MICHIANA OBSTETRICS AND GYNECOLOGY
FINANCIAL POLICY

We are committed to providing you with the best possible medical care. We are available to work with you if you have special financial needs. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Our office participates in a variety of insurance plans, and we will bill your insurance plan as a courtesy; however, it is your responsibility to:

- Bring your insurance card to every visit
- Obtain the necessary physician referral or pay all office fees at the time of service or completion of services.  
  NOTE: If the referral has not been obtained, you will be asked to sign an Insurance Referral Waiver, and pay for services rendered at the time of service.
- Remit payment for medical care not covered under your insurance (deductibles, copays, non-covered services, etc.) at time of service.
- Be prepared to pay your copay at each visit. Payment may be made by cash check or credit card. (Mastercard, Visa, Discover). If payment is not made at time of visit, there may be a processing fee charged.
- All patient due charges/prior balances will be collected at time of service. If payment is not made at time of visit, there may be a processing fee charged.

Out of Network Insurances

If we do not participate in your insurance program, our office is willing to file your claim; however, payment in full is expected within 30 days, either from your insurance program or you. You are ultimately responsible for balance when out of network. We will require you to sign an out of network form which requires your understanding that you are responsible for the difference between our charges for services rendered and the amount your insurance company remits on your behalf, regardless of their “usual and customary” determination.

Self Pay

Patients having no insurance coverage will be offered a prompt pay discount and a waiver will be signed. This discount will be applied to office based visits/procedures and must be paid at the time of service, during the checkout process.

Minor patient

For patients 17 years and younger, a parent or legal guardian must accompany them and sign below (exception: patients 17 years and younger declared emancipated minors, proof is necessary). It is the parent or guardian’s responsibility to bring the necessary referrals and insurance cards and also to make any payment due at the time of service. Proof of guardianship is required. We cannot examine patients 17 years and younger without a parent or legal guardian present (We will accept a letter of medical release from a parent or guardian from an adult accompanying the minor patient).

Additional Information

- Our charges are determined by what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.
- If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company’s Member Services department (the number is on your insurance card).
- If we are forced to send your account for further collection action, your balance due will be increased by any fees we may incur to collect the balance due from you. If your check is returned to us by the bank for insufficient funds, your account will be charged an NSF fee of $25.00 plus any additional fees we may incur as a result of the NSF check.
- If 2 checks are returned for NSF, we will require you to pay for all services with cash, money order, certified check or credit card.
- I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and communication. Questions about financial arrangements should be directed to our Billing Office. The office may be reached by dialing (574) 251-2100.

Please sign below to indicate that you have read and agree to this Financial Policy.

I understand and agree to this Financial Policy:

Signature of Patient or Responsible Party  
Printed Name  
Date
PATIENT INFORMATION

Last Name________________________________ First Name__________________________ MI _____ Sex: ☐ Male ☐ Female
Social Security # __________________ Date of Birth________ Marital Status: ☐ ☐ Married ☐ Single ☐ Other
Address __________________________________________ City________________________ State____ Zip________
Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Other____________ Religion: __________________________
Language: ☐ English ☐ Spanish ☐ Other____________ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Home Phone (___) __________ Cell (___) __________ Work (___) __________ ☐ Student ☐ Retired ☐ Employed
E-Mail Address______________________________________________________________
Patient’s Employer_________________________ Employer’s Address_____________________
Primary Care Physician: ___________________________________ Phone Number: ________________
Emergency Contact_________________________ Phone (___) __________ Relationship__________

GUARANTOR (RESPONSIBLE PARTY) INFORMATION

Last Name____________________________________ First Name________________________ MI_____
Address __________________________________________ City________________________ State____ Zip Code____
Relationship to Patient_______________ Sex: ☐ M ☐ F Employer: ____________________________
Date of Birth________________________ Social Security #____________________________
Home Phone (___) ___________ Cell (___) ___________ Work (___) __________

*PLEASE ALLOW US TO PHOTOCOPY YOUR INSURANCE CARD(S)*
PLEASE FILL OUT BELOW IF CARD HOLDER IS DIFFERENT THAN GUARANTOR

PRIMARY INSURANCE INFORMATION

Insurance Company Name___________________________________________________________
Name of Insured ________________________________________________________________ Sex: ☐ M ☐ F Date of Birth__________
Address __________________________________________ City________________________ State____ Zip________
Insured’s Social Security Number: ________________
Is this an Employer’s Plan? ☐ Yes ☐ No If so, Insured’s Employer: __________________________

