INFECTIOUS DISEASE OF INDIANA, P.S.C.

Patient Name: _____

Date of Birth: _____

Fall Risk Screening: Please Circle YES or NO

Do you use a walker, crutches, cane, of need other assistance to walk?	YES	NO
Have you experienced a loss of balance, dizziness or had a seizure in the last 30 days?	YES	NO
Have you experienced a fall in the last 30 days?	YES	NO

If "YES" to any of the above questions please see staff for assistance.

REVIEW OF SYSTEMS: Please check all conditions you are CURRENTLY experiencing.

GENERAL

- o Weight loss
- o Weight gain
- o Loss of appetite
- o Fever/Chills
- o Fatigue

CARDIOVASCULAR

- o Chest pain
- o Murmur
- o Palpitations
- o Fainting
- o Feet swelling

MUSCULOSKELETAL

- o Joint swelling
- o Joint redness
- o Joint pain
- o Gait problems
- o Back or neck pain
- o Muscle pain/weakness
- o Fibromyalgia
- o Osteoporosis

PSYCHOLOGICAL

- o Anxiety
- o Depression
- o Severe stress
- o Insomnia
- o Panic Attacks

EYES

- o Visual changes
- o Wear glasses/contacts
- o Eye disease/injury

GASTROINTESTINAL

- o Abdominal pain
- o Nausea
- o Vomiting
- o Diarrhea
- o Blood in stool
- o Ulcers
- o Hiatal Hernia
- o Reflux
- o Constipation

SKIN/BREAST

- o Rash
- o Sores
- o Itching
- o Abscess
- o Discharge

ENT

- o Sore throat
- o Hoarseness
- o Ringing in ears
- o Nose bleeds
- o Hard of hearing

GENITOURINARY

- o Urinary frequency
- o Urinary hesitation
- o Painful urination
- o Flank pain
- o Discharge
- o Incontinence

ENDOCRINE

- o Excessive sweating
- o Excessive thirst
- o Overly hot
- o Overly cold
- o Thyroid disease

RESPIRATORY

- o Wheezing
- o Cough
- o Shortness of breath
- o Sleep apnea

NEUROLOGICAL

- o Headaches
- o Confusion
- o Numbness
- o Slurred speech
- o Seizures
- o Head injury
- o Tremors
- o Dizziness

HEMATOLOGIC/LYMPHATIC

- o Bleeding tendencies
- o Easy bruising
- o Lymph node swelling
- o Blood clots

PAST SURGICAL HISTORY

Please list type of surgery and what year it was performed.

_____ _____

_____ _____

PAST MEDICAL HISTORY

Please check all conditions you **have now** or **have had in the past**.

- o NONE of the conditions below apply to me.
- o Heart Attack Year:_____
- o Pacemaker
- o High Blood Pressure
- o Stroke
- o Seizures
- o Cancer Type: _____
- o Arthritis
- o Diabetes
- o Thyroid dysfunction
- o Bleeding Disorder
- o Asthma
- o HIV
- o Hepatitis _____
- o Tuberculosis
- o Other:
  _____
  _____
  _____
  _____
  _____

ALLERGIES

Please list all medication allergies and reactions.

- o NONE

_____ _____

_____ _____

MEDICATIONS/SUPPLEMENTS

- o NONE; I am not taking any medications/supplements.
- o Please see attached list.

_____ _____

_____ _____

_____ _____

_____ _____

PHARMACY INFORMATION

Local Pharmacy (name and address): _____

Mail Order Pharmacy: _____

FAMILY HISTORY

Has an immediate family member (mother, father, brother or sister) ever experienced any of the following conditions?

- o Heart disease
- o Diabetes
- o Stroke
- o Cancer
- o Other : _____

SOCIAL HISTORY please check all that apply.

TOBACCO USE

- o Never
- o Chewing tobacco
- o Pipe
- o Cigars
- o Cigarettes
  Packs per day _____
- o Quit smoking
  When? _____

ALCOHOL USE

- o None
- o Socially
- o Daily: Drinks per day? _____

DRUG USE

- o None
- o Marijuana
- o Cocaine
- o Amphetamines
- o Other: _____

IMMUNIZATION HISTORY

Date of last influenza vaccine: _____

Date of last pneumonia vaccine: _____

Signature of patient or family member completing this form: _____

Relationship to patient: _____ Date: _____

INFECTIOUS DISEASE OF INDIANA, P.S.C.

Registration Form

Patient Name: _____ Birth Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell phone: _____

Work Phone: _____EXT: _____

Patient's Employer: _____

Social Security #: _____ Sex: Male: □ Female: □

Race: □ American Indian □ Asian □ African American □ Native Hawaiian □ White/Caucasian □ Other Pacific Islander □ More than one race □Unknown □ Refused

Are you: □ Single □ Married □ Divorced □ Separated □ Widowed □ Other

Preferred Language: □ English □ Spanish □ French □ Italian □ Russian □ German □ Croatian □ Ukrainian □ American Sign Language

Name of Spouse: _____ Birth Date: _____

Spouse's Social Security # _____ Spouse's Cell Phone _____

Spouse's Employer: _____ Work Phone: _____

If patient is not responsible for this bill please complete the following section (Responsible Party):

Name of Responsible Party: _____

Is this person the: □ Parent □ Foster Parent □ Legal Guardian □ Other _____

Responsible Party's Social Security #: _____

Responsible Party Address: _____

Responsible Party's Home Phone _____ Work Phone: _____

Responsible Party Cell Phone: _____

Name of Child's Case Worker if Foster Parent: _____

Caseworker's Phone Number: _____

Please list the patient's nearest living relative not living with the patient:

□ Parent □ Sibling □ Child □ Aunt/Uncle □ Grandparent □ Cousin □ Other

Name: _____

Address: _____

Home phone: _____ Work Phone: _____

Cell Phone: _____

Physician Information: Type of Doctor: □ MD □ DO □ OD □ DC □ Other _____

Name of Family Doctor: _____

Address of Family Doctor: _____

City: _____ State: _____ Zip: _____

Phone number: _____

Who is the doctor that referred you (or sent you) to our office (Referring Doctor)?

