222 E Virginia Street Evansville, IN 47711
Phone (812) 777-0127 Fax (812) 777-0129

PATIENT NOTICES

Patient Name _____ Date of Birth _____
Date _____Person signing (if other than patient) _____
Relationship _____ Phone _____

AUTHORIZATION AND ACKNOWLEDGEMENT OF PAYMENT

I agree to pay all finances relating to the services rendered today. I agree to pay the amount not covered by insurance. I understand I am responsible for these fees within 30 days of notification of my medical bill from Life in Motion Family Wellness Center DBA Kathalene Keller Riney NP, LLC. I also understand that I am responsible for any fees for collection of the money including attorney cost any collection fee from the agency, per your post judgment interest at a current legal rate and court cost. I also authorize my insurance company to make payments on my behalf directly to Life in Motion Family Wellness Center DBA Kathalene Keller Riney NP, LLC unless fees were paid completely at the time of service.

Initials _____

COLLECTION FEES

I agree to pay all fees associated with third-party collection agencies. I understand that II will be responsible to pay any unpaid balance, any fee responsible for collection, any attorney fees, or judgments fees to help in Collection of the unpaid balance. I also understand a collection fee of 33% will be added.

Initials _____

MEDICARE AUTHORIATION (Medicare Patients Only)

I agree any Medicare benefits rendered to me by Life in Motion Family Wellness Center DBA Kathalene Keller Riney NP LLC be made to either me or on my behalf to the facility. I give permission to release my medical information to the Healh Care Financing Administration (Medicare) or its agents if this information is needed for determination of benefits for related services. I also give permission to release my medical information as needed to the Social Security administration and its carrier for Medicare/Medicaid claims.

Initials _____

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RELEASE OF MEDICAL RECORDS

I agree for the release of any medical information to another healthcare provider to be sent in a timely fashion including any visit notes, laboratory results, radiological procedures facilitate my healthcare. I also give permission for the release of my personal healthcare information to aid in the processing of any claim to Workmen's Comp., Social Security, Medicare, Medicaid, my insurance company, or any other entity on their behalf.

Initials _____

MISSED APPOINTMENT FEE

I agree to be charged and pay a fee of $30 for any missed appointment or appointment scheduled with us than 24 hours in advance.

Initials _____

MEDICAL RECORDS

I agree I have the right to any information on my medical record. I understand the original belongs to my provider. If extensive medical records are requested over five pages, I will be susceptible to a charge of 10 cents per page. I understand I will not be charged for copies of lab results or radiological procedures reviewed with me the day of my visit with a provider.

Initials _____

HIPAA PRIVACY NOTICE

I received a copy of the HIPAA and Notice of Privacy Practices for Life in Motion Family Wellness Center DBA Kathalene Keller Riney NP, LLC.

Initials _____

PERSONAL REPRESENTATIVE AUTHORIZATION

I authorize Life in Motion Family Wellness Center DBA Kathalene Keller Riney NP, LLC to share or disclose my personal health information to the personal health representative listed below. I am giving them authorization to provide any healthcare and financial information to this individual if requested. As an appointed representative, they may access, correct, and have copies of any of my protected health information. They may also consent to the disclosure of any my protected health information. This will be effective starting from this day until termination of the personal representative by the patient. This can be done with written notice to our privacy manager.

Personal Representative Name _____ Relationship _____
Address _____
City _____ State _____ Zip _____ Phone # _____
Initial if you wish to not designate a personal representative. _____

I agree and understand that all of the above information I have reviewed and am in agreeance with.

Signature _____ Printed Name _____
Date: _____