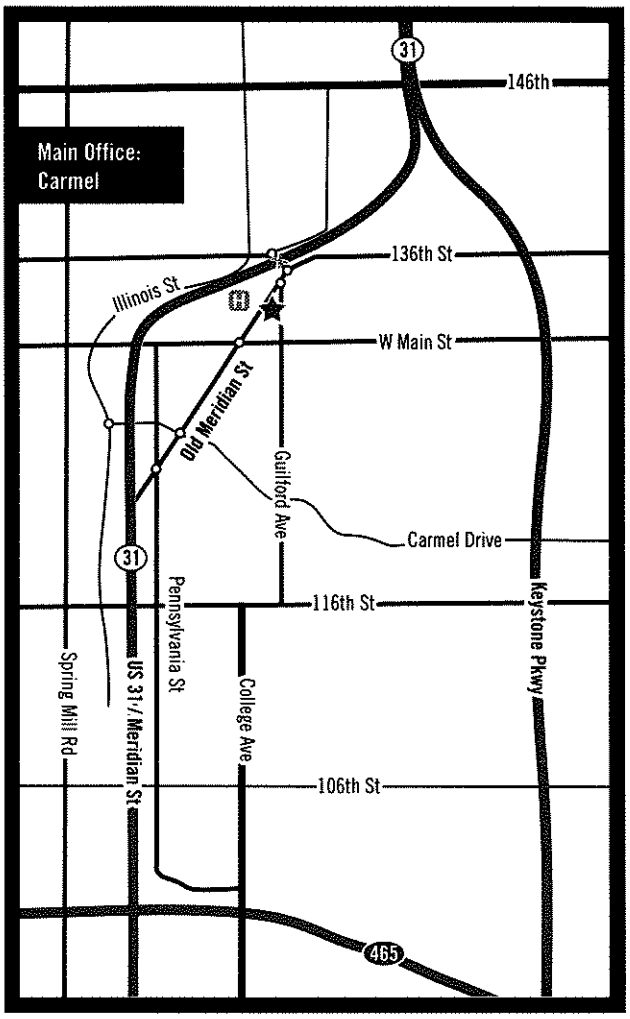
RHSI
RECONSTRUCTIVE HAND to SHOULDER of Indiana

All Appointments are made by calling only the Carmel phone below. This practice does not make reminder calls.

13431 Old Meridian Street | Suite 225 | Carmel, Indiana 46032

317.249.2616 | toll free 866.262.8631 | ***www.IndianaHandSurgeons.com***

Michael Pannunzio, M.D. | Alex Meyers, M.D. | Dale Dellacqua, M.D.
Lance Rettig, M.D. | Sebastian Peers, M.D. | James Strickland, M.D. (inactive)



From the North: South on US 31 to 136th Street exit # 128. Take exit and stay in left lane on ramp to enter the first roundabout. Move into the right lane through into a second roundabout taking the Old Meridian Street first right turn heading south. (Just past the emergency entrance to St. Vincent Hospital on your right) take the first left turn into the Carmel Ambulatory and Endoscopy Center parking lot. Make an immediate left proceeding to the end of the parking lot for the Carmel Medical Pavillion with the RHSI hand logo on the building's north entrance.

From South: Take I-465 to Meridian/US 31 North. Proceed north 4.0 miles to the 136th Street exit #128. You remain in the long exit ramp until you turn right onto Old Meridian St. (Just past the emergency entrance to St. Vincent Hospital on your right) take the first left turn into the Carmel Ambulatory and Endoscopy Center parking lot. Make an immediate left proceeding to the end of the parking lot for the Carmel Medical Pavillion with the RHSI hand logo on the building's north entrance.

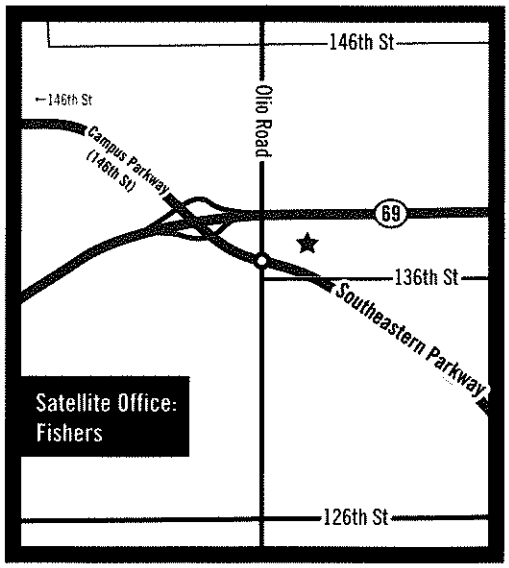
Satellite Office - Fishers: St Vincent Medical Center Northeast | 13861 Olio Road | Suite 301 (3rd Floor) | Noblesville, Indiana 46037

