered by this authorization:

- ☐ Appointment status/ scheduling
- ☐ Medical testing results and diagnosis
- ☐ Financial records
- ☐ ALL OF THE ABOVE AND NOT LIMITED TO

NAME: ______________________

PHONE: ______________________

RELATIONSHIP: ______________________

Please indicate the information covered by this authorization:

- ☐ Appointment status/ scheduling
- ☐ Medical testing results and diagnosis
- ☐ Financial records
- ☐ ALL OF THE ABOVE AND NOT LIMITED TO

NAME: ______________________

PHONE: ______________________

RELATIONSHIP: ______________________

Please indicate the information covered by this authorization:

- ☐ Appointment status/ scheduling
- ☐ Medical testing results and diagnosis
- ☐ Financial records
- ☐ ALL OF THE ABOVE AND NOT LIMITED TO

IS IT OK TO LEAVE A DETAILED MESSAGE ON VOICEMAIL OR ANSWERING MACHINE REGARDING TEST RESULTS? ☐ ***Yes*** ☐ ***No***

SIGNATURE:

Name of Patient (Print)______________________________

Signature of Patient______________________________ Date Signed ______________

Signature of Patient Representative: ______________________________ Relationship ______________

EXPIRATION OF AUTHORIZATION:
This authorization is effective for one year (1) from the date signed unless revoked, terminated by the patient or the patient's personal representative or the patient becomes 18 years of age.
A patient must sign a new form upon reaching the age of 18 years.

PUTNAM PEDIATRIC & INTERNAL MEDICINE

1542 S. Bloomington, Suite 1300
Greencastle, IN 46135

AUTHORIZATION OF CARE / RELEASE OF INFORMATION
ASSIGNMENT OF BENEFITS

If patient is under the age of 18, we must have a parent/legal guardian authorization before patient is seen.

(The term healthcare provider(s) in this document means Putnam Pediatric & Internal Medicine, its agents, employees, members of the medical staff and their agents and employees, and other healthcare practitioners who provide care to patients.)

CONSENT TO TREAT:

Permission is hereby granted to all healthcare providers involved in my care to administer such examination, treatment, testing and procedures as are deemed necessary in the course of my care.

FINANCIAL RESPONSIBILITY/HMO MEMBERS

I authorize any HMO insurance plan in which I am enrolled to pay benefits directly to my HMO healthcare provider. I agree to pay all relevant co-payments for services covered by my HMO plan. Payment for services not covered by my HMO benefits will be my responsibility. If co-payments and payment for non-covered services are not paid appropriately, collection of the amount due shall be as described under Financial Responsibility/Assignment of Benefits section. Co-payments are due at the time of service.

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

For those healthcare providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to pay directly to those healthcare providers who have rendered services to me, any benefits of any policies of insurance and who accept assignment.

I agree to pay all charges not paid in full by assigned insurance. If amounts due to the healthcare provider are not paid after reasonable notice, the account shall be deemed delinquent. In the event that I default on payment of my account, I agree to be responsible for collections fees and interest due on amounts in default, including court costs and reasonable attorney fees. If the debt is assigned to a third party for collection, I agree to be responsible for collections fees.

I understand I may be contacted at any telephone number associated with my account including wireless telephone numbers. Methods of contact may include using pre-recorded/artificial voice messages and/or use of any automatic dialing device, as applicable.

IF AT ANY TIME SERVICES ARE RELATED TO WORKMEN'S COMPENSATION OR AUTO ACCIDENT, I UNDERSTAND I MUST INDICATE TO PUTNAM PEDIATRIC & INTERNAL MEDICINE BEFORE THE INITIAL VISIT. UPON FAILURE TO NOTIFY OF SUCH, I AGREE TO BE FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED.

CLAIM PAYMENT AUTHORIZATION AND INFORMATION RELEASE

I understand my signature indicates payment by my insurance and/or Medicare carrier be made to my healthcare provider of any services furnished me by that provider. I authorize my healthcare provider to release medical information to my insurance and/or Medicare carrier needed to determine those benefits payable for such service

I understand I am responsible for deductibles, coinsurance and non-covered services as determined by my insurance and/or Medicare carrier.

