Community Health Network

**Community Spine Center**

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|---|---|---|---|
| Today's Date: | | | |
| **PATIENT INFORMATION** | | | |
| Patient's LAST name: FIRST: MIDDLE: | | | Social Security Number: |
| Sex: ❑ M ❑ F | Birthdate: / / | Preferred Name: | |
| Street Address: | Home Phone Number: ( ) | Cell Phone Number: ( ) | |
| City: | State: | Zip Code: | |
| Employer Phone Number: ( ) | Email Address: | Language: | |
| Interpreter Needed? | Marital Status: | Ethnicity: | |
| Race: | Appointment Reminder Calls? ❑ Yes ❑ No | Employer: | |
| Primary Care Physician Name: | | | |
| Employment Status: ❑Full Time ❑ Part time ❑Retired ❑ Not employed ❑ Disabled ❑Full time Student ❑ Part time Student ❑Self Employed ❑ On active military duty | | | |
| Name of local friend or relative (not living at same address): | Relationship to Patient: | Home Phone # ( ) | Work Phone # ( ) |
| Referred to Spine Center by: | | | |

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| **INSURANCE INFORMATION** | | | | |
| Please only fill out the next two lines if the person responsible for the bill is someone other than yourself | | | | |
| Person responsible for bill: | Social Security Number: | Sex: ❑ M ❑ F | | |
| Date of Birth: / / | Home Phone Number: ( ) | Employer Address: | | |
| Is this patient covered by insurance? ❑ Yes ❑ No | | | | |
| Please indicate name of primary insurance: | | | | |
| Subscriber's Name: | Subscriber's Social Security Number: | Birth Date: / / | | |
| Group Number: | ID Number: | | | |
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑Other-please describe: |
| Name of ***secondary*** insurance (if applicable): | Subscriber's Name: | Group Number: | ID Number: | |
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other-please describe: |

Community Health Network, Inc.

# PATIENT CONSENT AGREEMENT
# (PAGE 1 OF 2)

**THIS PATIENT CONSENT AGREEMENT** applies to services provided by Community Health Network, Inc.; Indiana Heart Hospital, LLC; Community Hospital South, Inc.; Indiana Surgery Centers; Indianapolis Endoscopy Center; Community Endoscopy Center; Community Physician Network; Community Home Health Services, Inc.; and their subsidiaries and affiliates (each of these health care providers whether individually licensed or operating under the license of another hereinafter referred to collectively as "Community").

**Medical Treatment**

I request or authorize Community to provide and perform under the direction of my physician(s) and/or his/her designee such care, procedures, services and supplies as are considered advisable for my health and well being. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me by my physician(s) or Community as to the result of any treatments, examinations, procedures or other services provided by Community. I understand that it is the responsibility of the physician to explain to me the nature of any diagnostic, therapeutic, medical and/or surgical procedures necessary to treat me and to explain risks and consequences associated with the services.

I authorize Community to dispose of any tissue, severed or amputated member, body part, or medical device removed in connection with services provided by Community.

**Patient Rights and Advance Directives**

If I am receiving hospital inpatient services, ambulatory surgical center services or home health services, I acknowledge I have been given written materials on my patient rights and responsibilities, which include my right to an advance directive. For all other Community services, I understand that information about advance directives is available upon request.

**Consent to Release Medical Records**

I understand Community will make every effort to treat my medical record information as confidential; however, I realize information must be shared with other providers involved in my care or in the payment of my care. I consent to the release of my medical information for treatment, payment and health care operational purposes as allowed by state and federal law, including the release of communicable disease information.

**Legal Relationships**

I understand my services may be provided by: (1) health care providers who are not employees of Community but who have a contract with Community to provide services, such as emergency physicians, anesthesiologists, radiologists, pathologists and other independent physicians; and (2) health care providers who have no employment or other contractual relationship with Community; and these providers may or may not participate in my insurance plan. I understand Community is responsible for carrying out the instructions of such providers, but I acknowledge (a) such providers are not employees or agents of Community; and (b) **Community is not responsible for the medical decisions, acts or omissions of such providers.**

**Assignment of Insurance Benefits**

I assign payment to: (1) Community; (2) health care providers who are not employees of Community, but who have a contract with Community to provide services, such as emergency physicians, anesthesiologists, radiologists, and pathologists; and (3) health care providers who have no employment or other contractual relationship with Community. I understand I will receive separate bills for services ordered or rendered by providers who are not employees of Community and who may or may not participate in my insurance plan.

I understand Community verifies my benefits and/or bills my insurance company as a courtesy to me. I authorize Community to release to Medicare and its agents any information needed to determine my benefits for services received. I authorize the release of my medical records and any other information necessary to obtain payment from Medicare, Medicaid and other payers. I request that payment of authorized benefits from Medicare, Medicaid and other payers be made on my behalf to Community for services provided by Community. This assignment does not apply to patients with insurance that is not accepted by Community.

***Continued...***

## PATIENT CONSENT AGREEMENT
## (PAGE 2 OF 2)

**Assignment of Insurance Benefits *(Continued)***
Further, I understand that verification of my benefits is not a guarantee the insurance company will pay those benefits and I am responsible for ensuring that any prior authorization required for my services is obtained in advance of treatment. In addition, I hereby appoint Community and its employees and agents as my representative to file grievances and appeals for me with my insurance plan/HMO as allowed by Indiana State law.

**Responsibility for Payment**
I understand that I may request and receive an estimate of anticipated charges. I understand and acknowledge that an estimate is not a guarantee; that the estimate is not binding upon Community; and that actual charges will be determined based on the services I receive and may be more or less than the estimate. I understand that I am financially responsible for all amounts not paid by insurance or other payers for services provided to me by Community and I agree to pay all charges when due or in accordance with any financial arrangement made at the time of discharge.

I understand Community provides financial assistance in the form of reduced charges, payment options, and payment plans to those who qualify. I understand I can request additional information on payment options or financial assistance if I believe I may not be able to pay or may not be able to pay timely.

In the event I do not pay such charges when due, I agree to pay costs of collection, including attorney fees and interest. I authorize Community or its agent to access my credit report in order to collect any charges due. If I provide Community with my cell phone number, I authorize Community or its agent to call my cell phone either manually or by auto-dialer in order to collect any amounts I owe.

**Release of Responsibility for Valuables**
I understand that Community is not liable for personal possessions including, but not limited to: money, valuables, dentures, eyeglasses, hearing aids or other property, that are lost or damaged. I know Community has the right to search anything on its premises, including wallets and purses, for the safety and welfare of its patients and visitors. I know I can avoid having my possessions searched by sending them home.

**Receipt of Notice of Privacy Practices**
I acknowledge that I have received the Community Health Network Notice of Privacy Practices and understand that I can also access a copy at www.eCommunity.com.

**I acknowledge that I have read and agree to pages 1 and 2 of this Patient Consent Agreement and my questions have been answered. I understand that I can request a copy of this document.**

| | | |
|---|---|---|
| ***Patient/Legal Representative Signature** | Date | Relationship (if not patient) |
| Guarantor Signature (if other than patient/legal representative) | Date | Relationship |
| Witness Signature | Date | Time |