Confidential Patient Information

Name: (First)_____(M.I.)___ (Last)_____Date of Birth:_____

Address:_____City:_____State:_____Zip Code:_____

Phone Home:_____ Phone Cell:_____ Phone Other:_____

Email Address:_____ Social Security Number:_____

Sex: □ Male □ Female

Marital Status: □ Married □ Single □ Divorced □ Widowed □ Student

Ethnicity: _____ Race: _____ Primary Language: _____

Are you currently living in a skilled nursing facility or using a Home Health Agency? □ Yes □ No

If yes, Name of Facility/Agency:_____

Address:_____ Phone #: _____

Pharmacy name: _____ Pharmacy Number: _____

Responsible Party if different than patient:

Name: _____ Address: _____

DOB: _____ Phone Number: _____

Patient Employment:

Work Status: □ Employed □ Retired (Date: _____) □ Other: _____

Employer Name:_____Occupation:_____

Employer Address:_____

City:_____ State:_____ Zip Code:_____ Employer Phone #:_____

Is your visit due to an injury suffered on the job? □ Yes □ No

Is your visit due to an automobile accident? □ Yes □ No

Date of accident:_____ State of accident:_____

(Indiana Spine Group will not file any third-party auto insurance claims. Any costs associated with an automobile accident not covered will be billed directly to the patient.)

How did you hear about us: □ Physician □ Relative □ Friend □ Internet Search □ Social Media □ Ad

□ Other_____

Physician Information:

Name of Referring Physician:_____ Phone #:_____

Referring Physician's address:_____ City: _____State: ____Zip Code: _____

Name of your Family Physician:_____ Phone #: _____

Family Physician's address:_____ City:_____ State:____ Zip Code:_____

Date:_____ Patient Name: _____ DOB: _____

Patient/Family History

Personal Health History:
Have you ever had or do you currently have?

- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Heart Disease
- ☐ Heart Surgery/Stents
- ☐ Pacemaker/AICD
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperlipidemia
- ☐ Stroke/CVA
- ☐ TIA/Mini Stroke
- ☐ Seizure Disorder
- ☐ Blood Clots/DVT's
- ☐ Pulmonary Embolism/PE
- ☐ COPD/Emphysema
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Gastric Reflux
- ☐ Ulcers
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Psychiatric Illness
- ☐ Anxiety
- ☐ Depression
- ☐ Claustrophobia
- ☐ Parkinson's
- ☐ Alzheimer's/Dementia
- ☐ Bleeding Disorder
- ☐ Cancer: _____
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ MRSA/VRE
- ☐ Previous Spinal Conditions
- ☐ Other: _____
- ☐ Other: _____

Drug Allergies:

_____
_____
_____
_____

Environmental/Food Allergies:

_____
_____
_____
_____

Allergy to Latex? N Y

Allergy to tape? N Y

Medications:

Name: Dose (mg): Frequency:

_____
_____
_____
_____
_____
_____
_____
_____

Date:_____ Patient Name: _____ DOB: _____

Previous Surgeries:

Type: Date:

_____

_____

_____

_____

_____

Family History (Mother, Father, Brother or Sister only):

		Relative			Relative
Anesthesia complications:	Y N	_____	Respiratory Complications:	Y N	_____
Bleeding Disorder:	Y N	_____	Seizure Disorders:	Y N	_____
Cancer: _____	Y N	_____	Stroke, history of:	Y N	_____
Diabetes I or II:	Y N	_____	Other: _____		
Heart Disease:	Y N	_____	□ Family History Unknown		
High Blood Pressure:	Y N	_____			

Social History:

Tobacco Use: Y N

IF YES, how many packs per day? _____

IF NO, have you ever smoked? _____

When did you quit? _____

Would you like information on smoking cessation?

_____

E-cigarette/Vaping: Y N

Smokeless Tobacco: Y N

Alcohol Use: Y N Type: _____

□ 1-2 times/year

□ 1-2 times/month

□ 1-2 times/week

□ 1-2 times/day

□ Daily

□ Several times/day

Recreational Drug Use: Y N

IF YES, Type: _____Frequency:_____

Educational Level:

□ Grade School

□ High School/GED

□ College/Trade School

□ Post Graduate/Doctorate

Exercise Level:

□ Never

□ Monthly

□ Weekly

□ Daily

Living Status

□ Live Alone

□ Live with someone

□ Assisted living

□ Extended Care facility

□ Home Health

□ Other: _____

MOTOR VEHICLE ACCIDENT INFORMATION

Motor Vehicle Accidents involve considerable administrative work and frequently result in a delay in claims being processed.

At the first visit, for a motor vehicle accident, we require the following information from your auto insurance carrier: case number, name of your claims manager, telephone number, address and date of injury. **You** will be responsible for obtaining this information from your Automobile Insurance Carrier, and it is best, when presented, in a letter format. This authorizes us to provide treatment and allows us to file a claim on your behalf. **Please call with authorization information prior to your appointment**. This will assist with expediting the check-in process when you arrive.

You will also need to bring your health insurance information.

If you cannot obtain claim authorization, you will be required to pay a $250.00 down payment prior to your visit. If you do not have authorization from your auto insurance carrier and you do not have health insurance, you will be treated as a self-pay patient. Please call for further information: 317-228-7000.

The process for filing claims for payment:

Your claim **must** first be filed with your auto insurance carrier prior to filing with your health insurance. Your health insurance company will not pay or will ask to return money once they realize the reason for your visit to the physician is due to an auto accident.

Once your claim is filed with the auto insurance carrier, they will either pay for your services or provide us with a denial for payment. Once we receive a written notice from your auto insurance with their denial or that your benefits are exhausted, we can then file your claims with your health insurance company, if applicable.