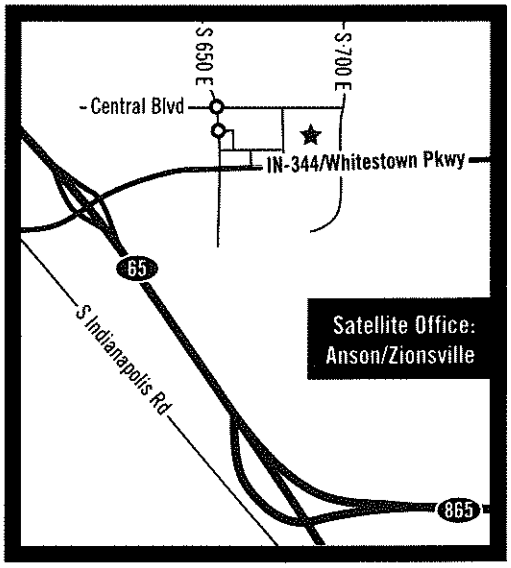
From South: On I-69 you exit at Fishers/Noblesville exit 210. Go east (right) onto Southeastern Pkwy entering a roundabout. The Medical Center is located on the Northeast corner of Southeastern Pkwy and Olio Rd (2nd exit off the roundabout).

From the West: Take 146th St (Campus Pkwy) past Hamilton Town Center on the right, go over I-69; 146th Street is now Southeastern Pkwy. Proceed through the roundabout taking the 2nd exit east to the Medical Center located on the northeast corner of Southeastern Pky and Olio Rd.

Satellite Office - Anson/ Zionsville:
Witham Health Services at Anson
6085 Heartland Drive | Suite 200 |
Zionsville, Indiana 46077

I-65 toward Zionsville to Exit 130, IN-344. Go East 0.4 miles. Witham Health Services at Anson is located on the North side of IN-334/Whitestown Parkway - directly across from Lowes Home Improvement store.





Reconstructive Hand to Shoulder of Indiana
OFFICE AND FINANCIAL POLICIES

We require you read, *initial,* and *sign* this document prior to any treatment

Your clear understanding of our financial policy is important to our professional relationship. Please let us know should you have any questions about our fees, financial policy or your responsibility.

Initial here ↓

- _____ **Responsible Party:**
  1. You are responsible for your charges regardless of any divorce decree or court order regarding payment of medical bills.
  2. Except for worker's compensation, we do not accept nor file third party insurance. Therefore, if your medical condition is a result of an accident, and you are not filing through your health insurance, you will be responsible for payment in full at the time of service. Furthermore, we will not hold any balances for payment from a third party.
  3. Your account will be charged $30.00 for each time a check is returned.
- _____ **Insurance:**
  1. If you are unable to provide proof of current insurance for treatment, you will be responsible for payment in full at the time of service.
  2. **If your policy requires a co-payment, this amount will be collected at each visit. Failure to pay at the time of service will result in the assessment of a $10.00 service charge.**
  3. If your insurance coverage changes, it is your responsibility to provide us with the current and accurate information. RHSI cannot be responsible for any penalties or denial of payment as a result of incorrect information.
  4. If your insurance requires a referral from your primary care physician (PCP), it is your responsibility to obtain that referral from your PCP prior to services being rendered.
- _____ **Collection Policies:**
  1. If you are unable to pay your balance in full after insurance adjudication, payment arrangements can be made with our Billing Department. Regular, timely, monthly payments must be made, with the balance being paid in full within 120 days of insurance adjudication.
  2. We reserve the right to charge 1.5% interest accrued monthly on any balance 90 days delinquent.
  3. Continued delinquency and/or default of a payment arrangement will result in your account be considered for agency collection. Further patient care with our office will be denied if your account is referred to a collection agency.
- _____ **Disability Forms, FMLA, AFLAC and Medical Records Requests:**
  1. There will be a **$30 charge** for completion of short/long term disability forms, Family Medical Leave Act forms, or AFLAC forms, **payable prior to completion**. Please allow 3-5 business days after receipt of payment for completion of these forms. Please ensure your portion is completed and signed.
  2. **We will provide copies of your medical records upon request and receipt of a letter of release. Please allow 5-7 business days to process your request. A fee for copying and postage will be assessed, based on the number of pages in your medical record.**
- _____ **Surgery:**
  1. Should you require surgery, our office will contact your insurance company to determine eligibility and benefits and obtain any necessary precertification. It is the policy of RHSI to collect a down payment prior to surgery. This will be applied toward your anticipated out of pocket expense based on your policy benefits and the ordered procedure.
  2. Most surgical procedures include a 90-day postoperative period (some have a 10-day global period while others have a 0-day global period). Routine post-operative visits with your surgeon are included in the surgery cost. However, any x-rays, splinting, casting, or visits with our occupational therapists are separately billed. Facility and anesthesia charges are billed separately.