SECONDARY INSURANCE INFORMATION

Insurance Company Name___________________________________________________________
Name of Insured ________________________________________________________________ Sex: ☐ M ☐ F Date of Birth__________
Consent for Treatment and Authorization for Release of Information

I hereby consent to and authorize Michiana Obstetrics & Gynecology to provide and perform such medical care, tests, procedures, drugs and other services and supplies as are considered advisable by such health care providers for my health and wellbeing. If I should not comply with the medical program of care provided or recommended by physician or designated alternate(s), I understand that I then relieve my physician, designated alternate(s), associated medical staff and Michiana Obstetrics & Gynecology of all responsibility resulting from my action.

I also authorize Michiana Obstetrics & Gynecology to gather, maintain and release any and all information that may be required for the processing of any and all claims for third party payers (including but not exclusive of, private insurance, Medicaid, Medicare, Tricare, Disability, etc.).

_____ I acknowledge that I have been given the ability to review Michiana Obstetrics & Gynecology’s Notice of Initial Privacy Practices.

Patient’s Signature_______________________________________________________Date_______________ Time___________ AM/PM
Other Authorized Person________________________________________ Relationship to Patient________________________
Witness:______________________________________________________________

NOTICE TO OUR PATIENTS

IN ORDER FOR US TO REMAIN HIPAA COMPLIANT, PLEASE LIST ANY PERSON(S) OR COMPANIES THAT YOU GIVE YOUR PERMISSION TO OBTAIN WRITTEN OR VERBAL INFORMATION ON YOUR BEHALF: (YOU DO NOT HAVE TO LIST YOURSELF OR OTHER PHYSICIANS)

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<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone Number</th>
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May we leave detailed messages, which may include but are not limited to, information about prescriptions or test results on your answering machine?  □ Yes  □ No

May we leave detailed messages which may include but are not limited to, information about prescriptions or test results with a member of your household? □ Yes □ No

Signature ____________________________________________________ Date __________
NAME: ______________________________________ DATE OF BIRTH: _____________ TODAY’S DATE: ____________

INITIAL PATIENT SELF-HISTORY FORM

Provide all information requested to the best of your ability.

Select One: _____New Patient _____Previous Patient (transferring) _____Current Patient

Why are you here today? _____Yearly Exam _____Pregnancy _____Other reason: ______________________________________

ALLERGIES (Include medications, Latex, Iodine)

__________________________________________________________

GYNECOLOGIC HISTORY

Age at first menses (period) ________ Age at menopause (if applicable) ________
(The following questions refer to your “natural” periods when not on birth control pills or hormones)
Usual # of days of period ________ Period interval (1st day to 1st day) ________ days
How many days are: Heavy ________ Medium ________ Light ________

Have you ever had an abnormal pap smear? ___If yes, how was it treated? ___________________ When? _____________

Date of last pap smear ________ Do you want to be screened for STD’s today? ____YES ____NO

Types of birth control used, including vasectomy _____________________________________________

Have you had any gynecologic surgery? (Including Tubal Ligations, D&C’s, Cryo, Leep, Ovarian surgery)
If yes, what kind? ___________________________________________ When? _____________

Have you ever had a mammogram? ___NO ___YES → Date: / / ____ Was it abnormal? ___NO ___YES → Please explain: ____________________________________________

Do you have any knowledge of your mother using hormones (DES, Diethylstilbestrol) during her pregnancy with you? ________

CANCER HISTORY

The following questions are in relation to yourself, Mother(M), Father(F), Sister(S), Brother(B), Grandmother(GM), Grandfather(GF) and Children(C) only.