If you have any questions, please feel free to call our office at (317) 228- 7000 or 1-(866) 947-7463 and ask for the billing department.

BILLING INFORMATION

In an attempt to help you understand how medical facilities charge for services rendered at the time of service, we have created this handout to answer questions that may occur.

1. **Facility Charge**: This charge represents the basic charge for use of the hospital, its services and supplies. Items included in the charge are nursing services, all pre-op and post-op care and anesthesia materials. There may be additional charges for medications and implants if applicable to your procedure. These bills will be from North Meridian Surgery Center or the hospital where you had your surgery/procedure.

2. **Physician Charge**: This charge represents the professional fee of the surgeon and any other doctors who cared for you, such as a cardiologist. This bill will be from the doctor's office, such as Indiana Spine Group.

3. **Anesthesiologist Charge**: This charge represents the professional fee of the anesthesiologist. This bill will be from Indiana Spine Group or the anesthesiologist's office.

4. **Durable Goods Charge**: This charge represents the charge for any back brace you received for treatment or following your surgery. This bill will be from Indiana Spine Group or EMPI.

5. **Radiology**: This charge represents the charge for interpreting the results of certain Xrays, MRI's, or CT's. This bill will be from Northwest Radiology.

I understand the above-mentioned charges and acknowledge receipt of this information.

_____ _____

Responsible Party (Please Print) Date

_____

Date of Birth

_____

Signature

Indiana Spine Group Notice of Privacy Practices for Protected Health Information

Acknowledgement of receipt of Notice of Privacy Practices

I have received Indiana Spine Group's Notice of Privacy Practices and understand my protected health information may be used by the practice as described in the notice.

Patient Name (printed): _____Date of Birth: _____

Patient (or guardian) Signature: _____ Date: _____

For your protection, information will **NOT** be released to any outside parties unless listed below:

Indiana Spine Group may release my protected health information/information re: my care to the following:

Name: _____ Relationship: _____

Phone number: _____Date of Birth:_____

Name: _____Relationship: _____

Phone number: _____ Date of Birth:_____

This authorization will remain in effect until I change or revoke it. The authorization can be revoked by writing to Indiana Spine Group or by completing a new form.

_____ I decline the release of my protected heath information to outside parties
Initial

Revised 2019

Financial Policy and Authorization

Patient Name: _____

1. **Authorization for Treatment** – I hereby authorize the physician(s) and healthcare professionals of Indiana Spine Group to conduct examinations and perform procedures as are medically required, and administer such treatment and medications as deemed necessary or advisable.
2. **Release of Information/Medical Record Diagnosis** – I hereby authorize the physician(s) and healthcare professionals of Indiana Spine Group to release a complete report of services rendered including diagnosis, findings and details of treatment and progress for the purpose of receiving payment for the services rendered to its authorized billing agents, my insurance carrier, employer's workers' compensation insurance company, or other category of third party payer, the Social Security Administration under Title XVIII (18) of the Social Security Act, any Professional Review Organization, or other intermediaries responsible for payment of my charges. I understand that I may revoke this consent at any time by giving written notice. I understand that if I refuse to consent to the release of information, I will be held personally responsible for payment of all charges for services rendered.
3. **Authorization for Assignment of Benefits** – In consideration of medical services provided, I hereby guarantee payment in full of my account in accordance with the financial arrangements made at the time of discharge or, if not such arrangements are made, then payment shall be made in full within thirty (30) days of discharge. I agree that in the event of default in payment, reasonable collection agency fees equal to fifty (50%) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court costs.
4. **Insurance Filing** – I understand that as a courtesy, Indiana Spine Group will file for benefits with my insurance carrier(s). Including Medicare Part B secondary carriers. I understand that fees may exceed the charges allowed by my insurance carrier. I agree to be responsible to Indiana Spine Group, P.C. for the full balance of the charges that are not paid by my private insurance carrier including any deductible, co-insurance and/or copayment.
5. **Payments at time of visit**- Indiana Spine Group, P.C. accepts cash, checks, Visa and Mastercard. I understand that non-sufficient fund checks will have a $30.00 fee added to my account. I understand that my insurance policy is a contract between me and my insurance carrier. I am aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under my medical insurance plan. I may be asked to sign a procedure specific waiver if Indiana Spine Group belives that my insurance may deny paymnent for that service. If my insurance carrier requires a co-payment or deductible, the payment is due AT THE TIME OF MY VISIT. I will also be responsible for payment of any outstanding patient balances. If I do not have health insurance coverage, I will be responsible for payment in full for all services and a depoist of $250.00 will be required before I see a provider.
6. **Payment Prior to Surgery/Procedures/Injections**- I understand that I may be asked to provide payment in full for any deductible or co-insurance prior to the scheduled date of the surgery, procedure or injection.
7. **Pre-certifications/Prior Authorization/Referral**- If my insurance requires any form of prior notifcation for any services rendered, I understand that it is my responsibility to obtain it. I agree to be held financially liable for any services provided by Indiana Spine Group, that are denied or reduced by my insurance carrier because I failed to obtain the necessary type of prior approval.
8. **Other**- If you are being treated for a personal injury, we DO NOT accept attorney liens. I understand that I am fully responsible for payment of any and all services not covered by medical insurance regardless of any legal issues that may be applicable. A **deposit** of $250.00 will be required before you see one of our providers.

I hereby certify that I have read and fully understand this Financial Policy and Authorization form. I also certify that no guarantee or assurance has been made as to the results that may be obtained from any treatment.

_____ _____

Patient Signature Date

or

_____ _____

Responsible Party Signature/Relationship to Patient Date