Plaza Park Family Practice LLC
3799 Venetian Way
Newburgh, IN 47630
(812) 471-4302

INSURANCE/PERSONAL INFORMATION

Please complete the form in entirety. If a section does not apply, please indicate "n/a". If the information requested is the same as patient, indicate "same". Do you prefer a nickname? _____

Patient Information:

First Name_____
M.I.____ Last Name_____
E-Mail Address_____
Home Address _____
City_____ State_____
Zip_____ Phone # _____
Work Phone #_____
Date of Birth_____
Age_____ Sex_____ Marital Status_____
Social Security # _____
Employer_____
Address_____
City_____ State_____
Zip_____ Full time /Part Time / Retired

Primary Insurance

Insurance Company_____
Policy Holder Name (as shown on insurance card)
_____
Policy Holder Address (if different from above)
_____
City_____ State_____
Zip_____ Phone # _____
Date of Birth _____
Social Security # _____
Effective Date _____
Insurance Patient ID # _____
Group # _____ Group Name _____
Employer Phone #
_____
Full time /Part Time / Retired

Secondary Insurance (if applicable)

Insurance Company_____
Policy Holder (full name)
_____
Policy Holder Address (if different from above)
_____
City_____ State_____ Zip_____
Phone # _____
Date of Birth _____ Social Security # _____
Effective Date of Insurance _____
Insurance Patient ID # _____
Group # _____ Group Name _____
Employer Phone # _____
Employed Full time /Part Time / Retired_____

Patient's Spouse/Guardian/Partner: (If applicable)

Name _____ Relationship_____
Address_____
City_____ State_____ Zip_____
Home Phone_____ Work Phone_____
Cell Phone _____ Date of Birth_____
Social Security # _____
Employer_____

Emergency Contact: (Not Living With You)

Name _____ Relationship_____
Address_____
City_____ State_____ Zip_____
Home or Cell Phone_____

***Please present two types of identification, your insurance card, and co-payment (if applicable).**

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance.

Signature_____
Date_____

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Patient Name_____ Patient DOB _____

- **Patient Authorization for Personal Representative.** Personal Representative (Friend or Relative that you authorize to have access to your health information, appointments, medication pickup, etc. You can revoke or terminate this by submitting in writing to Privacy Manager. This will remain in effect for one year from the date signed. I authorize Plaza Park Family Practice, LLC to disclose or provide my protected health and/or financial information to the following individual:

  Name of Personal Representative _____ Relationship _____ Phone number _____

- **Agreement to Pay/Authorization for Insurance Payment.** I agree to pay for all fees, or my portion not covered by medical insurance for the above-mentioned patient, at the time of service. I realize I am also responsible for full payment of fees, not paid by insurance, within 30 days of notification by Plaza Park Family Practice, LLC. I also agree to be responsible for any fees required to collect payment for services including attorney and court costs, collection agency fees, pre-judgment and/or post judgment interest at the current legal rate. I hereby authorize my insurance company to make payment directly to Plaza Park Family Practice, LLC, unless I pay in full at the time of service.

- **Collection Fee.** I understand that if any unpaid balance is assigned to a third-party collection agency for collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of 33% will be added to my account. I agree to pay that fee. I further agree to pay reasonable attorney fees and court costs.

- **Medical Records Release.** If it is necessary for any of my medical records, including progress notes and laboratory results, to be sent to another health care provider for medical reasons and to facilitate timely healthcare, I authorize Plaza Park Family Practice, LLC to do so. I also authorize the release of medical information, necessary to process my claim, to my insurance company, Workman's Comp plan, Social Security, Medicare/Medicaid, or any representatives acting on their behalf. I further authorize the release of my medical records to any individual or organization, engaged by Plaza Park Family Practice, LLC, my physician, or my third-party payer (insurance company), to conduct quality improvement and/or utilization review. I permit a copy of this

- authorization to be used in place of the original. I hereby release Plaza Park Family Practice, LLC from all legal liability that may arise from the disclosure of such information.

