



Allied Bone and Joint  
 Allied ENT Specialty Center  
 Allied Hearing & Balance Center  
 Allied Physical Therapy

Chadwell Facial Plastic Surgery  
 General and Vascular Surgery  
 Michiana Obstetrics & Gynecology  
 Michiana Sleep & ENT Solutions

ObGyn Associates of Northern IN  
 Pediatric Associates of South Bend  
 Urology Associates of South Bend

**Patient Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Gender  Male  Female

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Preferred Contact:  Home  Cell  Work Preferred method of contact?  Text Message  Phone message

Email Address: \_\_\_\_\_  Declined

Marital Status:  Married  Single  Divorced  Separated  Widowed Primary Language:  English  other \_\_\_\_\_

Race:  White  African American  Other Race  Declined Ethnicity:  Hispanic/Latino  Not Hispanic/Latino  Declined

Family physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

How did you hear about us?  Internet  Insurance Co.  Family/Friend  Hospital  Other \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Parent(s) /Guardian/Responsible Party Information (if the patient is under 18 years of age)**

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

First Middle I. Last

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Primary Insurance Information**

Name of Policy Holder \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address (if different from patients) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

**Secondary Insurance**

Name of Policy Holder \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address (if different from patients) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

**Is your injury related to a work or auto or other accident?**  YES  NO Date of injury/accident \_\_\_\_/\_\_\_\_/\_\_\_\_

Workman's Comp/Liability Carrier \_\_\_\_\_

Claim Number \_\_\_\_\_ Case Manager \_\_\_\_\_

Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_ Contact Fax Number: \_\_\_\_\_

**HIPAA Privacy Release: I authorized the release of my medical or appointment information to the following:**

As required by the HIPAA Privacy Regulations, all patients who receive health care service in our office must:

- Have the right to review or receive a copy of the "Notice of Privacy Practices" form;
  - How our office will use and disclose your medical information for legitimate business purposes only; and
- How each patient can exercise their rights with regard to this medical information;
- A complete list of this policy is available in our office at your request.

**In order for us to remain HIPAA compliant please list any person(s) or company(s) that you give your permission to obtain written or verbal information on your behalf about your medical condition: (do not list yourself or other physicians)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Interoperability**

In order to coordinate care, Allied Physicians participates with CommonWell Health Alliance and Carequality. These information exchanges are devoted to the vision that health data should be available to any provider organization involved in your care. This exchange of information is secure and compliant with HIPAA Privacy rules. Notify our office if you would like to opt out.

**Out of Network Referral Notice**

We may find it necessary to refer you for services with another provider for input or treatment of your condition. While we try to select the most appropriate provider to refer you to, some providers may be in-network or out-of-network with your insurance plan. Indiana Law, House Bill (HB) 1273, requires that we notify you on paper or electronically:

- (1) that at times we may refer you to an out-of-network provider to render health care items or services,
- (2) that an out-of-network provider is not bound by the same payment provisions that apply to health care items or services rendered by an in-network provider under your insurance plan. Meaning, that you may be responsible for more costs (co-pays, co-insurance) when seeing an out-of-network provider versus an in-network provider.
- (3) you may contact your insurance plan before receiving healthcare items or services rendered by an out-of-network provider
  - (A) to obtain a list of in and out of network providers that may render the health care items or services; and
  - (B) for additional assistance.

**Consent to access external medication history**

By signing this form Allied Physicians of Michiana, LLC may pull my external medication history from pharmacies. I understand that all prescriptions prescribed elsewhere and by other doctors will be electronically entered into my chart. This consent is valid for a three year period from the date signed and my medication list may be extracted each time I have an appointment with the physician.

**Preferred Pharmacy:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Automated calls**

I authorize Allied Physicians of Michiana, LLC or any outside agency to contact me regarding my patient balance. I understand and agree to receive artificial or pre-recorded voice or auto-dialed calls to designated cellular or residential telephone numbers for the purposes of debt collection or other purposes, such as appointment reminders

**Assignment and Release**

I certify that I, and/or my dependant(s) have insurance coverage with the above named insurance companies and assign directly to Allied Physicians of Michiana, LLC all insurance if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the release of any medical or other information necessary to process my insurance claim(s). The above named office may use my health care information and may disclose such information to the above named Insurance Company (ies) and agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

**X** \_\_\_\_\_  
Signature of patient/guardian/personal representative

\_\_\_\_\_  
Date