



220 E. Virginia Street Evansville, IN 47711
Phone: 812-777-0127 Fax: 812-777-0129

INSURANCE/PERSONAL INFORMATION

Please submit identification, insurance card and copayment if necessary.

Do you prefer a nickname? _____

Patient information

First Name _____ MI _____ Last Name _____ Date of Birth _____
Address _____
City _____ State _____ Zip Code _____ Social Security # _____
Age _____ Sex _____ Marital Status _____
Home Phone _____ Cell Phone _____
Occupation _____ Employer _____
Address _____
City _____ State _____ Zip Code _____
Email: _____

Primary Insurance

Insurance Company _____ Insurance ID # _____
Group # _____ Effective Date of Insurance _____
Policy Holder Name _____ Holder Address _____
City _____ State _____ Zip Code _____ DOB of Holder _____
Age _____ Sex _____ Marital Status of Policy Holder _____
Home Phone _____ Cell Phone _____
Occupation _____ Employer _____

Secondary Insurance

Insurance Company _____ Insurance ID# _____
Group # _____ Effective Date of Insurance _____
Policy Holder Name _____ Holder Address _____
City _____ State _____ Zip Code _____ DOB of Holder _____
Age _____ Sex _____ Marital Status of Policy Holder _____
Home Phone _____ Cell Phone _____
Occupation _____ Employer _____

Tertiary Insurance

Insurance Company _____ Insurance ID # _____
Group # _____ Effective Date of Insurance _____
Policy Holder Name _____ Holder Address _____
City _____ State _____ Zip Code _____ DOB of Holder _____
Age _____ Sex _____ Marital Status of Policy Holder _____
Home Phone _____ Cell Phone _____
Occupation _____ Employer _____

Spouse/Partner/Guardian Information

Name _____ Relationship _____
Address _____
City _____ State _____ Zip Code _____ Social Security # _____
Age _____ Sex _____ Marital Status _____
Home Phone _____ Cell Phone _____

Emergency Contact

Name _____ Relationship _____
Address _____
City _____ State _____ Zip Code _____ Contact # _____

I acknowledge the information listed above is correct and understand I am financially responsible for all charges completed today. Payments and copayments are due at time of service regardless of insurance coverage.

Signature _____ Date _____

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 I 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 AUTHORIZATION (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 Health 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 _____

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, and radiological procedures to facilitate my healthcare. I also give permission for the release of my personal healthcare information to aid in the processing of any claim to Workman'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 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 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 agreement with.

Signature _____ Printed Name _____

Date: _____

Privacy Policy

OUR LEGAL RESPONSIBILITIES

We are required by law to give you this notice. It provides you on how we may use and disclose protected health information about you and describes your rights and our obligations regarding the use and disclosure of that information. We shall maintain the privacy of protected health information and provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We have the right to change these policies at any time. If we change our privacy policies, we will notify you of these changes immediately. This current policy is in effect unless stated otherwise. If the policy is changed, it will apply to all your current and past health information.

You may request a copy of our notice any time. You may contact Life in Motion Family Wellness Center at 220 East Virginia Street in Evansville, IN at any time to request a copy of this privacy policy.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following examples describe ways that we may use your protected health information for your treatment, payments, healthcare operations etc. but please be advised that not every use or disclosure in a particular category will be listed.

Treatment: We may use and disclose your protected health information to provide you treatment. This includes disclosing your protected health information to other medical providers, trainees, therapists, medical staff, and office staff that are involved in your health care.

Payment: Your protected health information may also be used to obtain payment from an insurance company or another third part. This may include providing an insurance company your protected health information for a pre-authorization for a medication we prescribed.

Health Care Operations: We may use or disclose your protected health information in order to operate this medical practice. These activities include training students, reviewing cases with employees, utilizing your information to improve the quality of care, and contacting you by telephone, email, or text to remind you of your appointments.

If we have to share your protected health information to third party “business associates” such as a billing service, if so, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We will not use or disclose your protected health information for any purpose other than those identified in this policy without your specific, written Authorization. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. You can revoke this authorization at any time but will not affect the protected health information that was shared while the authorization was in effect.

Appointment reminders: We may contact you as a reminder that you have an appointment for your initial visit, follow up visit, or lab work via text, phone or email.

Others Involved in Your Health Care: We may disclose protected health information about you to your family members or friends if we obtain your verbal agreement to do so, or if we give you an opportunity to object to such a disclosure and you do not raise an objection. For example, we may assume that if your spouse or friend is present during your evaluation, that we can disclose protected professional information to this person. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment if there is an urgent or emergent need.

Research: We will not use or disclose your health information for research purposes unless you give us authorization to do so.

Organ Donation: If you are an organ donor, we may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation if it is necessary to facilitate this process.

Public Health Risks: We may disclose your protected health information, if necessary, in order to prevent or control disease, report adverse events from medications or products, prevent injury, disability or death. This information may be disclosed to healthcare systems, government agencies, or public health authorities. We may have to disclose your protected health information to the Food and Drug Administration to report adverse events, defects, problems, enable recalls etc. if required by FDA regulation.

Health Oversight Activities: We may disclose protected health information to health oversight agencies for audits, investigations, inspections or licensing purposes. These disclosures might be necessary for state and federal agencies to monitor healthcare systems and compliance with civil law.

Required by Law: We will disclose protected health information about you when required to do so by federal, state and/or local law.

Workman's compensation: We may disclose your protected health information to workman's comp or similar programs.

Lawsuits: We may disclose your protected health information in response to a court action, administrative action or a subpoena.