Name of Referring Doctor: _____

Type of Referring Doctor: : □ MD □ DO □ OD □ DC □ Other _____

Address of Referring Doctor: _____

City: _____ State: _____ Zip: _____

Phone number: _____

Insurance Information:

The front office staff is required to make a copy of your insurance card AND have you fill out this section. We copy your insurance card to help prevent insurance fraud. We expect you to complete this form with the most recent insurance information you have. This will help us bill your insurance company correctly and prevent problems in the future.

Primary Insurance:

Insurance Company Name: _____ Copay for Specialist Visit: _____

Name of Policy Holder (whose insurance is it?): _____

Relationship to Patient: _____ SS#: _____ Birth Date: _____

Policy Holder's Employer: _____

Group Number: _____ Policy ID Number: _____

Secondary Insurance:

Insurance Company Name: _____ Copay for Specialist Visit: _____

Name of Policy Holder (whose insurance is it?): _____

Relationship to Patient: _____ SS#: _____ Birth Date: _____

Policy Holder's Employer: _____

Group Number: _____ Policy ID Number: _____

Consent for Medical Services

I hereby authorize the physicians and/or employees of Infectious Diseases of Indiana, P.S.C. to release any current report or information acquired in the course of my examination or treatment by them to my family physician and referring physician(s). This authorization will remain in force until revoked by me in writing (per Indiana law: IN Code 16-4-8) (1-11).

I authorize and request insurance companies to pay directly to Infectious Diseases of Indiana, P.S.C. the medical/surgical benefits, if any, otherwise payable to me for their services, but not to exceed the charges for those services.

I request and authorize Infectious Disease of Indiana, its agents and employees, its physician, their associates, assistants and students ("providers") to provide medical and surgical care to me or the minor of whom I am a guardian.

This care may take place during an outpatient visit or hospitalization and may include exams, procedures, prescriptions/medication, test, communicable disease testing, and blood tests as considered advisable by my provider for my or my minor's well-being.

I agree that neither Infectious Disease of Indiana nor my provider has made any claims or statements about results or cures.

Signature of patient or family member completing form: _____

Relationship to patient: _____ **Date:** _____

Patient Condition Release of Information Form

I give myself permission for Infectious Disease of Indiana, PSC to discuss my condition of anything related to my condition with the individuals listed at the bottom of this form. If there is a change to this list it is the patient's responsibility to fill out a new form. No changes will be taken over the phone.

Name of Person	Relationship to Patient

Print Name of Patient

Date

Signature of Patient/Guardian

INFECTIOUS DISEASE OF INDIANA, P.S.C.

Financial Policy

11455 N Meridian Street, Suite 200
Carmel, IN 46032
317-582-8180
Fax 317-574-1088

Please read this policy carefully. Payment is expected at the time of service unless other arrangements have been made prior to the appointment. Our Patient Accounts representatives are available Monday through Friday from 7:30 AM to 4:00 PM to discuss financial arrangements. For your connivance we accept MasterCard and Visa. Please call (317) 564-4836.

Infectious Disease of Indiana, P.S.C. contracts with patients for their medical care: any arrangements made by the patient with attorneys, insurance companies, or other third party payers will not be considered in the collection of your account.

Charges for Professional Services – Every professional service and associated expense rendered will be charged to the patient according to a fee schedule prospectively determined by the clinic. Contractual discounts to third parties prospectively agreed to by the clinic will be honored in good faith. No fee or charge can be reduced or waived without the permission of only the administrator, billing manager, or his or her designee. An estimate of these fees can be requested prospectively.

Insurance – Health insurance is primarily a contract between the patient and the insurance company: however, Infectious Disease of Indiana, P.S.C. also has mutually agreed contractual obligations with certain private and government entities. The patient is primarily responsible for holding the insurance company accountable for claims reimbursement. Infectious Disease of Indiana, P.S.C. will make available substantial resources to facilitate insurance payment and will dedicate resources towards contractual obligations with these entities.

Payment – Payment for services rendered is due on the date of service and is part of the professional relationship. Infectious Disease of Indiana, P.S.C. reserves the right to request payment of the total negotiated fee on the due date unless directed otherwise by contract.

All co-payments will be collected at the time of service. All past-due balances or balances in collection must be paid prior to seeing an Infectious Disease of Indiana, P.S.C. practitioner. Non-urgent professional services may be delayed or terminated within the guidelines of good medical practice for bad-faith patient non-compliance with this financial policy. Only the administrator, billing manager, or their designated representative can amend this policy.

Patient Referrals and Out of Network – If patient is enrolled with an insurance carrier with network benefits, patient is entitled to full benefits of said plan when certain guidelines are followed. If patient does not obtain referral from his/her Primary Care Physician (PCP) for services rendered by Infectious Disease of Indiana, P.S.C. physician or provider, patient may be responsible for all or a portion of charges incurred. Patient will be responsible for charges incurred when choosing to go out of the designated managed care network.

Collection Agencies - Infectious Disease of Indiana, P.S.C. will use all reasonable means to collect owed funds. Defaults in payment of agreed amount will be referred to a collection agency for payment. Patient will be responsible for collection agency fees incurred while account is in collection.

Non-Sufficient Funds - Infectious Disease of Indiana, P.S.C. will charge a $25 fee for all checks returned by the bank for non-sufficient funds.

Medicare Patients - Infectious Disease of Indiana, P.S.C. are participating providers and accept Medicare assignment of benefits. Medicare patients will be responsible for deductibles, 20 percent coinsurance and/or non-covered charges when applicable. By signing this policy, the Medicare recipient requests payment of authorized Medicare benefits be made on patient's behalf for any services furnished by Infectious Disease of Indiana, P.S.C., including physician services.

Medigap/Secondary Insurance Authorization – Medicare recipient authorizes Infectious Disease of Indiana, P.S.C. or its agent to release medical or other information to supplemental insurance in order to process all medical claims. A copy of this authorization may be used in place of the original. Medicare recipient requests payment of medical insurance benefits to Infectious Disease of Indiana, P.S.C. for services provided.