- **PLEASE NOTE:** If you are released to return to work with restrictions and/or prescribed medication, it is your responsibility to comply with all applicable rules of law required in the operation of a motor vehicle.

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  - **Medicare Certification**: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician to release information from my medical record to the Social Security Administration, the Medicare Program, its intermediaries, third party administrators, or to the Professional Standards Review Organizations for processing of claims. I hereby request that payment of authorized benefits be paid directly to RHSI.
- _____ **Financial Agreement**: I acknowledge my accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. In the case of default, I agree to pay interest on the balance due along with any collection costs and reasonable attorney fees incurred to effect collection of my account.
- _____ **Consent to Treat**: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies considered to be medically necessary or beneficial by my physician for my health and well being. Lastly, I acknowledge that no representations, warranties or guarantees as to results or cures have been made nor are relied upon by me.

I, the undersigned, have read, understand, and agree to abide by the above information.

______________________________________ ______________

Patient/Guardian signature **Date**
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RECONSTRUCTIVE HAND TO SHOULDER OF INDIANA
13431 Old Meridian St Ste 225 * Carmel, IN 46032

PATIENT CONSENT TO SHARE PROTECTIVE HEALTH INFORMATION

I understand that if I want to receive treatment from one or more of the health care providers, ("Providers") associated with this Practice, I need to give permission for them to share information about my health, among themselves and with other individuals for treatment, billing purposes and other health care operations. I also understand that all reasonable efforts will be made to protect the privacy of my health information, whether it is maintained on paper or electronically, and regardless of the method by which it is communicated.

By signing below, I agree that any of the Providers associated with **RHSI** may:
1. Use my health information, on a need to know basis, to give me treatment.
2. Share my health information with others who are involved with my treatment either in or outside of this Practice.
3. Use my health information for billing purposes.
4. Share my health information with health insurance companies, government agencies, or other payors that request information related to benefits, claims filed, and other billing matters.
5. Share my health information either in or outside of this Practice for health care operations that include evaluation of the quality of heath care services received, and of the performance of the Providers to find better ways to provide care.
6. Share my health information with outside parties ("Business Associates") who contract with the practice to perform medical services on behalf of our patients. (ie: lab, radiology, night nurse triage)
7. Leave voicemail, email or text messages regarding upcoming appointments.

I understand that the Practice has a "Notice of Privacy Practices" ("Notice") that describes in detail (1) how my health care information is used and shared, (2) when I need to give further approval for the Providers to use and share my health information, (3) when my permission is not needed for the Providers to use and share my health information, (4) my rights regarding my health care information, and (5) grievance procedures if I believe my privacy rights have been violated.

I understand that I may request restrictions on the uses and disclosures of my health information. The Practice is not legally required to accept my request, but if it does, it will put any such restrictions in writing and abide by them except in emergency situations, or where required by law.

I understand that I have the right to receive a copy of the Notice and that I have the right to read the Notice before signing this Consent. I understand that **RHSI**. reserves the right to change the Notice at any time. I may obtain a current copy of the Notice by contacting RHSI at 317-249-2616.

I understand that I may revoke this consent, in writing, except to the extent that the Providers have already acted on it. I also understand that if I revoke this consent, the Providers have the right to refuse to provide further treatment to me.

My medical information can be disclosed to and used by the following individual.
(Please list all persons ie; family members/friend/emergency contact)

_____ _____
Name relationship

_____
Phone

_____ _____
Name relationship

_____
Phone

I consent to the uses and disclosure of my health information as described above.