A photocopy of these authorization assignments shall be valid as the original

A copy of this document may be given upon request

Patient signature _____ Legal Guardian Signature (If patient is under 18 yrs old) _____

Patient's Name (Please Print) _____ Legal Guardian Name (Please Print) _____

Date signed_____

Putnam County Hospital

AN IMPORTANT MESSAGE FROM MEDICARE

HOW TO REQUEST A REVIEW OF THE NOTICE OF NONCOVERAGE

- If the Notice of Non-coverage states that your **physician agrees** with the hospital's decision:
  - You must make your request for review to the PRO (Physician Review Officer) by noon of the first work day after you receive the Notice of Non-coverage by contacting the PRO by phone or in writing
  - The PRO must ask for your views about your case before making its decision. The PRO will inform you by phone and in writing of its decision on the review.
  - If the PRO agrees with the Notice of Non-coverage, you may be billed for all costs of your stay beginning at noon of the day **after** you receive the PRO's decision.
  - Thus, you will **not** be responsible for the cost of hospital care before you receive the PRO's decision.
- If the Notice of Non-coverage states that the **PRO agrees** with the hospital's decision:
  - You should make your request for reconsideration to the PRO **immediately** upon receipt of the Notice of Non-coverage by contacting the PRO by phone or in writing.
  - The PRO can take up to three working days from receipt of your request to complete the review. The PRO will inform you in writing of its decision on the review.
  - Since the PRO has already reviewed your case once, prior to the issuance of the Notice of Non-coverage the hospital is permitted to begin billing you for the cost of your stay beginning with the third calendar day after you receive your Notice of Non-coverage **even if the PRO has not completed its review.**
  - Thus, if the PRO continues to agree with the Notice of Non-coverage, **you may have to pay for at least one day of hospital care.**

NOTE: The process described above is called "immediate review." If you miss the deadline for this immediate review while you are in the hospital, you may still request a review of Medicare's decision to no longer pay for your dare at any point during your hospital stay or after you have left the hospital. The Notice of Non-coverage will tell you how to request this review.

POST-HOSPITAL CARE

When your doctor determines that you no longer need all the specialized services provided in a hospital, but you still require medical care, he or she may discharge you to a skilled nursing facility or home care. The discharge planner at the hospital will help arrange for the services you may need after your discharge. Medicare and supplemental insurance policies have limited coverage for skilled nursing facility care and home health care. Therefore, you should find out which services will or will not be covered and how payment will be made. Consult with your doctor, hospital discharge planner, patient representative and your family in making preparations for care after you leave the hospital. **Don't hesitate to ask questions.**

ACKNOWLEDGEMENT OF RECEIPT: ***My signature only acknowledges my receipt of this Message from Putnam County Hospital and does not waive any of my rights to request a review or make me liable for any payment.***

Signature of beneficiary or person acting on behalf of beneficiary

DATE

PCH 5183 5/98

PUTNAM PEDIATRIC & INTERNAL MEDICINE

1542 S. Bloomington, Suite 1100
Greencastle, IN 46135

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices for: PUTNAM PEDIATRIC & INTERNAL MEDICINE

_____
Name of Patient (Please Print)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

PUTNAM PEDIATRIC & INTERNAL MEDICINE reserves the right to modify the privacy practices outlined in the notice.

(OFFICE USE ONLY)

DOCUMENTATION OF ATTEMPT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on: Date: _____

The acknowledgement was not obtained because:

- ☐ The patient was undergoing emergency treatment
- ☐ The patient declined to sign the acknowledgment
- ☐ Other _____

Name of patient (please print) _____

Name of Staff Member _____

Putnam Pediatric & Internal Medicine
1542 S. Bloomington St. Suite 1300
Greencastle, IN 46135
Ph# 765-658-2700
Fax # 765-658-2703

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner: (Check all that apply)

____ Home Telephone _____

____Ok to leave message with detailed information

____Leave message with call-back number only

____Work Telephone _____

____Ok to leave message with detailed information

____Leave message with the call-back number only

____ Written Communication

____Ok to mail to my home

____Ok to mail to my work/office address

____Ok to fax to this number _____

____Other:_____

_____ _____
Patient Signature Date

_____ _____
Print Name Date