PATIENT'S INFORMATION

Date: _____

Patient Name: _____
Last Name *Suffix* *First Name* *MI*

Permanent Mailing Address: _____

Physical Address: _____
If different than mailing

Home Phone: _____ Cell Phone: _____ DOB: _____

Social Security #: _____ E-Mail: _____ Marital Status _____

Race: _____ Ethnicity: ☐ Hispanic ☐ Not Hispanic Language _____

Sex: ☐ M ☐ F Gender Identity: ☐ Female-to Male/ Transgender Male ☐ Male-to-Female/ Transgender Female ☐ Non-Binary/ Genderqueer ☐ Others

Employer Name: _____ Employer Phone: _____

Employer Address: _____

Preferred Pharmacy: _____ Pharmacy Location _____

Emergency Contact: _____ Relationship: _____ Phone: _____
Leave blank if none

INSURANCE INFORMATION

Is this visit due to one of the following? ☐ Worker's Comp ☐ Liability ☐ Motor Vehicle Date of Injury: _____

Primary Insurance Co.: _____ Relationship to Subscriber: _____
If patient is not the subscriber complete the following.

Subscriber's Full Name: _____ SSN: _____

Subscriber's Address: _____

Subscriber's Sex: ☐ M ☐ F DOB: _____ Employer: _____

Subscriber's Employer Address & Phone: _____

Secondary Insurance Co.: _____ Relationship to Subscriber: _____
If patient is not the subscriber complete the following.

Subscriber's Full Name: _____ SSN: _____

Subscriber's Address: _____

Subscriber's Sex: ☐ M ☐ F DOB: _____ Employer: _____

Subscriber's Employer Address & Phone: _____

PARENT/GUARDIAN INFORMATION

If patient is a minor.

Father's Name: _____
Last Name *Suffix* *First Name* *MI*

Father's Mailing Address: _____

Father's Home Phone: _____ Cell Phone: _____

Father's DOB: _____ Father's SS#: _____

Father's Employer: _____

Employer Address: _____ Phone: _____

Mother's Name: _____
Last Name *Suffix* *First Name* *MI*

Mother's Mailing Address: _____

Mother's Home Phone: _____ Cell Phone: _____

Mother's DOB: _____ Mother's SS#: _____

Mother's Employer: _____

Employer Address: _____ Phone: _____

SOUTHSIDE Family Practice
A UNITY HEALTHCARE PARTNER

3554 Promenade Pkwy Ste F
Lafayette, IN 47909-8418
Ph: (765) 471-9146 Fax: (765) 477-0277
SFPPatients@unityhc.com

Patient Name: _____ DOB: _____ Today's Date: _____

What type of problem(s) are you having? _____

Preferred Pharmacy and Location: _____

Do you smoke? ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐ No

Drug Name	Drug Name

Surgical History: ☐ None

Operation	Year	Operation	Year

How many siblings do you have? ____Older Brother(s) ____Younger Brother(s) ____Older Sister(s) ____Younger Sister(s)

Personal/Family Medical History: ☐ None
(please indicate any history of the following with yourself or other family member)

Medical Condition	Self	Other	Medical Condition	Self	Other
Alcohol or Chemical Dependency			Heart Bypass and/or Blocked Arteries		
Anxiety / Depression			High Blood Pressure		
Asthma			Insomnia		
Autoimmune Disease			Irritable Bowel Syndrome		
Bipolar / Schizophrenia			Kidney Stones		
Blood Clots			Migraines		
Cancer(s) (Skin or Other)			Obesity		
Cholesterol			Psoriasis		
Constipation			Sleep Apnea		
Diabetes (circle) Type 1 / Type 2			Snoring		
Gout			Stroke		
Heart Attack / Stents			Thyroid Disease		

UNITY HEALTHCARE, LLC
HIPAA RELEASE OF INFORMATION

Name: _____ Patient Number: _____ DOB: _____

Due to HIPAA rules and regulations, we are not permitted to discuss your medical information with anyone, including your family, without your consent or unless an exception to the rule applies (e.g. provider-to-provider discussions related to your treatment or to collect payment).

If you want to allow us to communicate with any person, please complete the following. You may change your mind at a later date.

Please list individuals (other than providers) we may speak with regarding your care:

Name:	Relationship:	Phone:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

A photocopy of this authorization shall be considered as valid as the original. **This Release of Information will remain in effect until terminated by the patient in writing.**

Patient Signature: _____ Date: _____

UNITY HEALTHCARE, LLC
DISCLOSURE AND RELEASE AUTHORIZATION

CONSENT TO TREAT: I request and give consent to my Unity Healthcare, LLC ("Unity") healthcare professional to provide and perform such medical/surgical care, therapy, tests, procedures, drugs, and other services and supplies as my healthcare professional, in their professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties, or guarantees as to the results or cures have been made to me or relied upon by me.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been offered a copy of the Unity Notice of Privacy Practices and understand that my protected health information ("PHI") may be used by Unity as described in such Notice.

