Southside Family Medical Group
5955 S. Emerson Avenue, Suite 100
Indianapolis, IN 46237

317-789-9600 317-789-0600 (fax)

Patient Registration & Change of Information Form

All information on this form must be completed in full.

Last Name	First Name	MI	Gender M F	Date of Birth	Social Security #
				Marital Status: ______ Single _____ Married	

Address	City	State	Zip	Home Phone

Employer *(or prior employer if unemployed)*	Address	City	State	Zip	Secondary Phone *(please identify)* Work Cell

Children who will be seen at SFMG

Child:________________________ M / F D.O.B.: ________________

Child:________________________ M / F D.O.B.: ________________

Child:________________________ M / F D.O.B.: ________________

Child:________________________ M / F D.O.B.: ________________

Child:________________________ M / F D.O.B.: ________________

In case of Emergency Contact:	Name	Relationship	Telephone

Responsible Party (Guarantor) Statement

Name of Guarantor *(printed)*: ________________________________
(One Guarantor per Family please)

As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility.
Signature: ____________________________ Relationship to Guarantor: *self spouse child guardian other*____________ Date: __________
(of Authorizing Party)

Guarantor's Address	City	State	Zip	Home Phone

Guarantor's Relationship to Patient	Guarantor's Social Security #	Guarantor's Employer	Work Phone

Pre-Authorized Release of Protected Health Information

I understand that SFMG may release my Protected Health Information (PHI), under certain circumstances without my consent, as outlined in the Notice of Privacy Practices for Protected Health Information. In addition, I authorize Southside Family Medical Group to release information concerning my treatment and PHI to the following named individuals/organizations. *This authorization will be effective for a period of 18 months from the date of my signature.*

____

____

____

Signature: ____ Date: ____________________

ASSIGNMENT AND AUTHORIZATION TO RELEASE INFORMATION FOR PAYMENT

To the extent allowed under HIPAA, I authorize the release of any information regarding services rendered to any insurance carrier and for MEDICARE related claims, to the Social Security Administration, its intermediaries, carriers, or fiscal agents. I permit a copy of this authorization to be used in place of the original, or the statement, “Signature on File” to be printed on claims and request payment of medical insurance benefits directly to the provider.

Signature: ____ Date: ____________________

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Summary of Notice of Privacy Practices

(A COPY OF OUR FULL NOTICE IS AVAILABLE UPON REQUEST)

Under a federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA') we are required to give you a printed copy of our Notice of Privacy Practices. For your convenience, we are providing this brief summary. Each section has a corresponding section in our full Notice, which we encourage you to read in its entirety. We are required to ask you to sign a one-time acknowledgment that our full Notice has been made available to you.

Your Rights as a Patient

You have many new and important rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices.

Use of Protected Health In formation (PHI)

We are permitted to use your protected health information for treatment purposes, to facilitate our being paid, and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operations of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid entirely, and considers them as permissible. For entities that are not covered under HIPAA to which we must send protected health information for treatment, payment, or operational purposes, we require that they sign a contract in which they agree to protect the confidentiality of this information.

Disclosures of PHI Requiring Your Authorization

For disclosures that are not related to treatment, payment, or operations, we will obtain your specific written consent, except as described below.

Disclosures of PHI Not Requiring Your Authorization

We are required by state and federal law to make disclosures of certain protected health information without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests.

Communication to You of Confidential Information by Alternative Means

If you make a written request, we will communicate confidential information to you by reasonable alternative means, or to an alternative address.

Restrictions to Use and Disclosure

You may request restrictions to the use or disclosure of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, then we are bound to honor your request. In the course of our use and disclosure of your protected health information, only the minimum amount of such information will be used to accomplish the intended goal.

Access to PHI

You may request access to or a copy of your medical records in writing. We will provide these within the time period specified, unless we are forbidden under HIPAA or by applicable state law to provide such records. If we deny access, we will tell you why. You may appeal this decision, which, under specified circumstances, will be reviewed by a third party not involved in the denial.

Amendments to PHI

You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have rights to dispute such denials and have your objections noted in your medical record.

Accounting of Disclosures of PHI

You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures made in the course of treatment, payment, or operations, and disclosures that were made as a result of your written authorization.

Other Uses of Your PHI

Optional uses, as permitted under HIPAA, are listed in our complete Notice of Privacy Practices.

How to Lodge Complaints Related to Perceived Violations of Your Privacy Rights

You may register a complaint about any of our privacy practices with our Privacy Official or with the Secretary of Health and Human Services without fear of retaliation, coercion, or intimidation.

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Financial Policy

We realize that the financial aspects of healthcare can be confusing, and will do our best to help make this as easy as possible. As long as we have accurate and current insurance information, we will file charges with your primary insurance company. It is therefore very important that you bring proof of coverage (ID cards or insurance forms) to your appointments.

Financial Responsibility

You are fully responsible for charges not directly paid by your insurance company.

Insurance

Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. If your insurance company delays payment or refuses to pay, you are responsible for the FULL AMOUNT due. If/when your insurance company does pay, we will promptly refund any money owed to you. Please note that SFMG is not a Medicaid provider and cannot bill Medicaid.

Secondary Insurance

Unfortunately, we can not bill non-Medicare associated secondary insurances.

Co-pay

Any co-payments required by your insurance company must be paid at the time of service. This is an insurance requirement. If your co-pay is not paid on the date of service, a $15.00 billing fee will be charged.

