Plaza Park Family Practice, LLC
3799 Venetian Way - Newburgh, IN 47630
Phone 812.471.4302 Fax 812.471.4303

INSURANCE/PERSONAL INFORMATION

Please complete the form in entirety. If a section does not apply, please indicate "n/a". If the information requested is the same as patient, indicate "same". Do you prefer a nickname? _____

Patient Information:
First Name_____ M.I.____ Last Name_____
Mailing Address_____
Physical Address (if different)
_____
City_____ State_____ Zip_____
Home Phone_____ Work Phone_____
Cell Phone _____ Date of Birth_____
Age_____ Sex_____ Marital Status_____
Social Security # _____
Occupation_____
Employer_____
Address_____
City_____ State_____ Zip_____
Employed Full time /Part Time / Retired _____

Primary Insurance
Insurance Company_____
Policy Holder Name (as shown on insurance card)
_____
Policy Holder Address (if different from above)
_____
City_____ State_____ Zip_____
Home or Cell Phone _____
Date of Birth _____ Social Security # _____
Effective Date of Insurance _____
Insurance Patient ID # _____
Group # _____ Group Name _____
Employer Phone # _____
Employed Full time /Part Time / Retired _____

Secondary Insurance (if applicable)
Insurance Company_____
Policy Holder (full name)
_____
Policy Holder Address (if different from above)
_____
City_____ State_____ Zip_____
Home or Cell Phone _____
Date of Birth _____ Social Security # _____
Effective Date of Insurance _____
Insurance Patient ID # _____
Group # _____ Group Name _____
Employer Phone # _____
Employed Full time /Part Time / Retired_____

Tertiary Insurance (if applicable)
Insurance Company_____
Policy Holder Name (as shown on insurance card)
_____
Effective Date of Insurance _____
Insurance Patient ID# _____
Group # _____ Group Name _____

Patient's Spouse/Guardian/Partner: (If applicable)
Name _____ Relationship_____
Address_____
City_____ State_____ Zip_____
Home Phone_____ Work Phone_____
Cell Phone _____ Date of Birth_____
Social Security # _____
Employer_____

Emergency Contact: (Not Living With You)
Name _____ Relationship_____
Address_____
City_____ State_____ Zip_____
Home or Cell Phone_____

***Please present two types of identification, your insurance card, and co-payment (if applicable).**

Payments / Copayments are due on date of service.

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance.

Signature_____
Date_____

_____
Office Use Only

Patient Account # _____ Date Entered _____ By _____

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Patient Name_____ Account Number_____

AGREEMENT TO PAY/AUTHORIZATION FOR INSURANCE PAYMENT

I agree to pay for all fees or my portion not covered by medical insurance for the above mentioned patient, at the time of service. I realize I am also responsible for full payment of fees, not paid by insurance, within 30 days of notification by Plaza Park Family Practice, LLC. I also agree to be responsible for any fees required to collect payment for services including: attorney and court costs, collection agency fees, pre-judgment and/or post judgment interest at the current legal rate. I hereby authorize my insurance company to make payment directly to Plaza Park Family Practice, LLC, unless I pay in full at the time of service.

Signature_____ Printed Name_____ Date_____

COLLECTION FEE

I understand that if any unpaid balance is assigned to a third party collection agency for collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of 33% will be added to my account. I agree to pay that fee. I further agree to pay reasonable attorney fees and court costs. I understand and agree to the above terms.

Signature_____ Printed Name_____ Date_____

MEDICARE AUTHORIZATION (Medicare patients ONLY)

I request that payment of authorized Medicare benefits for any services furnished to me by Plaza Park Family Practice, LLC (or any party who accepts assignment) be made to either me or on my behalf to Plaza Park Family Practice, LLC. I authorize the holder of medical or other information to release to the Health Care Financing Administration (Medicare) and its agents, any information needed to determine these benefits or benefits for related services. I further authorize Plaza Park Family Practice, LLC to release any information needed for this or any related Medicare/Medicaid claim to the Social Security Administration or its intermediaries or carriers.

Signature_____ Printed Name_____ Date_____

MEDICAL RECORDS RELEASE

If it is necessary for any of my medical records, including progress notes and laboratory results, to be sent to another health care provider for medical reasons and to facilitate timely healthcare, I authorize Plaza Park Family Practice, LLC to do so. I also authorize the release of medical information, necessary to process my claim, to my insurance company, Workman's Comp plan, Social Security, Medicare/Medicaid, or any representatives acting on their behalf.

I further authorize the release of my medical records to any individual or organization, engaged by Plaza Park Family Practice, LLC, my physician, or my third party payer (insurance company), to conduct quality improvement and/or utilization review. I permit a copy of this authorization to be used in place of the original. I hereby release Plaza Park Family Practice, LLC from all legal liability that may arise from the disclosure of such information.

Signature_____ Printed Name_____ Date_____

MISSED APPOINTMENT & RECORD COPYING FEE

I understand that I will be charged a fee of $30 for any missed doctor's appointment that I fail to cancel at least 24 hours in advance. I agree to this fee.