Breast Cancer ____NO ___YES → If YES, who? ____________________________________________

Cervical Cancer ____NO ___YES → If YES, who? ____________________________________________

Colon Cancer ____NO ___YES → If YES, who? ____________________________________________

Ovarian Cancer ____NO ___YES → If YES, who? ____________________________________________

Uterine Cancer ____NO ___YES → If YES, who? ____________________________________________

PREGNANCY HISTORY

# of full-term deliveries ___ # of premature deliveries ___ # of stillbirths ___ # of miscarriages ___ Was surgery needed? _________

# of abortions ______ Any complications? ___________________ Any “tubal” pregnancies? ____ When? _____________

# of vaginal deliveries _______ # of Cesarean sections ______ Years of deliveries ______________________________

Any serious complications during your pregnancies or deliveries? ____________________________________________

RISK FACTORS

Your answers to these questions help us to determine if you have risk factors for cancer, infections or AIDS:

Have you ever received a blood transfusion? ________ Do you smoke? _____ How much? ________ How many years? ______
Do you consume alcohol? ________  How often? _______________________

Have you ever used or had an addiction to marijuana, cocaine, heroin, meth or narcotics? _____ If yes, last used? ________ Any needles? ______

Are you sexually active? ____NO ____YES → Sexual partners are: ____male ____female ____both

Age at first intercourse ________ Total # of sexual partners ________ Total # of sexual partners in last year ________

Have you had any sexually transmitted infections? _______ If yes, what? _________________________ When? ___________

Do you believe yourself to be at risk of exposure to the AIDS virus? ____NO ____YES ____UNSURE

**SURGERY** (Other than gynecologic)

<table>
<thead>
<tr>
<th>TYPE</th>
<th>WHEN</th>
<th>DOCTOR</th>
<th>COMPLICATIONS</th>
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**HOSPITALIZATIONS** (Non-surgical, other than pregnancy)

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>WHEN</th>
<th>DOCTOR</th>
<th>TREATMENT</th>
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**PAST AND PRESENT MEDICAL PROBLEMS**

- [ ] Abnormal PAP, h/o
- [ ] Anemia
- [ ] Asthma
- [ ] Autoimmune disease
- [ ] Bartholin’s gland cyst
- [ ] Blood transfusion, h/o
- [ ] Breast cancer
- [ ] Breast mass
- [ ] Bruising / bleeding disorder
- [ ] Cerebrovascular accident
- [ ] Cervical cancer
- [ ] Clothing disorder
- [ ] Coronary heart disease
- [ ] Cystocele
- [ ] Depression
- [ ] DES Exposure
- [ ] Diabetes mellitus
- [ ] Drug/alcohol use
- [ ] Endometriosis
- [ ] Family hx of genetic disorder
- [ ] Fetal death, prior
- [ ] Fibroid uterus
- [ ] Gallbladder disease
- [ ] Gental herpes, exposure
- [ ] Gental herpes, h/o
- [ ] Heart murmur
- [ ] Hemoglobinopathy
- [ ] Hepatitis/Liver disease
- [ ] Hypercoaguable disorder
- [ ] Hyperlipidemia
- [ ] Hypertension
- [ ] Incompetent cervix
- [ ] Infertility
- [ ] Neonatal death, prior
- [ ] Phlebitis
- [ ] Obesity
- [ ] Ovarian cancer
- [ ] Ovarian cyst
- [ ] PID
- [ ] Polycystic ovary syndrome
- [ ] Prolapsed uterus
- [ ] Premature rupture of membrane
- [ ] Preterm delivery, prior
- [ ] Psychiatric disease
- [ ] Pulmonary embolism
- [ ] Recurrent miscarriages
- [ ] Seizure disorder
- [ ] Thyroid disease
- [ ] Tuberculosis
- [ ] Uterine cancer
- [ ] UTI, h/o recurrent
- [ ] Vaginal infections, recurrent
- [ ] STD