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Witness Signature Patient's Name

For office use only Infectious Disease of Indiana, P.S.C. Account # _____
Witnessed by: _____

Infectious Disease of Indiana, P.S.C.
Indiana Travel Medicine
Notice of Privacy Practices

Effective Date: May 1, 2018

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. If we revise this Notice, we will provide a revised Notice to you within 60 days of a material revision. If you have any questions about this Notice, please contact our Privacy Officer.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Health Care Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Examples:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. We may also disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Business Associates: There are some services that require the use of outside people and entities. Examples of these "business associates" include accountants, consultants, and attorneys. We may disclose your PHI to business associates so that they can perform the job that we ask them to do. To protect your PHI, we require the business associates to appropriately safeguard your information.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- Public Health issues as required by law, Communicable Diseases.
- Food and Drug Administration requirements.
- Legal Proceedings/Law Enforcement.
- To a coroner, medical examiner, or funeral director when an individual dies.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

With Authorization: Other uses and disclosures not specifically permitted by applicable law will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except for actions we have already taken relying on your authorization. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

We will reasonably limit the use and disclosure of your PHI to the minimum amount necessary to accomplish the intended purpose. We will safeguard your PHI against inappropriate use and disclosure consistent with applicable law.

<u>Your rights regarding your PHI</u>

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI (not to exceed 6 years). We may charge you a reasonable, cost-based fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request. If, however, you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

<u>Breaches:</u>

You will be notified immediately if we receive information that there has been a breach that may have compromised the privacy or security of your PHI.

Complaints:
If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Carla Henderson, at *Administrative Office, Infectious Disease of Indiana, P.S.C., 11455 N. Meridian, Suite 200, Carmel, IN 46032.*

You may also file a U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html.**

We will not retaliate against you for exercising your right to file a complaint.

If you have questions and would like additional information, you may contact us at *(317) 582-8180*.

Acknowledgement

By signing this document, I agree that I have read and understand all the information noted above.

_____ _____

Patient or Personal Representative * Signature Date

(*) If signed by Personal Representative, please state your relationship to Patient:

The FollowMyHealth™ patient portal at the Infectious Disease of Indiana is designed to enhance secure patient and provider communications and is provided as a courtesy to our valued patients. Please complete and submit this form along with copies of required legal documents to authorize Infectious Disease of Indiana to email an invitation to create a portal account.

Purpose for Access:	**PERSONAL ACCOUNT ACCESS: *(photo ID required)***
	☐ I am 14-17 years of age and request access to my own medical record information
	☐ I am 14-17 years of age and grant Read Only Access to my medical records to the authorized user listed below
	☐ I am 14-17 years of age and grant Full Access to my medical records to the authorized user listed below
	☐ I am 18 years or older and request access to my own medical record information
	☐ I am 18 years or older and grant Read Only Access to my medical records to the authorized user listed below
	☐ I am 18 years or older and grant Full Access to my medical records to the authorized listed below
	AUTHORIZED USER ACCESS: *(copies of legal documents and photo ID required)*
	☐ I am 18 years or older and request Read Only Access to a medical record *(indicate legal status below)*
	☐ I am 18 years or older and request Full Access to a patient medical record *(indicate legal status below)*
	☐ **I have legal paperwork for POA/Guardian/Adoption/Ward of the State or County for this patient**
	☐ **I am the parent of a Minor patient aged 11 or younger and possess their birth certificate**

Patient Information *(please print)***:**

Patient Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Patient DOB: _____ Phone: _____
MM/DD/YYYY

Email address where patient portal messages will be sent: _____
(PERSONAL EMAIL RECOMMENDED)

I hereby authorize Infectious Disease of Indiana to use/disclose individually identifiable health information to the FollowMyHealth™ patient portal for my online access to Infectious Disease of Indiana health care information:

Patient Signature: _____ Date: _____

Authorized User Information (*please print)***:** (Person receiving access to a Patient Portal account)

Authorized User Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Authorized User DOB: _____ Relationship to Patient: _____
MM/DD/YYYY

Email address where Authorized User portal messages will be sent: _____
(PERSONAL EMAIL RECOMMENDED)

Address: _____
STREET ADDRESS CITY, STATE ZIPCODE

Home phone: _____ Cell phone: _____

Authorized User Signature: Date:

For Front Desk Use Only

Photo ID & Copies of Legal Documents Verified By: Date:

For Portal Use Only

Patient Portal Invite sent by: Date:

(verified email address and legal documents, FMH invite sent, paperwork scanned and saved in patient chart)

The FollowMyHealth™ patient portal at the Infectious Disease of Indiana is designed to enhance secure patient and provider communications and is provided as a courtesy to our valued patients. Please complete and submit this form along with copies of required legal documents to authorize Infectious Disease of Indiana to email an invitation to create a portal account.

Purpose for Access:	**PERSONAL ACCOUNT ACCESS: *(photo ID required)***
	☐ I am 14-17 years of age and request access to my own medical record information
	☐ I am 14-17 years of age and grant Read Only Access to my medical records to the authorized user listed below
	☐ I am 14-17 years of age and grant Full Access to my medical records to the authorized user listed below
	☐ I am 18 years or older and request access to my own medical record information
	☐ I am 18 years or older and grant Read Only Access to my medical records to the authorized user listed below
	☐ I am 18 years or older and grant Full Access to my medical records to the authorized listed below
	AUTHORIZED USER ACCESS: *(copies of legal documents and photo ID required)*
	☐ I am 18 years or older and request Read Only Access to a medical record *(indicate legal status below)*
	☐ I am 18 years or older and request Full Access to a patient medical record *(indicate legal status below)*
	☐ **I have legal paperwork for POA/Guardian/Adoption/Ward of the State or County for this patient**
	☐ **I am the parent of a Minor patient aged 11 or younger and possess their birth certificate**

Patient Information *(please print)***:**

Patient Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Patient DOB: _____ Phone: _____
MM/DD/YYYY

