Michiana Internal Medicine PC
Consent to Treat

_____

Patients Name

I understand that I require treatment in this facility because of my condition. I permit my physician(s) or his employees, students in training, and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care may include tests, nursing care, and examinations, medical and surgical treatment.

I recognize it is the responsibility of my physician to explain to me the nature of any diagnostic test, medical, and/or surgical procedures judged by him/her as necessary for my treatment and to advise of risks and consequences of such procedures. I acknowledge that no guarantees have been made to me by my physician as to the result of any treatments, examinations, and/or operative procedure performed in the physician's office.

Release of Medical Information
I hereby authorize the physician involved with my care to release information from my medical record as may be required to any person, corporation, or agency which is legally responsible or has good cause to believe is legally responsible for processing and/or paying all or any part of the physicians charges and/or professional fee; to which any entity designated by me for discharge and planning purposes.

Medicare Consent (If applicable)
I certify that the information given by me in applying for payment under title XVIII (Medicare) of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. The Medicare intermediary advises that the type of services may no longer qualify as covered under Medicare.

Assignment of Benefits/Financial
I hereby assign payment directly to Michiana Internal Medicine PC all insurance benefits payments (including any major medical payments) due to me as a result of the named patient's outpatient treatment or service and pursuant to any insurance contract I have which provides for such treatment. I agree to be responsible for any charges incurred that are not paid by insurance or other third party payors.

By signing this document, I acknowledge that I have read and understand this consent. Further, I hereby consent and authorize this facility to use or disclose my protected health Information in conjunction with treatment, Payment or Health Care Operations in accordance with the terms of this consent.

_____

Patient Signature or Responsible person (if a minor)

_____

Date

MICHIANA INTERNAL MEDICINE, PC
Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-Payments and Deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payments at each visit.

3. **Non-covered Services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of Insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not a party to that contract.

6. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

_____

Name (Print)

NOTICE OF HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing below, I acknowledge that I have been informed, that at my request at any time, I could obtain a copy of Michiana Internal Medicine, PC's Notice of Privacy Practices to review or keep if so desired.

_____ _____

Patient Name **Date**

_____

Date of Birth

_____

Patient or Parent Signature (if a minor)

RELEASE OF CONFIDENTIAL INFORMATION

I _____ give permission to Michiana Internal Medicine, physicians, assistants, and staff to discuss any information in my medical record only to the following person(s) listed below:

1. _____ _____ _____

2. _____ _____ _____

Name Relationship Phone #

OR YOU MAY CHOOSE TO

_____ Check here if ANYONE has your authorization to receive your information

_____ Check here if NO ONE has your authorization to receive your information

AND IF IT IS OK

_____ Check here if we can leave detailed medical information on your answering machine or voicemail.

Please provide the best phone number to reach you at here_____.

_____ _____

Patient Signature Date

_____

Facility representative

Sleep Disorder Symptoms Assessment

Date _____

Name: _____

Date of Birth: (M/D/Y) ____/____/____ Gender: M____ F____

Insurance Plan: _____

FOR OFFICE USE:
Height: _____
Weight: _____
BMI: _____
Neck Size: _____
Blood Pressure: _____

Please check any of the following you may have:			
☐ High Blood Pressure	☐ Heart Disease	☐ Stroke	☐ Insomnia
☐ Frequent Urination at Night (Nocturia)	☐ Diabetes	☐ Depression	☐ Overweight

Snoring:		Score
1. Do you snore often (3 or more nights a week)?	☐ YES ☐ NO ☐ Don't Know	____Yes = 1
2. Is your snoring loud enough to be heard through a closed door or annoy other people?	☐ YES ☐ NO ☐ Don't Know	____Yes = 1
3. Have you noticed or been told that during sleep, you frequently stop breathing or gasp for air?	☐ YES ☐ NO ☐ Don't Know	____Yes = 2
	(sum of all numbers checked above) **Total Score**	

Epworth Sleepiness Scale:	Never would doze off	Slight Chance of dozing	Moderate Chance of dozing	High Chance of dozing
1. Do you get sleepy, or doze off, while sitting and reading?	0☐	1☐	2☐	3☐
2. Do you get sleepy, or doze off, while watching TV?	0☐	1☐	2☐	3☐
3. While sitting or inactive in a public place (meeting, theater)?	0☐	1☐	2☐	3☐
4. As a passenger in a car for an hour without a break?	0☐	1☐	2☐	3☐
5. Lying down to rest in the afternoon?	0☐	1☐	2☐	3☐
6. Sitting and talking to someone?	0☐	1☐	2☐	3☐
7. Sitting quietly after lunch without alcohol?	0☐	1☐	2☐	3☐
8. In a car, while stopped for a few minutes at a traffic light?	0☐	1☐	2☐	3☐
			(sum of all numbers checked above) **Total Score**	

CPAP:
Are you currently using CPAP? ☐ YES ☐ NO ☐ If yes, for how long? _____

PATIENT PORTAL
SIGN - UP

CureMD Patient Portal is a gateway to online appointments, messages, reminders, refills, medical records, lab results, history and more.

_____

Name

_____

Date of Birth

_____

E-mail