Welcome to our practice!
Please provide information about yourself.

5645 Lafayette Road
Indianapolis, IN 46254

PATIENT INFORMATION SECTION

Last Name: First: MI:	Telephone Cell
Address:	Birthdate: Sex: M F
Address:	Soc Sec #
City/State/Zip	Status: Married Single Divorced Widow
Patient email:	If married, name of spouse
Employer Name:	**Emergency Contact:**
Employer Address: Zip:	**Relationship: Spouse Parent Child Other**
Employer Phone:	**Emergency Contact Phone:**
Race: Ethnicity: Preferred Language:	Preferred Communication Method:

RESPONSIBLE PARTY INFORMATION SECTION (person bringing pt in)

Only needed if patient is under 18 years old

Last Name: First: MI:	Telephone: Cell
Address:	Birthdate: Sex: M F
Address:	Soc Sec #
City/State/Zip	Status: Married Single Divorced Widow
Name of parent not listed above:	
Employer Name:	Employer Phone:
Employer Address: Zip:	

MEDICAL INSURANCE INFORMATION

NOTE Supplying your insurance information does not mean that we "accept" your insurance or that your insurance plan "accepts" us as a provider It is ultimately your responsibility to know the provisions of your insurance plan Insurance card(s) must be provided at every visit

Primary Insurance Co Name:	Policy #: Group #:
Insured's Name:	Relationship to Patient: Self Spouse Parent Other
Insured's Employer:	**Insured's Date of Birth:**

Secondary Insurance Co Name:	Policy #: Group #:
Insured's Name:	Relationship to Patient: Self Spouse Parent Other
Insured's Employer:	**Insured's Date of Birth:**

Please continue on other side......

CONSENT AND ASSIGNMENT

_______ *initials*

CONSENT: I hereby authorize direct payment of surgical/medical benefits to Oliver Family Healthcare for services rendered by Dr. Oliver or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance. I also authorize Oliver Family Healthcare to release any medical or incidental information that my be necessary for either medical care or in processing applications for financial benefit. I certify that the information provided by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf. I also hereby authorize and consent to the giving of all treatments, examinations, medications, and any technical procedures which, in the judgment of the Medical Staff at Oliver Family Healthcare may be considered Necessary or Advisable for diagnosis and treatment.

_______ *initials*

GUARANTEE OF PAYMENT: In consideration of the furnishing of medical & related services to the patient by Dr. Oliver, or under his supervision, I guarantee payment in full of the patient's account in accordance with the financial arrangements made at the time of registration. If none are so made, then payment in full is expected at the time of service. The undersigned agrees that in the event of default in payment I agree to be responsible for any reasonable attorney's fees and collection agency fees incurred in the collection of this account.

_______ *initials*

NOTICE OF ACKNOWLEDGEMENT: I acknowledge receipt of Oliver Family Healthcare's Notice of Privacy Practices.

_______ *initials*

WALK-IN CARE: Proper medical management of chronic disease such as high blood pressure, diabetes, high cholesterol as well as chronic organ disorders need to be handled at scheduled appointments. Dealing with these disorders at a visit for acute care issues as a walk-in patient is not appropriate and can result in inadequate care.
Please schedule an appointment for these chronic problems to allow us to give you the best care possible.

_______ *initials*

NO SHOW FEE: Appointments must be cancelled prior to the time of the appointment. If an appointment is not cancelled a NO SHOW fee will be added to the patient's account. The NO SHOW FEE for an office visit is $25 and for a complete physical is $50.

_______ *initials*

STATEMENT FEE: Co-pays, co-insurance and deductibles are due and will be collected at the time of service. If any of these fees are not paid at time of service and our office has to send a statement for these fees, a Statement Fee of $20 will be added to the patient's account.

MEDICARE PATIENTS:

_______ *initials*

MEDICARE LIFETIME ASSIGNMENT: I request that payment of authorized Medicare benefits be made to me on or my behalf to Oliver Family Healthcare for any services furnished me by that provider. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine benefits or the benefits payable for related services. This authorization is in effect until I choose to revoke it.

______________________________ ______________________

Patient Signature ***Date***
(or person authorized to sign for patient/responsible party