Email address where patient portal messages will be sent: _____
(PERSONAL EMAIL RECOMMENDED)

I hereby authorize Infectious Disease of Indiana to use/disclose individually identifiable health information to the FollowMyHealth™ patient portal for my online access to Infectious Disease of Indiana health care information:

Patient Signature: _____ Date: _____

Authorized User Information (*please print)***:** (Person receiving access to a Patient Portal account)

Authorized User Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Authorized User DOB: _____ Relationship to Patient: _____
MM/DD/YYYY

Email address where Authorized User portal messages will be sent: _____
(PERSONAL EMAIL RECOMMENDED)

Address: _____
STREET ADDRESS CITY, STATE ZIPCODE

Home phone: _____ Cell phone: _____

Authorized User Signature: Date:

For Front Desk Use Only

Photo ID & Copies of Legal Documents Verified By: Date:

For Portal Use Only

Patient Portal Invite sent by: Date:

(verified email address and legal documents, FMH invite sent, paperwork scanned and saved in patient chart)

INFECTIOUS DISEASE OF INDIANA, P.S.C.

Registration Form
Pediatrics

Fall Risk Screening: Please Circle YES or NO

Do you use a walker, crutches, cane, of need other assistance to walk? YES NO

Have you experienced a loss of balance, dizziness or had a seizure in the last 30 days? YES NO

Have you experienced a fall in the last 30 days? YES NO

If "YES" to any of the above questions please see staff for assistance.

Patient Name: _____ Birth Date: _____
Patient's School (include City and State): _____
Patient's Social Security #: _____ Sex: Male: □ Female: □

Parent 1 / Guardian 1 (Custodial Parent if shared):_____
Date of Birth: _____ Social Security Number: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell phone: _____
Work Phone: _____EXT: _____

Parent 2 / Guardian 2 (Non-Custodial Parent, if applicable):_____
Date of Birth: _____ Social Security Number: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell phone: _____
Work Phone: _____EXT: _____
Does one parent have sole ❑ physical or ❑ legal custody? Who?_____

If patient is not responsible for this bill please complete the following section (Responsible Party):
Name of Responsible Party: _____
Is this person the: □ Parent □ Foster Parent □ Legal Guardian □ Other _____
Responsible Party's Social Security #: _____
Responsible Party Address: _____
Responsible Party's Home Phone _____ Work Phone: _____
Responsible Party Cell Phone: _____
Name of Child's Case Worker if Foster Parent: _____
Caseworker's Phone Number: _____

INFECTIOUS DISEASE OF INDIANA, P.S.C.

Please list the patient's nearest living relative not living with the patient:

□ Parent □ Sibling □ Child □ Aunt/Uncle □ Grandparent □ Cousin □ Other

Name: _____

Address: _____

Home phone: _____ Work Phone: _____

Cell Phone: _____

Physician Information

Name of Family Doctor or Provider: _____

Type of Professional: □ MD □ DO □ OD □ DC □ NP □ PA □ DPM □ Other _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____

Who is the Doctor or Provider that referred you (or sent you) to our office (Referring Doctor)?

Name of Referring Doctor or Provider: _____

Type of Professional: □ MD □ DO □ OD □ DC □ NP □ PA □ DPM □ Other _____

Address: _____City: _____ State: _____ Zip: _____Phone number:_____

Insurance Information:

The front office staff is required to make a copy of your insurance card AND have you fill out this section. We copy your insurance card to help prevent insurance fraud. We expect you to complete this form with the most recent insurance information you have. This will help us bill your insurance company correctly and prevent problems in the future.

Primary Insurance:

Insurance Company Name: _____ Copay for Specialist Visit: _____

Name of Policy Holder (whose insurance is it?): _____

Relationship to Patient: _____ SS#: _____ Birth Date: _____

Policy Holder's Employer: _____

Group Number: _____ Policy ID Number: _____

Secondary Insurance:

Insurance Company Name: _____ Copay for Specialist Visit: _____

Name of Policy Holder (whose insurance is it?): _____

Relationship to Patient: _____ SS#: _____ Birth Date: _____

Policy Holder's Employer: _____

Group Number: _____ Policy ID Number: _____

INFECTIOUS DISEASE OF INDIANA, P.S.C.

Consents:

I hereby authorize the physicians and/or employees of Infectious Diseases of Indiana, P.S.C. to release any current report or information acquired in the course of my examination or treatment by them to my family physician and referring physician(s). This authorization will remain in force until revoked by me in writing (per Indiana law: IN Code 16-4-8) (1-11).

I authorize and request insurance companies to pay directly to Infectious Diseases of Indiana, P.S.C. the medical/surgical benefits, if any, otherwise payable to me for their services, but not to exceed the charges for those services.

I request and authorize Infectious Disease of Indiana, its agents and employees, its physicians, their associates, assistants and students ("providers") to provide medical and surgical care to me or the minor of whom I am a guardian.
This care may take place during an outpatient visit or hospitalization and may include exams, procedures, prescriptions / medication, tests, communicable disease testing, and blood tests as considered advisable by my provider for my or my minor's well-being.

I agree that neither Infectious Disease of Indiana or my provider has made any claims or statements about results or cures.

Signed: _____ Date: _____

NOTE: This authorization MUST be signed and dated by the patient unless patient is a minor or has a legal guardian. In this case, a parent or legal guardian must sign and date this form

INFECTIOUS DISEASE OF INDIANA, P.S.C.

Patient Information Sheet

Patient name: _____ Date of Birth: _____

Please provide information on your preferred pharmacy:

Pharmacy name: _____

Pharmacy address: _____

Please provide us with your preferred language: _____

In which of the following categories would you place yourself?

- o American Indian
- o Native American
- o Black
- o Asian
- o White
- o Unknown
- o Decline

Ethnicity:

- o Hispanic Origin
- o Non-Hispanic
- o Unknown
- o Decline

How would you best describe your smoking status?

