Community Health Network

MedCheck Patient Information

Please Print! **If you are bleeding, feeling faint, having chest pain, etc., alert the staff.**

Is this visit work related? ☐ No ☐ Yes-STOP, return to desk for occupational health form.

Has the patient been seen at **this MedCheck** in the last 2 years? ☐ Yes ☐ No

Patient Last Name ______ **First Name** ______ **Mid Init** ______

Address ______ Home Ph. (____) ______ Work Ph. (____) ______

Cell Phone: ______ Email Address: ______

City/State/ZIP ______ Family Doctor ______

Birth Date ______ Age ______ Sex ______ Marital Status ______ Social Security # ______

All Patients: Do you have a chronic cough? ☐ No ☐ Yes Preference for Contact? ☐ Home ☐ Work ☐ Cell ☐ Email

Specific reason for this visit ______

1) If illness, date of onset ______

Symptoms ______

______

2) If accident, date of accident ______ time of accident ______

Where? ☐ Home ☐ Work ☐ Auto ☐ Other ______

What happened? ______

Person financially responsible for the account:

Last Name ______ First Name ______ Mid Init ______

Address ______ Home Phone ______ Work Phone ______

City/State/ZIP ______ Social Security # ______

Relationship to Patient ______ Employer ______

Insurance Information-Please attach insurance card(s) and photo ID under the clip.

Name of Primary Insurance ______ Secondary Insurance ______

Do you have HMO, PPO or POS coverage? ☐ Yes ☐ No

If **YES**, has this visit been authorized by your Primary Care Physician? ☐ Yes ☐ No

Name of PCP authorizing care ______ Authorization Number ______

How do you wish to pay for your visit today: ☐ Cash ☐ Check ☐ Charge ☐ Insurance

Please Read Carefully

Please be advised that all accrued charges may not be reflected on your charge ticket at the time of check out. You may receive an additional statement that will detail additional accrued charges, such as laboratory, radiology services or special procedures. If you provided our facility with insurance information all charges will be filed with the insurance on file. After the insurance company has processed your claim you will receive a bill indicating the amount due from you, if any.

As a courtesy to our patients, MedCheck agrees to file a claim with your **primary** insurance carrier if correct insurance information has been pro vided. Correct information is a copy of your current, valid medical insurance card. We do not guarantee payment from your insurance carrier. It is your responsibility to know the details of your policy.

We are unable to bill personal insurance for MOTOR VEHICLE ACCIDENTS. You will need to pay for your visit and we will give you a receipt to file with your insurance carrier.

Permission for Treatment, Release of Information and Financial Responsibility Agreement

I give permission for diagnosis and treatment by MedCheck physicians and staff. I authorize MedCheck to release any information needed for insurance claims. I assign my insurance benefits to MedCheck so payments may be applied to my MedCheck account. I agree to pay all accumulated charges not covered by insurance. In the event of default of payment, I agree to pay for collection fees, interest, court costs, and attorney fees. You must be at least 18 years old to sign permission for treatment.

In addition, I/we hereby designate the Hospital and its employees and agents as my/our representative to file grievances and to represent me/us in accordance with the Indiana Code, Title 27, Chapters 8 and 13.

______ Date ______ Time ______ Printed Name ______ Signature ______ Relationship to Patient

______ I acknowledge that I have received the Community Hospitals of Indiana, Inc. Notice of Privacy Practices.

Please Initial (If patient did not check box, give reason and initial.) ______

Do we have permission to call you back for follow-up: ☐ Yes ☐ No If Yes, what number should we contact you at: # ______ .