Other Medical/Surgery History not listed ________________________________________________________________
**FAMILY HISTORY** Include Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM), Grandfather (GF), and Children (C) only.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Family member Indicated by M-Mother, F-Father, B-Brother, C-Child, etc.</th>
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<tbody>
<tr>
<td>Alive and Well</td>
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<tr>
<td>Alcoholism</td>
<td><em>NO</em> YES ➔ WHO                                            Hemophilia-A</td>
</tr>
<tr>
<td>Asthma</td>
<td><em>NO</em> YES ➔ WHO                                            Hyperlipidemia</td>
</tr>
<tr>
<td>Autoimmune disorder</td>
<td><em>NO</em> YES ➔ WHO                                            Hypertension</td>
</tr>
<tr>
<td>Blood clotting (Coagulopathy)</td>
<td><em>NO</em> YES ➔ WHO                                           Mental illness</td>
</tr>
<tr>
<td>Coronary artery disease</td>
<td><em>NO</em> YES ➔ WHO                                           Mental retardation</td>
</tr>
<tr>
<td>Cerebrovascular accident</td>
<td><em>NO</em> YES ➔ WHO                                           Muscular dystrophy</td>
</tr>
<tr>
<td>Cystic fibrosis</td>
<td><em>NO</em> YES ➔ WHO                                           Seizure disorder</td>
</tr>
<tr>
<td>Depression</td>
<td><em>NO</em> YES ➔ WHO                                           Sickle cell disease</td>
</tr>
<tr>
<td>Developmental delay</td>
<td><em>NO</em> YES ➔ WHO                                           Spina bifida</td>
</tr>
<tr>
<td>Diabetes</td>
<td><em>NO</em> YES ➔ WHO                                           Thyroid Disease</td>
</tr>
<tr>
<td>Downs syndrome</td>
<td><em>NO</em> YES ➔ WHO                                           Other_________</td>
</tr>
</tbody>
</table>

Other Family History not listed

______________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

Patient Signature: ___________________________ Date: _____________
PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. OUR PLEDGE TO YOU. Your health information -- which means any written or oral information that we create or receive that describes your health condition, treatment or payments -- is personal. Therefore, our physician practice pledges to protect your health information as required by law. We give you this Privacy Notice to tell you (1) how we will use and disclose your "protected" health information, or "PHI" and (2) how you can exercise certain individual rights related to your PHI as a patient of our practice. Please note that if any of your PHI qualifies as mental health records, alcohol and drug treatment records, communicable disease records or genetic test records, we will safeguard these records as "Special PHI" which will be disclosed only with your prior express written authorization, pursuant to a valid court order or as otherwise required by law. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices.

II. HOW WE WILL USE AND DISCLOSE YOUR PHI

(A) To Provide Treatment. We may use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the management or coordination of your health status and care with another health care provider. For example, we may disclose your PHI to a pharmacy to fill a prescription, or to a laboratory to order a blood test. We may also disclose your PHI to another physician who may be treating you or consulting with us regarding your care.

(B) To Obtain Payment. Our practice and Allied Physicians of Michiana, LLC (APOM) may also use and disclose your PHI, as needed, to obtain payment for services that we provide to you. This may include certain communications to your health insurer or health plan to confirm (1) your eligibility for health benefits, (2) the medical necessity of a particular service or procedure, or (3) any prior authorization or utilization review requirements. We may also disclose your PHI to another provider involved in your care for the other provider's payment activities. For example, this may include disclosure of demographic information to another physician practice that is involved in your care, or to a hospital where you were recently hospitalized, for payment purposes.

(C) To Perform Health Care Operations. We may also use or disclose your PHI, as necessary, to carry on our day-to-day health care operations, and to provide quality care to all of our patients, but only on a "need to know" basis. These health care operations may include such activities as: quality improvement; physician and employee reviews; health professional training programs, including those in which students, trainees, or practitioners in health care learn under supervision; accreditation; certification; licensing or credentialing activities; compliance reviews and audits; defending a legal or administrative claim; business management development; and other administrative activities. In certain situations, we may also disclose your PHI to another
health care provider or health plan to conduct their own particular health care operation requirements.

(D) To Contact You. To support our treatment, payment and health care operations, we may also contact you at home, either by telephone or mail, from time to time (1) to remind you of an upcoming appointment date, or (2) to ask you of to return a call to the Practice unless you ask us, in writing, to use alternative means to communicate with you regarding these matters. We may also contact you by telephone to inform you of specific test results or treatment plans, but only with your prior written authorization.

(E) To Be In Contact With Your Family or Friends. Additionally, we may also disclose certain of your PHI to your family member or other relative, a close personal friend, or any other person specified by you from time to time, but only if the PHI is directly related (1) to the person’s involvement in your treatment or related payments, or (2) to notify the person of your physical location or a sudden change in your condition, while receiving treatment at our office. Although you have a right to request reasonable restrictions on these disclosures, we will only be able to grant those restrictions that are reasonable and not too difficult to administer, none of which would apply in the case of an emergency.