- o Current every day smoker
- o Current someday smoker
- o Never a smoker
- o Former smoker
- o Unknown

Please provide the following information (if known):

Height	
Weight	
Blood Pressure	

List all Allergies:

Pediatric Infectious Disease Clinic – New Patient Questionaire

Last Name:_____ First Name:_____ Birthday:_____

Has your child had any of these symptoms? (Check Yes or No):

General
☐Y ☐N Fever
☐Y ☐N Weight loss or gain
☐Y ☐N Chills
☐Y ☐N Poor appetite
☐Y ☐N Tiredness
☐Y ☐N Headache

Eyes and Ears
☐Y ☐N Pink eye / red eyes
☐Y ☐N Problems seeing
☐Y ☐N Runny nose
☐Y ☐N Stuffy nose
☐Y ☐N Ear pain
☐Y ☐N Ear drainage

Heart
☐Y ☐N Chest pain
☐Y ☐N Palpitations

Throat and Neck
☐Y ☐N Sore teeth
☐Y ☐N Mouth sores
☐Y ☐N Sore throat
☐Y ☐N Swollen "glands"
☐Y ☐N Stiff neck
☐Y ☐N Hoarse voice

Lungs
☐Y ☐N Cough
☐Y ☐N Wheezing
☐Y ☐N Trouble breathing

Abdominal
☐Y ☐N Vomiting
☐Y ☐N Abdominal pain
☐Y ☐N Diarrhea
☐Y ☐N Constipation
☐Y ☐N Heartburn / Reflux

Genitals
☐Y ☐N Pain
☐Y ☐N Discharge
☐Y ☐N Rash
☐Y ☐N Wetting self

Muscles and Bones
☐Y ☐N Aches / pains
☐Y ☐N Swelling
☐Y ☐N Redness
☐Y ☐N Limp

Skin
☐Y ☐N Rashes
☐Y ☐N Sores

Neurologic
☐Y ☐N Seizures
☐Y ☐N Fainting
☐Y ☐N Weakness

Please list the month, year, and reason if your child has:
Had any surgeries?_____
_____
_____
Spent the night in the hospital?_____
_____
_____

Please list any past or current medical problems your child has (asthma, eczema, diabetes, etc.)
_____
_____
_____

Is there a family history of (Check Yes or No):

☐Y ☐N Repeated fevers
☐Y ☐N Repeated ear infections
☐Y ☐N Sinus infections
☐Y ☐N Heart disease
☐Y ☐N Diabetes
☐Y ☐N Cancer
☐Y ☐N HIV or AIDS
☐Y ☐N Immune system problems
☐Y ☐N Acid Reflux
☐Y ☐N Urinary or Kidney problems
☐Y ☐N Allergies
☐Y ☐N Asthma
☐Y ☐N Tonsillectomy
☐Y ☐N Rheumatologic disease
☐Y ☐N Arthritis
☐Y ☐N Lupus / SLE
☐Y ☐N Infant Death

Please describe:_____
_____

Who lives with the child?:_____

In the last 6 months, has the child or family been exposed to, or participated in:

☐Y ☐N Out of home care
☐Y ☐N Travel outside Indiana
☐Y ☐N Farms / wild animals
☐Y ☐N Cats
☐Y ☐N Mice, rodents, rabbits
☐Y ☐N Reptiles, amphibians
☐Y ☐N Birds, bats or nests
☐Y ☐N Camping / hunting
☐Y ☐N Well water
☐Y ☐N Ticks, mosquitos
☐Y ☐N Tuberculosis
☐Y ☐N Foreign immigrants
☐Y ☐N Nursing homes
☐Y ☐N Prisoners / convicts
☐Y ☐N Chemicals / toxins

_____ _____
Parent or Guardian Signature Date

Medication List/PCP Contact Information

Name_____Date_____

Please list *all* medications you currently take. Please include those prescribed by a physician and those you take over the counter.

1. _____ 7._____
2. _____ 8._____
3. _____ 9._____
4. _____ 10._____
5. _____ 11._____
6. _____ 12._____

Primary Care Provider Contact Information:

PCP Name: _____

Address: _____

_____

_____

Phone #: _____

Patient Condition Release of Information Form

I give myself permission for Infectious Disease of Indiana, PSC to discuss my condition of anything related to my condition with the individuals listed at the bottom of this form. If there is a change to this list it is the patient's responsibility to fill out a new form. No changes will be taken over the phone.

Name of Person	Relationship to Patient

Print Name of Patient

Date

Signature of Patient/Guardian

INFECTIOUS DISEASE OF INDIANA, P.S.C.

Financial Policy

11455 N Meridian Street, Suite 200
Carmel, IN 46032
317-582-8180
Fax 317-574-1088

Please read this policy carefully. Payment is expected at the time of service unless other arrangements have been made prior to the appointment. Our Patient Accounts representatives are available Monday through Friday from 7:30 AM to 4:00 PM to discuss financial arrangements. For your connivance we accept MasterCard and Visa. Please call (317) 564-4836.

Infectious Disease of Indiana, P.S.C. contracts with patients for their medical care: any arrangements made by the patient with attorneys, insurance companies, or other third party payers will not be considered in the collection of your account.

Charges for Professional Services – Every professional service and associated expense rendered will be charged to the patient according to a fee schedule prospectively determined by the clinic. Contractual discounts to third parties prospectively agreed to by the clinic will be honored in good faith. No fee or charge can be reduced or waived without the permission of only the administrator, billing manager, or his or her designee. An estimate of these fees can be requested prospectively.

Insurance – Health insurance is primarily a contract between the patient and the insurance company: however, Infectious Disease of Indiana, P.S.C. also has mutually agreed contractual obligations with certain private and government entities. The patient is primarily responsible for holding the insurance company accountable for claims reimbursement. Infectious Disease of Indiana, P.S.C. will make available substantial resources to facilitate insurance payment and will dedicate resources towards contractual obligations with these entities.

Payment – Payment for services rendered is due on the date of service and is part of the professional relationship. Infectious Disease of Indiana, P.S.C. reserves the right to request payment of the total negotiated fee on the due date unless directed otherwise by contract.