OWNERSHIP DISCLOSURE: I acknowledge that Unity and indirectly, Unity's physicians, have an ownership interest in Unity Surgical Center ("USC"), and InnerVision Advanced Medical Imaging Center ("InnerVision"). I understand that I am free to determine which facility to utilize for health care services, and neither Unity nor my physician shall discriminate in the care provided to me should I desire to use a facility other than USC and InnerVision.

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize Unity and my healthcare professional to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries or services for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my healthcare professional on my behalf.

FINANCIAL AGREEMENT: I understand and agree to all the following:

a. All accounts are the full responsibility of the patient and/or the patient's responsible party guarantor.
b. No conditional payments accepted, and payments with attempted conditions will be applied to any amounts owed.
c. Unity will assist me in obtaining insurance benefits when those benefits are assigned to my/the patient's healthcare professional. I have provided complete information regarding my/the patient's primary and secondary health insurance, as applicable.
d. I am responsible for making sure insurance payments are processed and paid promptly to my healthcare professional. In addition, I must provide my prompt payment of any amount owed to Unity that is deemed "Patient Responsibility" under my insurance contract (for those payors with which Unity is a participating healthcare professional or "in-network"). Otherwise, it is my responsibility if my insurance does not cover such services or Unity is a non-participating healthcare professional or "out-of-network".
e. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. I agree that reasonable attorney fees shall be interpreted as 40% of any balance due at the time the account is sent to an attorney or collection agency for collection, or $300.00, whichever is greater.
f. Tippecanoe County, Indiana, shall be the preferred venue for any legal action related to this financial agreement, and I agree to waive my right to a trial by jury.
g. This financial agreement is being entered into individually and as an authorized agent for my spouse, if any. This financial agreement may be assigned by Unity to an attorney who purchases Unity's delinquent accounts, and the terms of this agreement shall remain binding.
h. A fee may be charged for any appointments not cancelled at least twenty-four (24) hours in advance or missed for any other reason. These are generally not payable by insurance. I am responsible for these fees.
i. Unity Immediate Care (UICC) is not a participating provider with or under the Indiana Medicaid program. As a result, any medical or related services provided by the UICC will not be covered or paid for by the Medicaid program.

OTHER PROVIDERS: I understand that in addition to the attending physician, other healthcare professionals, such as radiologists and pathologists, and other providers, such as laboratories and other medical professionals, may be involved in my care and may separately bill me for their services.

INDIANA LAW AND JURISDICTION: I understand that I am being provided treatment in the State of Indiana, and I agree that if I should have any claim with regard to my care or treatment, such will be decided in accordance with Indiana law and such action will be brought and decided in a Court in the State of Indiana.

NOTICE OF NONDISCRIMINATION: Unity complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, sex, or gender identity.

MEDICARE CERTIFICATION: (IF APPLICABLE) I certify that the information given by me, or by Unity on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating healthcare professional to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of the processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to Unity or my treating physician on my behalf.

AUTOMATED CONTACT: I understand that Unity and its affiliates and agents will utilize automated messages to contact me using the e-mail and phone numbers I have provided. These messages will provide information to me, such as *appointment information*, *closure messages*, *health services*, *account information, and statements*. These may come as a text message, automated call (whether a cell phone or a landline), or email and will be left at the number or e-mail provided to any Unity healthcare professional. If I receive treatment from multiple Unity healthcare professionals, I may receive multiple messages referencing appointments/services from each office. I understand that I have the right to opt out of any of these contact methods at any time by an opt-out within the text or e-mail message. For voice calls, I can speak to my healthcare provider's office to opt out of voice messages. Different companies are providing the above information to me, and I may need to opt out of each vendor.

PHOTO CONSENT: My healthcare professional may request photos. I consent to have my photographs taken by my healthcare professional or designated associate **if required** and permit the use of photographs for identification, medical records, education, and lectures.

My signature below constitutes my acknowledgment and agreement that I have read and understand the consent, notices, disclosure, and other information provided.

Patient/Parent/Guardian

Print Patient Name: _____ Signature: _____ Date: _____

SOUTHSIDE
Family Practice
A UNITY HEALTHCARE PARTNER

John P. Cusack, MD
Shadi Resheidat, MD

To Our Patients:

Southside Family Practice has implemented the following policies so that we can better serve the needs of our patients:

In regard to prescription refills, call your pharmacy and ask them to fax a request to our office. We require a minimum of 48 hours for all prescription refills.

In regard to mail-in prescriptions, it is the patient's responsibility to take care of their own mail-in prescription forms. Patients may pick up their scripts at the office 48 hours after request per physician approval.
PATIENTS ARE RESPONSIBLE FOR ALL COSTS INCURRED FOR MAIL-ORDER PRESCRIPTIONS.

There will be a $30.00 fee for a NO SHOW appointment or if an appointment is CANCELLED within 24 hours of original appointment.

The practice policy is to call patients with test results. If you have not been contacted within 2 weeks, call the office for status. Please do not assume that tests are normal if you have not heard from us.

Sincerely,

Deborah Cusack
RN, BN / Office Administrator
Southside Family Practice

DC/nw

Patient Signature: _____