(F) To Conduct Research. Under certain circumstances, we may use and disclose certain of your PHI for research purposes, but only if the research is subject to special approval procedures and the necessary rules governing uses and disclosures are agreed to by the researchers. For example, a research project may compare two different medications used to treat a particular condition in two different groups of patients by comparing the patients' health and recovery in one group with the second group. Any other research will require your written authorization.

(G) According to Laws That Require or Permit Disclosure. We may disclose your PHI when we are required or permitted to do so by any federal, state or local law, as follows:

When There Are Risks to Public Health. We may disclose your PHI to (1) report disease, injury or disability; (2) report vital events such as births and deaths; (3) conduct public health activities; (4) collect and track FDA-related events and defects; (5) notify appropriate persons regarding communicable disease concerns; or (6) inform employers about particular workforce issues.

To Report Suspected Abuse, Neglect Or Domestic Violence. We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence, but only when specifically required or authorized by law or when the patient agrees to the disclosure.

To Conduct Health Oversight Activities. We may disclose your PHI to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight, but we will not disclose your PHI if you are the subject of an investigation and your PHI is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings. We may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal. In certain circumstances, we may disclose your PHI in response to a subpoena if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

For Law Enforcement Purposes. We may disclose your PHI to a law enforcement official to, among other things, (1) report certain types of wounds or physical injuries, (2) identify or locate certain individuals, (3) report limited information if you are the victim
of a crime or if your health care was the result of criminal activity, but only to the extent required or permitted by law.

**To Coroners, Funeral Directors, and for Organ Donation.** We may disclose PHI to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties. We may also disclose PHI to a funeral director in order to permit the funeral director to carry out their duties. PHI may also be disclosed for organ, eye or tissue donation purposes.

**In the Event of a Serious Threat to Health or Safety, or For Specific Government Functions.** We may, consistent with applicable law and ethical standards of conduct, use or disclose your PHI if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public, or for certain other specified government functions permitted by law.

**For Worker’s Compensation.** We may disclose your PHI to comply with worker’s compensation laws or similar programs.

**(H) With Your Prior Express Written Authorization.** Other than as stated above, we will not disclose your PHI, or more importantly, your Special PHI, without first obtaining your express written authorization. We will not use or disclose your PHI in any of the following situations without your written authorization:

1. Uses and disclosures of Special PHI (if recorded by us in the medical record) except to carry out your treatment, payment or health care operations, to the extent permitted or required by law;
2. Uses and disclosures of your PHI for marketing purposes, that are not otherwise permitted under HIPAA;
3. Disclosures of PHI that constitute a sale of your PHI, and which are not otherwise permitted under HIPAA; and
4. Other uses and disclosures not described in this Notice.

## III. YOUR INDIVIDUAL RIGHTS CONCERNING YOUR PHI

**(A) The Right to Request Restrictions on How We Use and Disclose Your PHI.** You may ask us (1) not to use or disclose certain parts of your PHI but only if the request is reasonable. For example, if you pay for a particular service in full, out-of-pocket, on the date of services, you may ask us not to disclose any related PHI to your health plan. You may also ask us not to disclose your PHI to certain family members or friends who may be involved in your care or for other notification purposes described in this Privacy Notice, or how you would like us to communicate with you regarding upcoming appointments, treatment alternatives and the like by contacting you at a telephone number or address other than at home. Please note that we are only required to agree to those restrictions that are reasonable and which are not too difficult for us to administer. We will notify you if we deny any part of your request, but if we are able to agree to a particular restriction, we will communicate and comply with your request, except in the case of an emergency. Under certain circumstances, we may choose to terminate our agreement to a restriction if it becomes too burdensome to carry out. Finally, please note that it is your obligation to notify us if you wish to change or update these restrictions after your visit by contacting the Privacy Officer directly.
(B) **The Right to Receive Confidential Communications of PHI.** You may request to receive communications of PHI from us by alternative means or at alternative locations, and we will work with you to reasonably accommodate your request. For example, if you prefer to receive communications of PHI from us only at a certain address, phone number or other method, you may request such a method.