Law Enforcement: We may release protected health information to a law enforcement official in response to a court order, subpoena, warrant, subject to all applicable legal requirements.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Access to medical records: You have the right to access and receive copies of your protected health information that we use to make decisions about your care. You must submit a written request to obtain your protected health information to the individual listed at the end of this privacy policy. We reserve the right to charge you a fee for the time it takes to obtain and copy the protected health information and provide it to you.

Amendment: If you believe the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You will need to submit a written request on why you feel the health information should be amended. We may deny your request to amend if you did not send a written request or give a reason on why it should be amended. If we deny your request, we will provide you a written explanation. We may deny your request if we believe the protected health information is accurate and complete.

Accounting of Disclosures: You have the right to receive a list of instances in which we disclosed your personal health information unless the disclosure was used for treatment, payment, healthcare operations, was pursuant to a valid authorization and as otherwise provided in applicable federal and state laws and regulations. You must submit a written request to obtain this "accounting of disclosures" to the individual listed at the bottom of this policy. After your request has been approved, we will provide you the dates of the disclosure, the name of the individual or entity we disclosed the

information to, a description of the information that was disclosed, the reason why it was disclosed, and any additional pertinent information. This information may not be longer than (STATUTE OF LIMITATIONS) years ago prior to the date the accounting is requested. We reserve the right to charge a reasonable fee for this process.

Restriction Requests: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. We shall accommodate your request except where the disclosure is required by law. We require this to be a written request submitted to the individual at the end of this policy.

Confidential Communication: You have the right to request that we communicate with you about healthcare matters in a certain way and at a certain location. We must accommodate your request if it is reasonable and allows us to continue to collect payments and bill you.

Paper copy of this notice: You may request a hard copy of this practice policy if you reviewed and signed it via electronic means. To obtain this copy, contact the individual at the end of this privacy policy.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office. You also file a complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

Name of Contact Person:

Kathalene Keller Riney, NP

(812) 777-0127

Please sign and date indicating you have read and understand your Patient Rights.

Name _____ Date _____

Patient Health History

Name _____ Date of Birth _____

Marital Status: Single Partnered Separated Divorced Widowed

Phone # _____ Email: _____

Previous Doctor _____ Date of last physical _____

Personal Health History

Childhood Illness: Measles Mumps Rubella Chickenpox Rheumatic Fever
 Polio

Immunizations: Tetanus Hepatitis Influenza Pneumonia Chickenpox
 MMR

Please list any medical problems that other doctors have diagnosed:

Surgeries

Year	Reason	Hospital

Have you ever had a blood transfusion? Yes No

List your prescribed and over-the-counter medications:

Name the Drug	Strength	Frequency Taken

Allergies to Medications

Name of Drug	Reaction You Had

Health Habits and Personal Safety

(All questions contained in this questionnaire are optional and will be kept strictly confidential)

Exercise: Sedentary (no exercise) Mild Exercise (climb stairs, golf)
 Occasional Vigorous Exercise Regular Vigorous Exercise

Diet: Are you dieting? Yes No

If yes, are you on a physician prescribed diet? Yes No

Rank Salt Intake: High Med Low

Rank Fat Intake: High Med Low

Caffeine: None Coffee Tea Soda

How many cups per day? _____

Alcohol: Do you drink alcohol? Yes No

If yes, what kind? _____

How many drinks per week? _____

Are you concerned about how much you drink? Yes No

Have you considered stopping? Yes No

Have you experienced blackouts? Yes No

Do you drive after drinking? Yes No

Tobacco: Do you use tobacco? Yes No

How many per day? _____

of years? _____

Year you quit? _____

Drugs: Do you currently use recreational or street drugs? Yes No

Have you ever given yourself street drugs with a needle? Yes No

Sex: Are you sexually active? Yes No

Are you trying for a pregnancy? Yes No

If not trying, what contraceptive are you using? _____

Any discomfort with intercourse? Yes No

Personal Safety: Do you live alone? Yes No

Do you have hearing or vision loss? Yes No

Mental Health

Is stress a major problem for you? Yes No

Do you feel depressed? Yes No

Do you have problems with your appetite? Yes No

Do you cry frequently? Yes No

Have you ever attempted suicide? Yes No

Do you have trouble sleeping? Yes No

Women Only

Age on onset of menstruation? _____
Date of last menstruation: _____
Period lasts _____ days
Heavy periods, irregularly, spotting, pain? Yes No
Number of pregnancies? _____ Number of live births? _____
Are you pregnant or breastfeeding? Yes No
Have you had a D&C, hysterectomy, or cesarean? Yes No
Any problems controlling urination? Yes No
Hot flashes or sweating at night? Yes No
Experienced any recent breast tenderness or lumps? Yes No
Date of last pap and rectal exam? _____

Men Only

Do you get up to urinate during the night? Yes No
If yes, # of times _____
Do you feel burning or pain with urination? Yes No
Any blood in urine? Yes No
Do you have problems emptying your bladder completely? Yes No
Any difficulty with erection or ejaculation? Yes No
Any testicle pain or swelling? Yes No
Date of last prostate and rectal exam? _____

Other Problems

Please note below if you are having issues or concerns with anything else.

Authorization for Release of Information to Family Members

Name _____ Date of Birth _____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to individuals indicated below.

I authorize Life in Motion Family Wellness Center to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

3. _____ Relation to Patient: _____

Patient Information: I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. You have the right to revoke this consent in writing.

Signature: _____ Date: _____