Lisa Robinsion M.D.

REGISTRATION FORM

PATIENT INFORMATION

Today's Date: _____

Legal Last Name: _____ First: _____ M.I. _____

Birth Date: _____ Gender: _____ Marital Status:_____

SSN: _____ Primary Phone: _____ Secondary Phone: _____

Address: _____ Zip Code: _____

Occupation: _____ Employer: _____ Employer Phone: _____

If patient is a minor, custodial parent's:

Name: _____ Birth Date: _____ Phone: _____

Name: _____ Birth Date: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance

(If different from patient) Subscriber's Name: _____ Date of Birth: _____

Address: _____ Relationship to Patient: _____

Group No: _____ Patient's Member ID: _____

Secondary Insurance

(If different from patient) Subscriber's Name: _____ Date of Birth: _____

Address: _____ Relationship to Patient: _____

Group No: _____ Patient's Member ID: _____

IN CASE OF EMERGENCY

Name: _____ Relationship to Patient: _____

Primary Phone: _____ Secondary Phone: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand I am financially responsible for any balance or services not covered by my insurance. I also authorize Joie de Vivre Medical or the insurance company to release any information required to process my claims.

_____ _____

Patient / Guardian Signature Date

Lisa Robinson M.D.

HIPPA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose Protected Health Information. This notice contains a patient's rights section describing your rights under the law.

You ascertain that by your signature you have reviewed our notice before signing this consent. The terms of the notice may change. If so, you will be notified at your next visit to update your signature. You have the right to restrict how your Protected Health Information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of Protected Health Information for treatment, payment or healthcare operations. By signing this form you consent to our use and disclosure of your Protected Health Information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, however, such a revocation will not be retroactive.

By signing this form I understand that:

- Protected Health Information may be disclosed for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time, and all full disclosures will then cease. The patient may also request that the practice not disclose treatments paid for out of pocket.
- The practice may condition receipt of the treatment upon execution of this consent.

Patient Signature: _____

Patient Printed Name: _____

Date of Signature: _____

Lisa Robinson M.D.

Patient Authorization to Release Medical Information and Payment Agreement

Release of Medical Information

I hereby authorize the release of any and all Protected Health Information to the following parties. I understand that if their name is not listed here, the medical practice is forbidden to communicate my Protected Health Information to anyone other than the parties in the Notice of Privacy Practices. I understand I may add or remove anyone from the above list at any given time if given in writing to the medical practice. I further understand this authorization includes the release of information concerning psychiatric and psychological conditions, drug abuse, HIV testing and treatment or related conditions contained in my medical records.

Please list any party other than yourself you authorize the medical practice to release you Protected Health Information to.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Payment Agreement

I hereby authorize the release of any and all Protected Health Information the medical practice may need to process payments for medical and surgical services received. I also hereby authorize any insurance company payments to be made directly to the medical practice Joie de Vivre, LLC.

Our medical practice accepts and processes many types of insurance company coverage options. It is the patient's responsibility to inform us if there is a copay, deductible, surgical pre-certification and/or second surgical opinion required by your insurance company. It is also the patient's responsibility to inform us if they would like to arrange an installment payment plan.

I understand I am responsible for any collection of payment amounts incurred including third-party collections efforts and attorney's fees. If I am not currently insured, I understand that I have sole responsibility and agree to pay for all services received at the time of service.

Signature: _____ Date: _____

Lisa Robinson M.D.

Authorization to Release Healthcare Information

Legal Name: _____ Date of Birth: _____

I authorize: _____ Phone/Fax: _____
to release healthcare information of the above named patient to:

Joie de Vivre Medical
1310 West Bloomfield Road, Suite C
Bloomington IN, 47403
Fax 812-323-7347

Please send the following records:

Charges for copies of documents shall be in accordance with Indiana Code 16-39-9 effective January 2006.

☐ One year of current medical records for continuing medical care.