Signature of Patient or Legal Guardian/Representative: _____

Print (guardian) Name: _____Relationship to patient_____

Patient Name _____ Patient Date of Birth _____Today's Date _____

PATIENT DEMOGRAPHICS (please print) **Reconstructive Hand to Shoulder of Indiana**

First name	**Middle**	**Last**	
DOB	**SSN**	**Gender** ☐ Male	☐ Female
Marital Status	☐ Married ☐ Single ☐ Divorced ☐ Legally separated ☐ Life Partner ☐ widow/widower		
Ethnicity	☐ NOT Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown ☐ decline to answer		
Preferred language	☐ English ☐ Spanish ☐ other ☐ unknown		
Race	☐African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other ☐ unknown ☐ decline answer		

Patient Address and Contact Information

Home address	**City**	**State**	**Zip**
Email address			
Primary telephone # ☐ Cell ☐ Home		**Secondary #** ☐ Cell ☐ Home	
Employer		**Telephone #**	
Employer's Address	**City**	**State**	**Zip**

Primary Insurance (*please give insurance card/s to receptionist)*

Policy holder's name and address (if other than above)			**Policy holder's DOB**
Patient's relationship to policy holder ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Life Partner ☐ other			
Carrier name		**effective date**	
Address	**City**	**State**	**Zip**
Policy/ID #	**Group#**	**co-pay amount**	

2ndry Insurance

Policy holder's name and address (if other than above)			**Policy holder's DOB**
Patient's relationship to policy holder ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Life Partner ☐ other			
Carrier name		**effective date**	
Address	**City**	**State**	**Zip**
Policy/ID #	**Group#**	**co-pay amount**	

Emergency Contact (not living at same address)

Name	**Relationship to patient**	**Telephone #**

How were you referred to our office?

☐ Friend/Family ☐ Advertisement ☐ Internet search ☐ I am a previous patient ☐ Family Doctor ☐ ER Doctor

RECONSTRUCTIVE HAND TO SHOULDER OF INDIANA

New Patient History and Physical Form

Michael Pannunzio, MD Alex Meyers, MD Dale Dellacqua, MD Lance Rettig, MD Sebastian Peers, MD

Please complete all areas to the best of your ability

PATIENT NAME:	DOB:	AGE:	HEIGHT:	WEIGHT:
PATIENT ADDRESS:	FAMILY PHYSICIAN:			
REFERRING PHYSICIAN:				
CHIEF COMPLAINT:	HOW THE INJURY OCCURRED OR CAUSE OF SYMPTOMS:			
DATE OF INJURY ONSET:	SIDE TO BE TREATED: (circle one) LEFT RIGHT		DOMINATE HAND: (circle one) LEFT RIGHT	
NAME OF FACILITY WHERE PREVIOUS TREATMENT WAS SOUGHT:				
DIAGNOSTIC TEST PERFORMED: (circle all that apply) X-RAY MRI CT EMG	DATE OF TEST:	LOCATION OF TEST:		
Is this condition related to employment (current or previous)? YES NO				

MEDICAL HISTORY (Please check all that apply)

- o Alzheimer's
- o Anemia
- o Anxiety / Depression
- o Arthritis
- o Asthma
- o Bleeding Ulcers
- o Broken Bones
- o Bronchitis
- o Cancer
- o Chest Pain
- o Coronary Artery Disease
- o Concussions
- o Dementia
- o Diabetes
- o Dialysis
- o Emphysema
- o Epilepsy
- o Headaches
- o Heart Attack (MI)
- o Heart Disease
- o High Blood Pressure
- o High Cholesterol
- o High Thyroid
- o HIV infection
- o Hepatitis
- o Kidney Disease
- o Liver Disease
- o Low Thyroid
- o Pacemaker/Defibrillator
- o Peptic Ulcer Disease/Ulcers
- o Stroke
- o Tuberculosis

Please list any other medical conditions not listed above:

List any previous surgeries (include dates):

Do you have any implants? YES NO
If yes, please list:

If female, when was your first menstrual cycle? _____ Have you ever had any problems with anesthesia? YES NO

CURRENT MEDICATIONS (Please list all prescription and non-prescription drugs, vitamins and supplements.)

DO YOU HAVE ANY DRUG ALLERGIES? YES NO
If yes, please list allergies below:

Do you use tobacco? YES NO
Packs per day?

Any family history of significant medical problems? YES NO
Explain:

MD / RN _____(Initials) DATE _____