(C) **The Right to Inspect and Copy Your PHI.** You may inspect and obtain a copy of your PHI that we have created or received as we provide your treatment or obtain payment for your treatment. A copy may be made available to you either in paper or electronic format if we use an electronic health format. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to a law prohibiting access. Depending on the circumstances, you may have the right to request a second review if our Privacy Officer denies your request to access your PHI. Please note that you may not inspect or copy your PHI if your physician believes that the access requested is likely to endanger your life or safety or that of another person, or if it is likely to cause substantial harm to another person referenced within the information. As before, you have the right to request a second review of this decision. To inspect and copy your PHI, you must submit a written request to the Privacy Officer. We may charge you a fee for the reasonable costs that we incur in processing your request.

(D) **The Right to Request Amendments To Your PHI.** You may request that your PHI be amended so long as it is a part of our designated record set. All such requests must be in writing and directed to our Privacy Officer. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may respond to your statement in writing and provide you with a copy.

(E) **The Right to Receive an Accounting of Disclosures of PHI.** You have the right to request an accounting of those disclosures of your PHI that we have made for reasons other than those for treatment, payment and health care operations, which are specified in Section III (A-C) above. The accounting is not required to report PHI disclosures (1) to those family, friends and other persons involved in your treatment or payment, (2) that you otherwise requested in writing, (3) that you agreed to by signing an authorization form, or (4) that we are otherwise required or permitted to make by law. As before, your request must be made in writing to our Privacy Officer. The request should specify the time period, but please note that we are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

(F) **The Right to Receive Notice of a Breach.** You have the right to receive written notice in the event we learn of any unauthorized acquisition, use or disclosure of your PHI that was not otherwise properly secured as required by HIPAA. We will notify you of the breach as soon as possible but no later than sixty (60) days after the breach has been discovered.

(G) **The Right to File A Complaint.** You have the right to contact our Privacy Officer at any time if you have questions, comments or complaints about our privacy practices or if you believe we have violated your privacy rights. You also have the right to contact our Privacy Officer or the Department of Health and Human Services’ Office for Civil Rights in Baltimore, Maryland regarding these privacy matters, particularly if you do not believe that we have been
responsive to your concerns. We urge you to contact our Privacy Officer if you have any questions, comments or complaints, either in writing or by telephone as follows:

HIPAA Privacy Officer
Allied Physicians of Michiana, LLC
6301 University Commons, Suite 230
South Bend IN 46635
(574) 251-2100

Please note that we will not take any action, or otherwise retaliate, against you in any way as a result of your communications to the Practice or to the Department of Health and Human Services’ Office for Civil Rights. As always, please feel free contact us. We look forward to serving you as a patient of our Practice.

(H) Your Right to Revoke Authorization. Any other uses and disclosures not described in this Notice will be made only with your written authorization. Please note that you may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.
ALLIED PHYSICIANS OF MICHIANA, LLC
NOTICE OF PRIVACY PRACTICES

IMPORTANT NOTICE TO OUR PATIENTS

As required by HIPAA, all Patients who receive health care services from the Practice must:

- **Receive** or at least be offered the attached "Notice of Privacy Practices" Form; and
- **Sign** the "Acknowledgement" Form below and return it to our front desk for our records.

Please note that the attached Notice is *not* a consent form that must be read in full and signed before treatment can be provided; rather, the Notice provides our Patients with a summary description of (1) how our office will use and disclose medical and billing information for legitimate business purposes, and (2) how our Patients can exercise their rights with regard to this medical information. These notices are similar to the ones that the general public received from their banks and other financial institutions last year.

Please Sign the Acknowledgement Form below and return it to our front desk for our records.

Thank you very much.

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**ACKNOWLEDGMENT FORM**

I hereby acknowledge that I have received (or was at least offered) a current copy of the Practice’s Privacy Notice.

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Patient or Personal Representative* Signature  Date

(*) If signed by Personal Representative, please state your relationship to Resident:
IMPORTANT NOTICE TO OUR PATIENTS

As required by HIPAA, all Patients who receive health care services from the Practice must:

- Receive or at least be offered the attached “Notice of Privacy Practices” Form; and
- Sign the “Acknowledgement” Form below and return it to our front desk for our records.