☐ Specific records from the following dates: _____ to _____

☐ Records for personal use. (The fee for records will include * $20.00 for the first 10 (ten) pages * $0.50 per page for pages eleven (11) through fifty (50) * $0.25 per page for pages fifty-one (51) and higher * The cost of mailing the records * An additional $10.00 fee to be applied if records are needed within two (2) working days.)

Authorization Agreement

I, the undersigned, understand that I may revoke this authorization at any time, in writing, but the request shall remain valid until revoked or upon the expiration of 60 days, whichever occurs first, except to the extent that action has been taken thereon. Information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by the HIPAA rule. I understand that I am giving permission to release medical information which may include treatment for physical and/or emotional illness, communicable disease, alcohol or drug abuse treatment, and/or HIV, AIDS, AIDS-related information, unless I otherwise restrict such release of information.

Authorization must be signed by the parent or legal guardian of any patient under 18, the legal guardian of any patient under guardianship, the personal representative of a deceased patient, of if no personal representative, the spouse or adult child of a deceased patient. If the patient is under 18 and records are protected by Federal Law (42 CFR Part 2) regarding drug and alcohol abuse, authorizations must be signed by both patient and parent or legal guardian. Emancipated minors may sign for themselves.

Patient Signature: _____ Date: _____

Authorized Representative: _____ Date: _____

Lisa Robinson M.D.

Billing Policy

Please review this information and initial the following statements:

_____ I understand that it is my responsibility to provide the office of Dr. Robinson with current, accurate billing information at the time of check-in and to notify staff of any changes in this information.

_____ I understand that if I present an insufficient funds check for payment on my account, I will be charged a fee of $35. I further understand that to rectify my account I will be required to pay with cash, a money order, a cashier's check or a credit card.

_____ I understand that there is a $25 fee to complete disability paperwork associated with my care. However, if additional disability forms such as FMLA require completion, a separate fee of $25 is required prior to completion. I understand that if the paperwork takes the doctor longer than 15 minutes, additional charges may be added.

_____ I understand that I will be billed for any amounts due by me including copayments, coinsurance amounts and deductibles, and that I have a financial responsibility to pay those amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice," meaning it may be sent to an outside collection service if I do not fulfill my financial obligations. I understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.

_____ I understand that if I have a balance older than 30 days and plan on receiving healthcare at Joie de Vivre Medical, I will be required to pay at least half of that balance and any copays due at the time of service.

_____ I understand that Joie de Vivre, LLC will obtain the necessary prior authorizations before rendering service. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

My signature below confirms that I have read these billing policies and my financial obligation as pertains to Joie de Vivre, LLC, Dr. Lisa Robinson.

Signature: _____ Date: _____

Printed Name: _____

Lisa Robinson M.D.

Statement of Patient Financial Responsibility

Patient Name: _____ Date of Birth: _____

Joie de Vivre, LLC appreciates the confidence you have shown in choosing us to provide for your healthcare needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. You are responsible for payment of any deductible, copayment and coinsurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Joie de Vivre, LLC for providing rehabilitative services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Joie de Vivre, LLC, the full and entire amount of bill incurred by me or the above named patient; or if applicable, any amount due after payment has been made by my insurance carrier.

Patient Signature: _____ Date: _____
Guarantor Signature: _____ Date: _____
(If guarantor is not the patient or the patient is a minor)

Copay Policy
Some health insurance carriers require the patient to pay a copay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature: _____

Consent for Treatment and Authorization to Release Information
I hereby authorize Joie de Vivre, LLC, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures. I hereby authorize Joie de Vivre, LLC, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature: _____

Lisa Robinson M.D.

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours prior to cancelling your appointment.

I understand that if I "no show" for 2 (two) consecutive appointments, "no show" for 3 (three) appointments in a year, or cancel for a total of 4 (four) appointments within a year, I may be immediately discharged from care.

Joie de Vivre, LLC will notify you by writing by mail or telephone call if you are discharged from care.

I have read and understand the above information, and I agree to the terms described.

Patient / Guarantor Signature: _____ Date: _____