WELCOME TO
Michiana Spine, Sports & Occupational Rehab PC

PATIENT INFORMATION

Please complete the following by printing neatly. Today's Date: _____

Name: _____ Birth Date: _____
Last Name First Name Middle Initial Month/Date/Year

Address: _____
Street City State Zip Code

Home Phone: (_____) _____ Work Phone: (_____) _____ x _____
Area Code Area Code Extension

Cell Phone: (_____) _____ Sex: ☐ Male ☐ Female SS # _____
Area Code

Patient's Employer/School: _____ Patient's Occupation: _____

Patient's Employer/School Address: _____ Patient's Employer Phone: _____

City: _____ State: _____ Zip Code: _____

Referred By: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Do you have any allergies? ☐ No ☐ Yes If so, please list _____

In case of emergency who should be notified? _____

Relationship: _____ Phone: _____

Name of responsible party for this account: _____ Relationship: _____

Home phone and address (if different from patient): (_____) _____
Area Code

_____
Street City State Zip Code

☐ Married ☐ Widowed ☐ Divorced ☐ Single Spouse's Name: _____ Date of Birth: _____

Spouse's SS# _____ Spouse's Employer & Phone: _____

INSURANCE COVERAGE

Due to insurance filing policies, you are required to provide all information requested to assure accurate claim processing. If this information is not provided, your account is considered self-pay and the balance is due at the time of service. Any other arrangements must be made prior to seeing the physician.

PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO BE COPIED.

Please note: for insurance plans requiring referrals, authorizations, or precertifications, you are responsible to be sure that requirements have been met. Outstanding balances will be billed to you.

Is this a worker comp injury? ☐ Yes ☐ No ***Or*** Is this a motor vehicle accident? ☐ Yes ☐ No

Or Other Liability Injury? ☐ Yes ☐ No

Date Of Injury: _____ State: _____ Claim No.: _____

Case Manager Name: _____ Phone: _____

Please make sure you fill out BOTH SIDES of this form. ▶

PRIMARY INSURANCE

Primary Insurance Company Name: _____

Subscriber Name: _____
Last Name First Name Middle Initial

Relationship to Patient: _____ Social Security No.: _____ Birth Date: _____

Contract /ID No.: _____ Group Name/No.: _____ Date Effective: _____

Employer Name: _____ Phone: (_____) _____
Area Code

Employer Address: _____
Street City State Zip Code

ADDITIONAL INSURANCE

Please note we will file secondary insurance and allow 60 days for payment to be received after primary insurance payment. We bill two insurance carriers only.

Your secondary insurance company name: _____

Subscriber Name: _____
Last Name First Name Middle Initial

Relationship to Patient: _____ Social Security No.: _____ Birth Date: _____

Contract /ID No.: _____ Group Name/No.: _____ Date Effective: _____

Employer Name: _____ Phone: (_____) _____
Area Code

Employer Address: _____
Street City State Zip Code

ASSIGNMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of information including the diagnosis and the records of any treatments or examination rendered to my dependent or me during the period of such care to third party payor/and/or other health care practitioners. I authorize and request my insurance company/payor to pay directly to the doctor/doctors insurance benefits, otherwise payable to me. I authorize the release of my insurance carrier information to any other health care practitioners involved in my care.

I understand that my insurance carrier may pay less than the actual bill for the services and that I am responsible for the balance of the difference.

_____
Signature of patient or parent if a minor Date

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment:

☐ Cash ☐ Personal Check ☐ Credit Card ☐ Payment Arrangements

CO-PAYS ARE TO BE MADE AT THE TIME OF SERVICE PER FEDERAL LAWS.

Late charges: If I do not pay the entire balance within 60 days, I may be assessed a late fee of 1.5% on the unpaid balance and will be assessed each month (if allowed by law). I realize that my failure to keep this account current may result in Michiana Spine, Sports & Occupational Rehab, PC being unable to provide additional services. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this unpaid amount.

Please refer to the handout given to you at your initial appointment for the detailed office financial policy

_____
Signature of patient or parent if a minor Date

Thank you for filling out this form completely. This information will help us serve your needs more effectively.

MICHIANA SPINE SPORTS AND OCCUPATIONAL REHAB P.C.
3740 Edison Lakes Parkway, Mishawaka, IN 46545

CONSENT FORM FOR USE AND RELEASE OF MEDICAL INFORMATION

Participant Ill/injured person's First and Last name) _____

I,_____ hereby authorize MISSOR to obtain from, release to, and /or discuss with practitioners, providers or facilities, or their authorized agents, medical records, history or other information regarding my employment or my physical, medical, mental or emotional condition and capacity for the purpose of assessing my medical or vocational status and developing alternative programs or an appropriate rehabilitation plan if deemed appropriate and information related to my medical treatment for the purpose of coordinating my medical care or the validation and determination of benefits payable.

This authorization includes the release of the following, if applicable:

1. CONFIDENTIAL HIV-RELATED INFORMATION
2. CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION
3. CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION
4. CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION
5. CONFIDENTIAL GENETIC TESTING INFORMATION

I hereby release anyone disclosing the records or information specified above from any and all liability arising from that disclosure. I understand that I may revoke this authorization by writing MISSOR at the address on the form at any time except to the extent that action has been taken in reliance upon it. This consent will expire on the earlier of three hundred sixty five (365) days after the date of this signature or the date when I no longer participate with MISSOR.

I HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION: DATE:_____

Signature of Ill/injured Person:_____

This authorization expires on December 31, 2016 unless revoked by you in writing.

The provision of treatment, payment, health care operations, enrollment or eligibility does not depend on whether you sign this authorization. You should keep a copy of this authorization form for your records, however a copy of this signed authorization will be provided upon your request.

DISCLOSURES FOR WORKERS COMPENSATION PURPOSES (45 CFR 164.51)

The HIPAA Privacy Rule does not apply to articles that are either Workers' Compensation Insurers, workers' compensation administrative agencies or employees except to the extent they may otherwise be covered entities. However these entities need access to the health information of individuals who are injured on the job or who have a work-related Illness to process or adjudicate claims or to coordinate care under workers' compensation systems. Generally, this health information is obtained from health care providers who treat these individuals and who may be covered by the Privacy Rule. The Privacy Rule recognizes the legitimate need of insurers and other entities involved in the workers' compensation systems to have access to individuals' health information as authorized by State or other law.

PROHIBITION OF REDISCLOSURE:

If the information disclosed to you relates to substance abuse treatment, federal law protects the confidentiality of these records. Federal regulations(42 CFR Part 2) prohibits you from making any further disclosures without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. The Federal Rules restrict any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the confidentiality of patient records.

A COPY OF THIS RELEASE IS AS VALID AS AN ORIGINAL