Please note that the attached Notice is not a consent form that must be read in full and signed before treatment can be provided; rather, the Notice provides our Patients with a summary description of (1) how our office will use and disclose medical and billing information for legitimate business purposes, and (2) how our Patients can exercise their rights with regard to this medical information. These notices are similar to the ones that the general public received from their banks and other financial institutions last year.

Please Sign the Acknowledgment Form below and return it to our front desk for our records.

Thank you very much.

ACKNOWLEDGEMENT FORM

I hereby acknowledge that I have received (or was at least offered) a current copy of the Practice’s Privacy Notice.

_________________________  __________________________
Patient or Personal Representative* Signature          Date

(*) If signed by Personal Representative, please state your relationship to the Patient:
Dear Obstetrical Patient:

Thank you for choosing Michiana Obstetrics and Gynecology to care for you during your pregnancy. If you have questions or concerns at any time, please call our office at 574-232-2037 to speak with one of our nursing staff.

Please bring your actual insurance card to your initial history visit. You will need to verify maternity benefits with your insurance company.

Most insurance global fees for obstetrical care include 13 routine prenatal visits and one postpartum exam. Any other visit(s) or service(s) provided during the obstetrical period that fall outside the global description, as above, will be billed separately. Ultrasound studies may or may not be a covered benefit depending on your individual insurance coverage. Additional charges for multiple births will be billed according to the services rendered.

Fees routinely not covered in the global fee:

- Circumcision
- Ultrasound
- Ultrasound consultation
- Non-stress testing
- Assistant Surgeon for Cesarean Section

*These fees are subject to change.* Patients transferring into or out of the practice as well as some insurance companies will be billed for each individual visit/service provided during pregnancy. All laboratory fees are billed by the facility performing the service. If your insurance carrier requires a specific laboratory, please advise our staff for appropriate routing.

If you do not have insurance coverage or there is not a maternity benefit with your insurance carrier, a prepayment of ½ the total global fee is required at the initial appointment. The balance of the estimated bill is due prior to the 7th month of pregnancy. Charges for additional services outside the global fee are payable at the time of service.

If you have insurance coverage, prepayment of any co-payment and/or deductible amount is requested prior to the 7th month of pregnancy. A verification of benefits form will be sent to you for completion. After you return the form, you will be notified of the prepay amount.

Please call our patient representative at 251-2100 for additional insurance assistance or information. Payment schedules can be arranged.
NOTE: FMLA/Disability forms require 10-14 working days for completion.

Please complete the enclosed papers and bring them to your appointment along with your insurance card, if applicable. Failure to have the papers completed may require the rescheduling of your appointment. The first appointment, with the nurse, takes approximately one and a half hours. We ask that you not bring children to this appointment.

If you are unable to keep the reserved appointment time, please call our offices so that another patient can be seen.

Any minor, under age 18, being seen at Michiana Obstetrics and Gynecology MUST be accompanied by a parent or legal guardian to the initial visit. Written consent must be given before any treatment is rendered.

Thank you.

I have read and understand my financial responsibilities for my care.

Printed Name: ______________________________________ Date:_______________
Signature: __________________________________________
Signature of Parent or Legal Guardian: _________________________
Witness: __________________________  ______________________________________

Your appointment is scheduled for:

Date: _____________________  Time__________________________
Allied Physicians Surgery Center
Ownership Disclosure
(Indiana H.B.1306)

Each of the physicians of Michiana Obstetrics and Gynecology is also part-owner of the Allied Physicians Surgery Center. Your physician believes the Allied Physicians Surgery Center is an appropriate setting for the medical care and services for which you are being referred. Nevertheless, the selection of a specific health care provider always rests with the patient, and you may choose to be referred to an alternate setting if you so desire.

Please sign and return the original for filing in your medical record to acknowledge receipt of this notice.

________________________________________  __________________
Patient’s Signature                           Date
Dear Obstetrical Patient:

Thank you for choosing Michiana Obstetrics and Gynecology to care for you during your pregnancy. If you have questions or concerns at any time, please call our office at 574-232-2037 to speak with one of our nursing staff.

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Printed Name: ______________________________________ Date:_______________
Signature: __________________________________________
Signature of Parent or Legal Guardian: ______________________________________
Witness: __________________________

Your appointment is scheduled for:

Date: _____________________ Time______________________