Monthly Statement

If you have a balance on your account that is no longer pending with an insurance company, we will send you a Patient Statement. It will detail your balance due. Payment is expected within 15 days. IF YOU HAVE *ANY* QUESTIONS ABOUT YOUR BILL, YOU ARE RESPONSIBLE FOR CALLING THE OFFICE. If we have to rebill you, a rebilling fee will apply.

Past Due Accounts

After we have made reasonable attempts to collect on a past due account, we may turn any uncollected balance over to a collection agency. You will be responsible for any collection cost, including court and attorney fees, which are incurred. As a result your collection status may be reported to the major credit bureaus, and the collection agency may decide to litigate the claim. In either instance, the fact that you received treatment in our office may become a matter of public record.

Divorce

In the case of divorce or separation, the parent authorizing treatment for a child will be responsible for the associated copay. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Workers Compensation

We are not contracted for Workers Compensation Claims. You are responsible for payment in full at the time of service. We will provide you with the necessary receipts to turn in to your employer,

Motor Vehicle Accidents (MVAs)

Because MVAs are not covered by Health Insurance, and because we are not a party to your auto insurance contract, you (the patient) are expected to pay for the mva related visit in full at the time of service. You can turn your receipt into your auto insurance agent for reimbursement.

Special Fees

We reserve the right to charge for the following services:

- Disability, FMLA & Miscellaneous forms (fee depends on the extent of the forms, $30 minimum)
- MVA reports (fee depends on the extent of the report, $30 minimum)
- Copying medical records (fee depends on the amount of records to be copied, $20 minimum)
- Rebilling Fee ($15.00 after 60 days, $25 after 90 days)
- Returned Checks ($15.00)
- Missed Appointments ($25.00)
- Postage & Handling (actual cost, applies if we have to mail forms)

For your convenience, we do accept Visa, MasterCard, Discover Card, checks or cash.

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Acknowledgement of Receipt of
Notice of Privacy Practices
Financial Policy
Lab/Test Policy

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received. Southside Family Medical Group is also providing you with its Financial Policy and including the following notice relating to lab and test results:

Lab/Test Policy

It is our policy to call all patients with their lab and/or test results regardless of outcome. However, you are ultimately responsible for your own healthcare. Unfortunately, we are not always able to track when or if an individual patient has had a test done. And, while the testing facilities make every effort to forward a copy of your test results to your doctor, we do not always receive them. Therefore, ***if you do not receive a call from Southside Family Medical Group within two weeks of having a lab/test performed, you are responsible for calling our office to determine your test results.***

I acknowledge that I have read the above Lab/Test Policy and that **Southside Family Medical Group, LLC** has provided a written copy of its Notice of Privacy Practices for Protected Health Information and a copy of its Financial Policy to me to read on behalf of myself, my family and/or specify: ____.

___________________________________	___/___/20___	_________________________	_________________
Signature of Patient or Personal Representative	Date (mm/dd/yyyy)	Printed Name	Relationship to Patient (if not self)

(If signing as a personal representative, documentation of your legal right to do so must be provided.)

To be completed by Southside Family Medical Group, LLC

We made a good faith attempt to provide the above named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reason:

____

__________________________	__________________________	___________________________	__/__ /20
Printed Name	Title	Signature	Date (mm/dd/yyyy)

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Request for Release of Protected Health Information

You are allowed access to your protected health information, with certain exceptions. Elements of your protected health information that may be restricted from access are governed by HIPAA. If access is granted, you will be allowed to inspect these records in person and/or request a copy of the records as a readable printed copy, or in another format. Alternatively, you can ask for a summary of your protected health information. Regardless of how your information is provided, a fee may be charged.

You will receive a decision on your request for access within 30 days, or within 60 days if you are informed in writing as to why we are unable to make a decision within 30 days, and the date by which you can expect to have an answer.

Patient Name		Social Security Number	Date of Birth
Patient's Home Address	City	State	Zip Code

I hereby authorize a copy of patient's/my medical records to be released **TO**:

Name		Phone	Fax
Southside Family Medical Group, LLC		317-789-9600	317-789-0600
Address	City	State	Zip Code
5955 S. Emerson Avenue, Suite 100	Indianapolis, IN		46237

I hereby authorize a copy of patient's/my medical records to be released **FROM**:

Name		Phone	Fax
Address	City	State	Zip Code

Information to be released:

☒ Complete medical records

☐ Summary of patient treatment/diagnosis from ________________________ to ________________________ needed for continuity of care

☐ Other: (explain) ____

____

Information *not* to be released: ____

Reason/Need for disclosure: Treatment (Transfer) Other:____
(please circle one)

I understand that I have the right to inspect the information to be released and I may withdraw this authorization. I understand that this authorization will expire, without my express revocation, 60 days from the date written below. I also understand that there may be fees associated with copying/mailing this information.

Patient/Consenting Party (if patient is a minor) Relationship to Patient ______________________________

Print Name ____ Signature ________________________________ Date ____________

A photocopy or facsimile of this authorization shall be valid as the original

Note: This information is disclosed from records, the confidentially of which are, protected by Federal Law. Federal Regulations (42 CFR, Part 2) prohibits any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.

Internal Use Only	*yes*	*no*	
Approved by Practice Manager? ______________________________	☐	☐	Cost $______________________
Approved by Doctor?__________________________________	☐	☐	