All co-payments will be collected at the time of service. All past-due balances or balances in collection must be paid prior to seeing an Infectious Disease of Indiana, P.S.C. practitioner. Non-urgent professional services may be delayed or terminated within the guidelines of good medical practice for bad-faith patient non-compliance with this financial policy. Only the administrator, billing manager, or their designated representative can amend this policy.

Patient Referrals and Out of Network – If patient is enrolled with an insurance carrier with network benefits, patient is entitled to full benefits of said plan when certain guidelines are followed. If patient does not obtain referral from his/her Primary Care Physician (PCP) for services rendered by Infectious Disease of Indiana, P.S.C. physician or provider, patient may be responsible for all or a portion of charges incurred. Patient will be responsible for charges incurred when choosing to go out of the designated managed care network.

Collection Agencies - Infectious Disease of Indiana, P.S.C. will use all reasonable means to collect owed funds. Defaults in payment of agreed amount will be referred to a collection agency for payment. Patient will be responsible for collection agency fees incurred while account is in collection.

Non-Sufficient Funds - Infectious Disease of Indiana, P.S.C. will charge a $25 fee for all checks returned by the bank for non-sufficient funds.

Medicare Patients - Infectious Disease of Indiana, P.S.C. are participating providers and accept Medicare assignment of benefits. Medicare patients will be responsible for deductibles, 20 percent coinsurance and/or non-covered charges when applicable. By signing this policy, the Medicare recipient requests payment of authorized Medicare benefits be made on patient's behalf for any services furnished by Infectious Disease of Indiana, P.S.C., including physician services.

Medigap/Secondary Insurance Authorization – Medicare recipient authorizes Infectious Disease of Indiana, P.S.C. or its agent to release medical or other information to supplemental insurance in order to process all medical claims. A copy of this authorization may be used in place of the original. Medicare recipient requests payment of medical insurance benefits to Infectious Disease of Indiana, P.S.C. for services provided.

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Witness Signature Patient's Name

For office use only Infectious Disease of Indiana, P.S.C. Account # _____
Witnessed by: _____

Infectious Disease of Indiana, P.S.C.
Indiana Travel Medicine
Notice of Privacy Practices

Effective Date: May 1, 2018

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. If we revise this Notice, we will provide a revised Notice to you within 60 days of a material revision. If you have any questions about this Notice, please contact our Privacy Officer.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Health Care Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Examples:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. We may also disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Business Associates: There are some services that require the use of outside people and entities. Examples of these "business associates" include accountants, consultants, and attorneys. We may disclose your PHI to business associates so that they can perform the job that we ask them to do. To protect your PHI, we require the business associates to appropriately safeguard your information.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- Public Health issues as required by law, Communicable Diseases.
- Food and Drug Administration requirements.
- Legal Proceedings/Law Enforcement.
- To a coroner, medical examiner, or funeral director when an individual dies.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

With Authorization: Other uses and disclosures not specifically permitted by applicable law will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except for actions we have already taken relying on your authorization. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

We will reasonably limit the use and disclosure of your PHI to the minimum amount necessary to accomplish the intended purpose. We will safeguard your PHI against inappropriate use and disclosure consistent with applicable law.

<u>Your rights regarding your PHI</u>

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI (not to exceed 6 years). We may charge you a reasonable, cost-based fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request. If, however, you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

<u>Breaches:</u>

You will be notified immediately if we receive information that there has been a breach that may have compromised the privacy or security of your PHI.

Complaints:
If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Carla Henderson, at *Administrative Office, Infectious Disease of Indiana, P.S.C., 11455 N. Meridian, Suite 200, Carmel, IN 46032.*

You may also file a U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html.**

We will not retaliate against you for exercising your right to file a complaint.

If you have questions and would like additional information, you may contact us at *(317) 582-8180*.

Acknowledgement

By signing this document, I agree that I have read and understand all the information noted above.

_____ _____

Patient or Personal Representative * Signature Date

(*) If signed by Personal Representative, please state your relationship to Patient:

The FollowMyHealth™ patient portal at the Infectious Disease of Indiana is designed to enhance secure patient and provider communications and is provided as a courtesy to our valued patients. Please complete and submit this form along with copies of required legal documents to authorize Infectious Disease of Indiana to email an invitation to create a portal account.

Purpose for Access:	**PERSONAL ACCOUNT ACCESS: *(photo ID required)***
	☐ I am 14-17 years of age and request access to my own medical record information
	☐ I am 14-17 years of age and grant Read Only Access to my medical records to the authorized user listed below
	☐ I am 14-17 years of age and grant Full Access to my medical records to the authorized user listed below
	☐ I am 18 years or older and request access to my own medical record information
	☐ I am 18 years or older and grant Read Only Access to my medical records to the authorized user listed below
	☐ I am 18 years or older and grant Full Access to my medical records to the authorized listed below
	AUTHORIZED USER ACCESS: *(copies of legal documents and photo ID required)*
	☐ I am 18 years or older and request Read Only Access to a medical record *(indicate legal status below)*
	☐ I am 18 years or older and request Full Access to a patient medical record *(indicate legal status below)*
	☐ **I have legal paperwork for POA/Guardian/Adoption/Ward of the State or County for this patient**
	☐ **I am the parent of a Minor patient aged 11 or younger and possess their birth certificate**

Patient Information *(please print)***:**

Patient Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Patient DOB: _____ Phone: _____
MM/DD/YYYY

Email address where patient portal messages will be sent: _____
(PERSONAL EMAIL RECOMMENDED)

I hereby authorize Infectious Disease of Indiana to use/disclose individually identifiable health information to the FollowMyHealth™ patient portal for my online access to Infectious Disease of Indiana health care information:

Patient Signature: _____ Date: _____

Authorized User Information (*please print)***:** (Person receiving access to a Patient Portal account)

Authorized User Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Authorized User DOB: _____ Relationship to Patient: _____
MM/DD/YYYY

Email address where Authorized User portal messages will be sent: _____
(PERSONAL EMAIL RECOMMENDED)

Address: _____
STREET ADDRESS CITY, STATE ZIPCODE

Home phone: _____ Cell phone: _____

Authorized User Signature: Date:

For Front Desk Use Only

Photo ID & Copies of Legal Documents Verified By: Date:

For Portal Use Only

Patient Portal Invite sent by: Date:

(verified email address and legal documents, FMH invite sent, paperwork scanned and saved in patient chart)

INFECTIOUS DISEASE OF INDIANA, P.S.C.

