Registration
Indiana Craniofacial Center, PC

Patient Information

Last Name	First Name	MI	Gender	Marital Status	Birthdate	SS#

Address	Home Phone	Cell Phone

City	St	Zip	Employer	Occupation	FT/ PT

Pharmacy Phone	Employer Address	Work Phone

Email	Reason For Referral

Primary Care Physician	Referring Provider

Insurance	Address	Policyholder Name/Birthdate	Relationship	Policy ID	Group #
1.					
2.					

Guarantor (Person To Be Billed, If Different Than Patient)

1Last Name	First Name	MI	Gender	Marital Status	Birthdate	SS#

Address	Home Phone	Work Phone	Occupation

City	St	Zip	Employer Name	Employer Address

2Last Name	First Name	MI	Gender	Marital Status	Birthdate	SS#

Address	Home Phone	Work Phone	Occupation

City	St	Zip	Employer Name	Employer Address

Patient's or Authorized Person's Signature

I authorize any holder of medical information about me to release to Medicare and Medicaid Services or any other insurance company and its agents, any information needed to determine these benefits be made on my behalf or benefits for related services. I further request that payment of authorized Medicare, Medigap, or any other insurance company benefits be made on my behalf directly to Indiana Craniofacial Center, PC, for any services furnished to me by my physician. I acknowledge responsibility for payment of any deductibles, co-insurance, and non-covered services. This authorization is valid until revoked by me or my legal representative. A photocopy of this authorization shall be considered as valid as the original. If for any reason the account should become delinquent, I agree to pay for all collection and legal fees. I understand that payment is expected at the time of service.

I acknowledge receipt of Indiana Craniofacial Center, PC's Notice of Privacy Practices. I authorize Indiana Craniofacial Center, PC to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature **X**	**Signature Date**	Indiana Craniofacial Center, PC 3750 Guion Road, Suite 250 Indianapolis, IN 46222	Phone: 317-283-1900 Fax: 317-283-1901 Email: asmr@me.com

Release of Medical Records Indiana Craniofacial Center, PC

It may become necessary in the course of your medical evaluation and treatment for your physician to review the results of diagnostic tests or procedures, such as lab work or x-rays ordered by other physicians. In this era of heightened concern about the confidentiality of medical information, we are being asked more frequently for written authorization from the patient before this information will be released to us.

By signing below, you are giving a hospital, clinical laboratory, radiology facility, or any other medical provider who has information pertinent to the diagnosis and treatment of the condition for which you have consulted our physicians permission to release that information to Indiana Craniofacial Center, PC.

Print Patient Name	Date of Birth
Patient/Responsible Party Signature **X**	Date

No –Show Policy Indiana Craniofacial Center, PC

Scheduling Phone Number: 317-283-1900

Please understand that when you do not cancel an appointment you are unable to keep, it may prevent other patients from receiving care. We ask that you notify our office by 2:00 pm one working day before your appointment if you need to cancel. We understand that there will be situations that involve medical emergencies or that are weather related. Failure to do so will result in the following charges applied to your account. These fees cannot be billed to your insurance carrier and must be paid before any new appointments can be made for you. Continued no-show no-call events may result in your dismissal from our practice. Medical care will not be withheld in the event of emergency.

- **$25.00 - Office visit No-Show**
- **$50.00 - Office procedure No - Show**

I have read, understand, and agree to the above policy.

Print Patient Name	Date of Birth
Patient/Responsible Party Signature **X**	Date

Notice of Privacy Practices **Indiana Craniofacial Center, PC**

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. **Please review this notice carefully.**

Our Commitment To Your Privacy:

Our practice is dedicated to maintaining the privacy of your health information. In conducting our business, we will create records regarding you and the treatment and services we provide for you. We are required by law to maintain the confidentiality of your health information. We also are required by law to tell you how we may use and disclose your health information: your privacy right in your health information, and our obligations concerning the use and disclosure of your health information.

The terms of this notice apply to all records containing your health information that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will provide you a paper copy of our current Notice at your request at any time.

We may use and disclose your health information without your specific written authorization in the following circumstances:

Treatment: Our practice may use your health information to treat you. For example, we might use your health information to order laboratory or other diagnostic tests, schedule surgery, or to write or phone in a prescription for you. Many of the people who work for our practice--including, but not limited to, our doctors and nurses---may use or disclose your health information to a physician to whom we have referred you for further care. Additionally we may disclose your health information to others who may assist in your care, such as your spouse, children, or parents.

Payment: Our practice may use and disclose your health information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, pay for, your treatment. We also may use and disclose your health information to obtain payment from third parties that may be responsible for such costs, such as family members.

Health Care Operations: Our practice may use and disclose your health information in the business operations of our practice. These activities include, but are not limited to, quality assessment reviews, employee reviews, training of medical students, residents, and fellows, and the preparation and recording of your treatment in our practice. An example of the use of your health information for operations is that our practice may contact you and remind you of an appointment.

Other services: We may use your health information to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest of you. We may use your name and address to send you a newsletter about our practice and the services we offer.

Special Circumstances: The following categories describe unique scenarios in which we may use or disclose your health information:

To public health authorities and health oversight agencies that are authorized by law to collect information

- Lawsuits and similar proceedings in response to a court or administrative order
- If required to do so by a law enforcement official
- When necessary to reduce or prevent a serious threat to our health and safety, or that of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat
- If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- To federal officials for intelligence and nation security activities authorized by law.
- To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
- For workers Compensation and similar programs

Your Rights Regarding Your Health Information

Right to Provide an Authorization for Other Uses and Disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization.

