REBECCA BREWER, M.D., LLC **PATIENT INFORMATION & CONSENT** PLEASE PRINT

Date_____

Name_____ Birth Date_____ SS#:_____
First MI Last

Address_____ City_____

State_____ ZIP_____ Home Phone_____

Patient's Employer_____ Work Phone_____

Spouse Name_____ Birth Date_____ SS#:_____

Spouse's Employer_____ Work Phone_____

Person to contact in case of emergency_____ Phone_____

Name of nearest relative_____ Phone_____

Address_____

RESPONSIBLE PARTY

Relationship

Name of Person Responsible for this Account_____ to patient _____

Address_____ Home Phone_____

Employer_____ Work Phone_____

PRIMARY CARE PHYSICIAN

Primary care physician_____ Phone_____

It is the patient's responsibility to bring any referrals from their primary care physician.

INSURANCE INFORMATION

PRIMARY

Relationship

Name of Insured_____ to patient_____

Birth Date_____ SS#:_____ Work Phone_____

SECONDARY

Relationship

Name of Insured_____ to patient_____

Birth Date_____ SS#:_____ Work Phone_____

Does your plan require use of specific labs, hospitals, or x-ray facilities? YES NO

If yes, please list facilities to be used: _____

Do you have maternity coverage? YES NO

IMPORTANT!!! Turn Over ☞

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

PAYMENT POLICY

In order to avoid misunderstandings between the doctor and the patient we have the following policy in place. Co-pays and deductibles are due at time of service. Patients with no insurance should except to pay at the time of service. Please talk with a Financial Counselor if you need to set up payment agreements for your visit. We will process insurance claims for office procedures or surgery, however, please be aware that you, the patient, are responsible for the bill. Accounts that are delinquent after 90 days may be subject to collection and all costs involved, including attorney fees, will be considered patient responsibility. Any legal action originating form a Dr. Rebecca Brewer, M.D., LLC account will be filed in the Monroe County Court system. I hereby authorize payment of medical benefits to Rebecca Brewer, M.D., LLC for services furnished to me by my provider. I further agree to pay all co-pays, deductibles, non-covered services or charges considered above usual and customary (non-contracted carries only) by my insurance company.

_____
(Initials)

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Rebecca Brewer, M.D., LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Rebecca Brewer, M.D., LLC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to singing this consent. Rebecca Brewer, M.D., LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Rebecca Brewer, M.D., LLC's Privacy Officer at 3925 Hagan Street, Suite 104, Bloomington, IN 47401.

With this consent, Rebecca Brewer, M.D., LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any times that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With this consent, Rebecca Brewer, M.D., LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. With this consent, Rebecca Brewer, M.D., LLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Rebecca Brewer, M.D., LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. IF YOU WOULD LIKE US TO RELEASE INFORMATION TO ANYONE OTHER THAN YOURSELF PLEASE LIST THEIR NAMES ACCORDINGLY TO THE RIGHT OF YOUR SIGNATURE PLEASE INCLUDE D.O.B. FOR VERIFICATION PURPOSES.

By signing this form, I am consenting to Rebecca Brewer, M.D., LLC's use of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Rebecca Brewer, M.D., LLC may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient Name Date

_____
Print Name of Patient or Legal Guardian

Patients 18 years and under will need a parent or guardian signature authorizing treatment and consenting to financial responsibility.