11455 N Meridian St. Suite 200
Carmel, IN 46032
Phone (317) 582-8180
Fax (317)574-1088

Patient Information

Name: _____

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

Address: _____

City: _____ State: _____ Zip: _____

Phone # to call when confirming appointments: _____

Secondary #: _____

Primary Care Physician: _____

Address: _____

_____

Phone #: _____

Fall Risk Screening: Please Circle YES or NO

Do you use a walker, crutches, cane, of need other assistance to walk?	YES	NO
Have you experienced a loss of balance, dizziness or had a seizure in the last 30 days?	YES	NO
Have you experienced a fall in the last 30 days?	YES	NO

If "YES" to any of the above questions please see staff for assistance.

INFECTIOUS DISEASE OF INDIANA, P.S.C.

11455 N Meridian St. Suite 200
Carmel, IN 46032
Phone (317) 582-8180
Fax (317)574-1088

Consent for Medical Services

I hereby authorize the physicians and/or employees of Infectious Diseases of Indiana, P.S.C. to release any current report or information acquired in the course of my examination or treatment by them to my family physician and referring physician(s). This authorization will remain in force until revoked by me in writing (per Indiana law: IN Code 16-4-8) (1-11).

I authorize and request insurance companies to pay directly to Infectious Diseases of Indiana, P.S.C. the medical/surgical benefits, if any, otherwise payable to me for their services, but not to exceed the charges for those services.

I request and authorize Infectious Disease of Indiana, its agents and employees, its physician, their associates, assistants and students ("providers") to provide medical and surgical care to me or the minor of whom I am a guardian.

This care may take place during an outpatient visit or hospitalization and may include exams, procedures, prescriptions/medication, test, communicable disease testing, and blood tests as considered advisable by my provider for my or my minor's well-being.

I agree that neither Infectious Disease of Indiana nor my provider has made any claims or statements about results or cures.

Print Name of Patient: _____

Signature of patient or family member completing form: _____

Relationship to patient: _____ Date: _____

INFECTIOUS DISEASE OF INDIANA, P.S.C.

Patient Information Sheet

Patient name: _____ Date of Birth: _____

Please provide information on your preferred pharmacy:

Pharmacy name: _____

Pharmacy address: _____

Please provide us with your preferred language: _____

In which of the following categories would you place yourself?

- o American Indian
- o Native American
- o Black
- o Asian
- o White
- o Unknown
- o Decline

Ethnicity:

- o Hispanic Origin
- o Non-Hispanic
- o Unknown
- o Decline

How would you best describe your smoking status?

- o Current every day smoker
- o Current someday smoker
- o Never a smoker
- o Former smoker
- o Unknown

Please provide the following information (if known):

Height	
Weight	
Blood Pressure	

List all Allergies:

Medication List/PCP Contact Information

Name_____Date_____

Please list *all* medications you currently take. Please include those prescribed by a physician and those you take over the counter.

1. _____ 7._____
2. _____ 8._____
3. _____ 9._____
4. _____ 10._____
5. _____ 11._____
6. _____ 12._____

Primary Care Provider Contact Information:

PCP Name: _____

Address: _____

_____

_____

Phone #: _____

Patient Condition Release of Information Form

I give myself permission for Infectious Disease of Indiana, PSC to discuss my condition of anything related to my condition with the individuals listed at the bottom of this form. If there is a change to this list it is the patient's responsibility to fill out a new form. No changes will be taken over the phone.

Name of Person	Relationship to Patient

Print Name of Patient

Date

Signature of Patient/Guardian

INFECTIOUS DISEASE OF INDIANA, P.S.C.

Financial Policy

11455 N Meridian Street, Suite 200
Carmel, IN 46032
317-582-8180
Fax 317-574-1088

Please read this policy carefully. Payment is expected at the time of service unless other arrangements have been made prior to the appointment. Our Patient Accounts representatives are available Monday through Friday from 7:30 AM to 4:00 PM to discuss financial arrangements. For your connivance we accept MasterCard and Visa. Please call (317) 564-4836.

Infectious Disease of Indiana, P.S.C. contracts with patients for their medical care: any arrangements made by the patient with attorneys, insurance companies, or other third party payers will not be considered in the collection of your account.

Charges for Professional Services – Every professional service and associated expense rendered will be charged to the patient according to a fee schedule prospectively determined by the clinic. Contractual discounts to third parties prospectively agreed to by the clinic will be honored in good faith. No fee or charge can be reduced or waived without the permission of only the administrator, billing manager, or his or her designee. An estimate of these fees can be requested prospectively.

Insurance – Health insurance is primarily a contract between the patient and the insurance company: however, Infectious Disease of Indiana, P.S.C. also has mutually agreed contractual obligations with certain private and government entities. The patient is primarily responsible for holding the insurance company accountable for claims reimbursement. Infectious Disease of Indiana, P.S.C. will make available substantial resources to facilitate insurance payment and will dedicate resources towards contractual obligations with these entities.

Payment – Payment for services rendered is due on the date of service and is part of the professional relationship. Infectious Disease of Indiana, P.S.C. reserves the right to request payment of the total negotiated fee on the due date unless directed otherwise by contract.

All co-payments will be collected at the time of service. All past-due balances or balances in collection must be paid prior to seeing an Infectious Disease of Indiana, P.S.C. practitioner. Non-urgent professional services may be delayed or terminated within the guidelines of good medical practice for bad-faith patient non-compliance with this financial policy. Only the administrator, billing manager, or their designated representative can amend this policy.