I understand that I have a right to the information in my medical records, but the original records belong to my doctor. I understand that it is expensive and time consuming to copy medical records. I understand that a reasonable copying fee will be charged anytime I request a copy of my records or transfer my records to another doctor. I agree to this fee.

I will not be charged for: (1) copies of lab tests that I request on the day they are reviewed with me by the doctor or (2) records sent to a specialist that my doctor refers me to.

Signature_____ Printed Name_____ Date_____

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I received a copy of Notice of Privacy Practices / HIPAA for Plaza Park Family Practice, LLC

Name:_____

Signature:_____**Date:**_____

❒ I was offered a copy of the Notice of Privacy Practices / HIPAA for Plaza Park Family Practice LLC, but declined to take a copy.

PATIENT AUTHORIZATION FOR PERSONAL REPRESENTATIVE

Type of Authorization: Personal Representative (**Friend or Relative that you authorize to have access to your health information, appointments, medication pickup, etc. See information below).**

Print Patient Name: _____ Date of Birth: _____

Purpose of request: I authorize Plaza Park Family Practice, LLC, to disclose or provide my protected health and/or financial information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information and financial information about myself. As my designated personal representative, they may exercise my right to inspect, copy, and correct my protected health information. They may also consent or authorize the use or disclosure of my protected health information.

Name of Personal Representative **Relationship**

Address

City, State, Zip **Phone Number**

❒ INITIAL HERE IF YOU DO NOT WISH TO DESIGNATE A PERSONAL REPRESENTATIVE

Description of information to be disclosed: I authorize Plaza Park Family Practice, LLC, to disclose all of my protected health and/or financial information to my designated personal representative.

Expiration or termination of authorization: This authorization will remain in effect for one year from the date signed or until terminated by you, your personal representative, or another individual(s) of legal entity authorized to do so by a court of law.

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in person by signing below or by mailing a request to:

Attn: Krista Pierson, Office Manager
Plaza Park Family Practice, LLC
3799 Venetian Way
Newburgh, IN 47630

Redisclosure: We have no control over the person you have listed as your personal representative. Therefore, your protected health information and financial information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Plaza Park Family Practice, LLC.

PATIENT SIGNATURE **DATE**

❒ ***I HEREBY REVOKE THIS AUTHORIZATION FOR:***

PATIENT SIGNATURE **DATE**

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PATIENT TELEPHONE/EMAIL AUTHORIZATION

Print Patient Name: _____ Date of Birth: _____

Purpose of this request: By signing this agreement and providing **Plaza Park Family Practice, LLC** with my telephone number(s), I consent to **Plaza Park Family Practice, LLC**, its agents and assigns, including but not limited to: **eMP Billing, Inc., HSC Medical Billing & Consulting, LLC** and other collection agents, contacting me at these telephone numbers, or at any other contact number that is later acquired for me, and leaving live and/or prerecorded messages regarding any accounts or services. I agree that for greater efficiency, calls may be delivered by an auto-dialer. I also understand that any email address that I provide is my personal, private email address and I authorize Plaza Park Family Practice, LLC or its agents to contact me by that email address as well. I am also aware that providing my telephone number, cellular number or email address is not a required condition of receiving services.

Email Address_____

Phone Number_____

Phone Number_____

PATIENT SIGNATURE **DATE**

_____

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Print Patient Name: _____ Date of Birth: _____

PATIENT HIPAA ACKNOWLEDGEMENT AND CONSENT FORM
Consent to Email and Text Usage for Appointment Reminders

Plaza Park Family Practice, LLC patients may be contacted via email and/or text messaging to remind you of an appointment.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders at that email or text address from the Practice.

_____ (Patient Initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders unless I request a change in writing (see revocation section below).

_____ (Patient Initials) I understand that text message and email appointment reminders are not encrypted and may not be confidential.

_____ (Patient Initials) I also understand that Plaza Park Family Practice, LLC cannot assure the privacy of a text or email appointment reminder. Text messages and emails travel via the public internet or my carrier's network. It is not possible to verify that a text message or email is actually received, opened and read by the intended recipient. I accept the risk that my medical information may not be confidential when being sent via text message or email.

_____ (Patient Initials) I agree and understand that Plaza Park Family Practice, LLC takes no responsibility for and disclaims any and all liability arising from any breach of confidentiality not caused by Plaza Park Family Practice, LLC, inaccuracies or defects in the software, communication lines, virtual private network, the internet or my internet service provider, mobile carrier or mobile carrier's network, access system, computer hardware or software, or any other service or device that I use to access text messages and emails.

The cell phone number that I authorize to receive text messages for appointment reminders is (include area code) _____.

The email that I authorize to receive email messages for appointment reminders is _____.

Plaza Park Family Practice, LLC does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient Name (Print Clearly) _____

Patient Signature _____ Date _____

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<u>Revocation:</u> I hereby revoke my request for future communications via email and/or text. Please note that this revocation only applies to communications from this practice.

__ I hereby revoke my request to receive any future appointment reminders via text messages.

__ I hereby revoke my request to receive any future appointment reminders via email.

Patient Name _____

Patient/Representative Signature _____

Date _____ Time _____