Patient Record of Disclosure

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____Day _____ Year_____

ADDRESS _____

_____

CITY _____STATE_____ ZIP_____

PHONE (____)_____ ALT. PHONE (____)_____

EMAIL ADDRESS (Optional): _____

I wish to be contacted in the following manner (check all that apply)

__Home phone number_____

__Cell phone number_____

ok to leave message with detailed info

leave message with call back number only

Written Communication

ok to mail to my home address

ok to mail to work/office

ok to fax to this number

__Work Telephone_____

ok to leave message with detailed info

leave message with call back number only

I AUTHORIZE THE FOLLOWING T O DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name *Terre Haute Internal Medicine*

Address 420 East Hospital Lane

City *Terre Haute* State *IN* Zip Code *47802*

Phone *(812)238-0958* Fax *(812) 238-0960*

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person Name _____

Phone (_____)_____

Person Name _____

Phone (_____)_____

Person Name_____ _____

Phone (_____)_____

Person Name_____ _____

Phone (_____)_____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

☐ All health information ☐ History/Physical Exam ☐ Past/Present Medications ☐ Lab Results ☐ Physician's Orders ☐ Patient Allergies ☐ Operation Reports ☐ Consultation Reports __ Progress Notes__ Discharge Summary__ Diagnostic Test Reports ☐ EKG/Cardiology Reports ☐ Pathology Reports ☐ Billing Information ☐ Radiology Reports & Images
Other_____

Your initials are required to release the following information:
_____ Mental Health Records (excluding psychotherapy notes) _____ Genetic Information (including Genetic Test Results) _____ Drug, Alcohol, or Substance Abuse Records
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date(optional) _____
RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE
X_____
Signature of Individual or Individual's Legally Authorized Representative

DATE_____

Patient Registration

Patient Name:_____

DOB_____

Race: Please circle one of the following

Hispanic Black or African American White American Indian/Alaska Native

Asian Native Hawaiian Other Pacific islander Other Refuse to report

Ethnicity: Please circle one of the following

Hispanic or Latin Non Hispanic Refuse to report

Language: Please circle one of the following

English Spanish Russian Indian-including Hindi&Tamil Other

Email address _____

Authorization for Release of Information

I hereby authorize Terre Haute Internal Medicine to release information requested by my insurance carrier and/or Workers' Compensation carrier. Additionally, I authorize the release and or obtain information regarding my Rx history from any external sources such as hospitals, Physicians, Pharmacies and etc.

Authorization to send Information to Pharmacy

I hereby authorize Dr. Pardeep Kumar, MD and/or Dr. Tejaswini Kumar, MD to send any confidential information to the pharmacy of my choosing.

Authorization to Obtain Information From Pharmacy

I hereby authorize Dr. Pardeep Kumar, MD and/or Dr. Tejaswini Kumar, MD to obtain and view my prescription history from external sources.

Authorization for Treatment

I hereby authorize Dr. Pardeep Kumar, MD or Dr. Tejaswini Kumar, MD to treat me for any medical issues

Assignment of Benefits

I hereby authorize assignment and payment be made directly to Terre Haute Internal Medicine of any medical benefits and/or Medicare assignment. I understand that insurance may not and the Medicare does not pay 100% of the medical charges.

I hereby acknowledge and agree to pay any and all charges that exceed or that are not covered by insurance, including any deductible, co-pays and co-insurances. I am aware that all co-pays are due at the time of service, unless prior arrangements have been made. I am aware that if I do not have insurance that services are to be paid at the time of service.

Collections

I hereby acknowledge that I am responsible for reasonable interest, collection fees, attorney fees of 38% or $300.00 added to the outstanding balance, and/or court cost incurred in connection with any attempt to collect amounts I may owe. I am aware that my account will become inactive due to non compliance of payment on my account and no services will be provided until debt has been paid in full.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge I have received a copy of Terre Haute Internal Medicine Associates Notice of Privacy Practice

Signature_____

Date_____