Patient Referrals and Out of Network – If patient is enrolled with an insurance carrier with network benefits, patient is entitled to full benefits of said plan when certain guidelines are followed. If patient does not obtain referral from his/her Primary Care Physician (PCP) for services rendered by Infectious Disease of Indiana, P.S.C. physician or provider, patient may be responsible for all or a portion of charges incurred. Patient will be responsible for charges incurred when choosing to go out of the designated managed care network.

Collection Agencies - Infectious Disease of Indiana, P.S.C. will use all reasonable means to collect owed funds. Defaults in payment of agreed amount will be referred to a collection agency for payment. Patient will be responsible for collection agency fees incurred while account is in collection.

Non-Sufficient Funds - Infectious Disease of Indiana, P.S.C. will charge a $25 fee for all checks returned by the bank for non-sufficient funds.

Medicare Patients - Infectious Disease of Indiana, P.S.C. are participating providers and accept Medicare assignment of benefits. Medicare patients will be responsible for deductibles, 20 percent coinsurance and/or non-covered charges when applicable. By signing this policy, the Medicare recipient requests payment of authorized Medicare benefits be made on patient's behalf for any services furnished by Infectious Disease of Indiana, P.S.C., including physician services.

Medigap/Secondary Insurance Authorization – Medicare recipient authorizes Infectious Disease of Indiana, P.S.C. or its agent to release medical or other information to supplemental insurance in order to process all medical claims. A copy of this authorization may be used in place of the original. Medicare recipient requests payment of medical insurance benefits to Infectious Disease of Indiana, P.S.C. for services provided.

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Witness Signature Patient's Name

For office use only Infectious Disease of Indiana, P.S.C. Account # _____
Witnessed by: _____

Infectious Disease of Indiana, P.S.C.
Indiana Travel Medicine
Notice of Privacy Practices

Effective Date: May 1, 2018

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. If we revise this Notice, we will provide a revised Notice to you within 60 days of a material revision. If you have any questions about this Notice, please contact our Privacy Officer.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Health Care Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Examples:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. We may also disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Business Associates: There are some services that require the use of outside people and entities. Examples of these "business associates" include accountants, consultants, and attorneys. We may disclose your PHI to business associates so that they can perform the job that we ask them to do. To protect your PHI, we require the business associates to appropriately safeguard your information.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- Public Health issues as required by law, Communicable Diseases.
- Food and Drug Administration requirements.
- Legal Proceedings/Law Enforcement.
- To a coroner, medical examiner, or funeral director when an individual dies.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

With Authorization: Other uses and disclosures not specifically permitted by applicable law will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except for actions we have already taken relying on your authorization. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

We will reasonably limit the use and disclosure of your PHI to the minimum amount necessary to accomplish the intended purpose. We will safeguard your PHI against inappropriate use and disclosure consistent with applicable law.

<u>Your rights regarding your PHI</u>

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI (not to exceed 6 years). We may charge you a reasonable, cost-based fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request. If, however, you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

<u>Breaches:</u>

You will be notified immediately if we receive information that there has been a breach that may have compromised the privacy or security of your PHI.

Complaints:
If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, Carla Henderson, at *Administrative Office, Infectious Disease of Indiana, P.S.C., 11455 N. Meridian, Suite 200, Carmel, IN 46032.*

You may also file a U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html.**

We will not retaliate against you for exercising your right to file a complaint.

If you have questions and would like additional information, you may contact us at *(317) 582-8180*.

Acknowledgement

By signing this document, I agree that I have read and understand all the information noted above.

_____ _____

Patient or Personal Representative * Signature Date

(*) If signed by Personal Representative, please state your relationship to Patient:

The FollowMyHealth™ patient portal at the Infectious Disease of Indiana is designed to enhance secure patient and provider communications and is provided as a courtesy to our valued patients. Please complete and submit this form along with copies of required legal documents to authorize Infectious Disease of Indiana to email an invitation to create a portal account.

Purpose for Access:	**PERSONAL ACCOUNT ACCESS: *(photo ID required)***
	☐ I am 14-17 years of age and request access to my own medical record information
	☐ I am 14-17 years of age and grant Read Only Access to my medical records to the authorized user listed below
	☐ I am 14-17 years of age and grant Full Access to my medical records to the authorized user listed below
	☐ I am 18 years or older and request access to my own medical record information
	☐ I am 18 years or older and grant Read Only Access to my medical records to the authorized user listed below
	☐ I am 18 years or older and grant Full Access to my medical records to the authorized listed below
	AUTHORIZED USER ACCESS: *(copies of legal documents and photo ID required)*
	☐ I am 18 years or older and request Read Only Access to a medical record *(indicate legal status below)*
	☐ I am 18 years or older and request Full Access to a patient medical record *(indicate legal status below)*
	☐ **I have legal paperwork for POA/Guardian/Adoption/Ward of the State or County for this patient**
	☐ **I am the parent of a Minor patient aged 11 or younger and possess their birth certificate**

Patient Information *(please print)***:**

Patient Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Patient DOB: _____ Phone: _____
MM/DD/YYYY

Email address where patient portal messages will be sent: _____
(PERSONAL EMAIL RECOMMENDED)

I hereby authorize Infectious Disease of Indiana to use/disclose individually identifiable health information to the FollowMyHealth™ patient portal for my online access to Infectious Disease of Indiana health care information:

Patient Signature: _____ Date: _____

Authorized User Information (*please print)***:** (Person receiving access to a Patient Portal account)

Authorized User Name: _____
FIRST NAME MIDDLE NAME LAST NAME

Authorized User DOB: _____ Relationship to Patient: _____
MM/DD/YYYY

Email address where Authorized User portal messages will be sent: _____
(PERSONAL EMAIL RECOMMENDED)

Address: _____
STREET ADDRESS CITY, STATE ZIPCODE

Home phone: _____ Cell phone: _____

Authorized User Signature: Date:

For Front Desk Use Only

Photo ID & Copies of Legal Documents Verified By: Date:

For Portal Use Only

Patient Portal Invite sent by: Date:

(verified email address and legal documents, FMH invite sent, paperwork scanned and saved in patient chart)