Confidential Communications: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather that work. Unless you instruct us to the contrary, we may leave messages reminding you of an appointment at your home with a relative or on your answering machine and allow your spouse, parent, or child to schedule or change your appointments. To request a type of confidential communication, please let us know specifying the requested method or contact, or the location where you wish to be contacted. We will accommodate reasonable requests.

Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members or friends. We are not required to agree to your request; however, if we do agree, we are bound to our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. To request a restriction in our use or disclosure of your health information, please describe in a clear and concise fashion the information you wish restricted; whether you are requesting to limit our practice's use, disclosure, or both; and to whom you want the limits to apply.

Inspection and Copies: You have the right to inspect and obtain a copy of the health information we maintain on you, including patient medical records and billing records.

Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, please contact us. You must provide us with a reason that supports your request for amendment. We may deny your request if it is not in writing or if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of health information kept by or for the practice; or (c) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosure: All of our patients have the right to request a list of any disclosures our practice has made of your health information for reasons other that treatment, payment, or operations or which were not authorized by you. In order to obtain an accounting of disclosures, you must submit your request in writing and state a time period for which you are requesting the accounting, which may not be longer that six (6) years from the date of disclosure and may not include dates before June 1, 2008. The first list your request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice, with the Secretary of the Department of Health and Human Services, or with the Office of Civil Rights. To file a complaint with our practice, write our Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Whether you are a new to our practice or we have had the pleasure of serving you over the years, we would like you to be aware of our financial policy. Please read this information carefully, sign and return to the receptionist. We will be happy to give you another copy to keep for your records.

Registration: At each visit our receptionist will verify and update your demographic information and insurance coverage and may periodically ask you to complete a new registration form to insure our information is accurate. Please bring your insurance card to each visit.

Patient responsibility balances:
You will be responsible for:

- Payment in full

Insurance: We are not providers for Medicaid, Medicare, or any other commercial insurance but will bill your insurance. Therefore, you will need to be familiar with your policy and know what is required to access medical care. You have to be aware of the following requirements:

- Network participation of providers
- Referral from your primary care physician authorizing your visit with our doctor, done either by a specific form or by tracking number assigned to your visit. (If your insurance card has a physician's name on it, that physician must authorize your care by a specialist)
- Co-pay that must be paid each visit
- Specific hospitals, x-ray facilities, and clinical laboratories that must be utilized for any services.

If you are unsure of what you need, contact your insurance representative or primary care physician before your visit. It is your responsibility to advise us of any insurance changes at time of service. Any billing errors resulting in non-payment of claims will be the responsibility of the patient or guarantor.

A further note about Referral Authorization: If your insurance policy requires this referral, it is your responsibility to make sure we have authorization prior to being seen by the doctor. Unless you have a medical emergency, if we do not have a referral authorization for your visit and you are unable to obtain one, the visit will be rescheduled. While this may seem harsh, it if for your protection as much as ours, as some insurance plans will not pay for any tests or treatments that result from an unauthorized initial visit. If you have a second insurance company, please consider whether that insurance company may require prior referral authorization for the services, if so, and none has been obtained, they will deny payment and you will be responsible for the amounts they might otherwise pay on your behalf.

Self-Pay and Services not covered by insurance: If you do not have insurance or we are not contracted with your insurance, you will be expected to pay <u>at the time of service</u> or, in some instances, prior to service. Not all services are covered benefits by all insurance policies. Some insurance policies arbitrarily select certain services that will not be covered. Non-covered services will be the financial responsibility of the patient and/or guarantor.

Medical Care to Minors: If both parents have insurance, the insurance of the parent whose birthday falls first in the calendar year will be considered primary for the child, and the other parent's insurance will be secondary. When the parents are divorced, we will consider the parent/legal guardian who presents a child for care to be responsible party for payment of services, regardless of financial responsibility established in a divorce decree. Further care for a patient under 18 years of age must be authorized by a parent, legal guardian, or someone to who you give written authorization to present the child for care.

Motor Vehicle Accidents: If your medical condition results from a motor vehicle accident, we will treat your account as any other, i.e., we will consider you, not your auto insurance, to be the responsible party for all fees. If you have health insurance, we will bill the health insurance and look to you for any unpaid balances. It will be up to your health insurance company to obtain reimbursement from either your automobile insurance or that of another party who is held responsible for the accident. If you have no health insurance, you will be considered a Self-Pay patient.

Payment methods: For your convenience, in addition to cash or personal check, we also accept Visa, Mastercard, Discover and American Express. Please be aware that checks returned for insufficient funds will

result in a $25.00 fee being added to your account. Twelve month interest free financing is available through care credit.

We are committed to providing you with the best possible care and are pleased to discuss our fees with you at any time. It is the policy of this office that fees for services rendered will be paid in full at the time of service.

We do not accept insurance as payment on your treatment. However, we will complete the claim forms for you so that you can be reimbursed by your insurance company to the extent of your coverage, for the services rendered.

Insurance is a contract between you and your insurance company. We are not usually a party to this contract. However, we will file claim forms as a courtesy to our patients, but please remember, you are responsible for the payment of your account.

Acknowledgement and Authorization: I have read, understand, and agree to the above policies. Regardless of any insurance I may have, I am ultimately responsible for payment for any professional services rendered. I authorize the release of medical information necessary to process a claim for benefits under my policy and assign payment of my insurance benefits to Indiana Craniofacial Center, PC. If my account should become delinquent, I agree to pay the cost of collection, including legal fees and court costs.

Print Patient Name	Date of Birth
Patient/Responsible Party Signature **X**	Date