- **Missed Appointment & Record Copying Fee.** I understand that I will be charged a fee of $30 for any missed follow-up or acute and $50.00 for physicals and new patients doctor's appointment that I fail to cancel at least 24 business hours in advance. I agree to this fee. I understand that I have a right to the information in my medical records, but the original records belong to my doctor. I understand that it is expensive and time consuming to copy medical records. I understand that a reasonable copying fee will be charged anytime I request a copy of my records or transfer my records to another doctor. I agree to this fee. I will not be charged for: (1) copies of lab tests that I request on the day they are reviewed with me by the doctor or (2) records sent to a specialist that my doctor refers me to.

- **Medicare Authorization (MEDICARE PATIENTS ONLY).** I request that payment of authorized Medicare benefits for any services furnished to me by Plaza Park Family Practice, LLC (or any party who accepts assignment) be made to either me or on my behalf to Plaza Park Family Practice, LLC. I authorize the holder of medical or other information to release to the Health Care Financing Administration (Medicare) and its agents, any information needed to determine these benefits or benefits for related services. I further authorize Plaza Park Family Practice, LLC to release any information needed for this or any related Medicare/Medicaid claim to the Social Security Administration or its intermediaries or carriers.

- **Credit Card Processing Fee.** I understand that beginning July 1, 2023, there will be a credit card processing fee of 4% added when paying by credit card. (Excluding HSA cards)

- **Privacy policy.** I received a copy of the Notice of Privacy Practices for Plaza Park Family Practice, LLC

Print Patient Name: _____ Date: _____

Patient Signature: _____

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PATIENT TELEPHONE/EMAIL AUTHORIZATION

Print Patient Name: _____ Date of Birth: _____

Purpose of this request: By signing this agreement and providing **Plaza Park Family Practice, LLC** with my telephone number(s), I consent to **Plaza Park Family Practice, LLC**, its agents and assigns, including but not limited to: **HSC Medical Billing & Consulting, LLC** and other collection agents, contacting me at these telephone numbers, or at any other contact number that is later acquired for me, and leaving live and/or prerecorded messages regarding any accounts or services. I agree that for greater efficiency, calls may be delivered by an auto-dialer. I also understand that any email address that I provide is my personal, private email address and I authorize Plaza Park Family Practice, LLC or its agents to contact me by that email address as well. I am also aware that providing my telephone number, cellular number or email address is not a required condition of receiving services.

Plaza Park Family Practice, LLC patients may be contacted via email and/or text messaging to remind you of an appointment.

I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders unless I request a change in writing from the Office Manager, Tracey Hill.

Plaza Park Family Practice, LLC does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient Name (Print Clearly) _____

Patient Signature_____ Date _____

Email Address_____

Phone Number_____

Plaza Park Family Practice LLC
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Request for Transfer of Medical Records
TO Plaza Park Family Practice, LLC

Patient: _____ Date of Birth: _____

Address: _____ Phone #: _____

City, State, Zip: _____

I hereby request:

Doctor's Name: _____ Phone #: _____

Address: _____ Fax #: _____

City, State, Zip: _____

Mail/Fax my records to: Plaza Park Family Practice, LLC
3799 Venetian Way
Newburgh, IN 47630
Phone #: 812-471-4302
Fax #: 812-471-4303

Send:
- □ Entire record
- □ Records from _____to _____.
- □ Specific portions of the record:

_____.

The purpose of this release is for continued medical care.
This authorization will expire on December 31, 20__ or on a defined event: _____.

This consent for the release of medical information is subject to revocation at any time except to the extent that actions have already been taken. I understand that this request will include the release of information regarding physical and/or emotional illness, communicable diseases, alcohol or drug abuse, and/or HIV/AIDS information.

Signature of patient or legal guardian: _____ Date: _____