AlliedPhysicians
your allies for life

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_(____)_____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_____Sate_____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 (If no, skip to next section)

Workman's Comp/Liability Carrier_____ Date of injury/accident _____/_____/_____

Claim Number_____ Case Manager_____

Billing Address_____City_____State_____Zip_____

Contact Phone #_(_____)_____Contact Fax #_(____)_____

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 have the right to review or receive a copy of the "Notice of Privacy Practices" form which describes:

- 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:_____

Name: _____Relationship:_____

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. This means, 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, I agree that 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:_____ St:_____

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 use of my signature on all insurance admissions. 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