

TODAY'S DATE:				
LAST NAME:	FIRST NAME & IN	FIRST NAME & INITIAL:		
	DATE OF BIRTH:			
MARITAL STATUS: MARRIED/	SINGLE/DIVORCED/WIDOWED	SEX: MALE / FEMALE		
ADDRESS:				
CITY:	STATE:	ZIP:		
		WORK:		
E-MAIL ADDRESS:				
EMPLOYER:	ADDRESS:			
	EMPLOYMENT STATUS: FULL TIME/PART TIME/RETIRED			
	WORK #:			
FTHNICITY: YES HISPANIC	NO, NOT HISPANIC			
IS THIS: WORK RELATED	□ RESULT OF A FALL AT □HO			
□ AUTO ACCIDENT				
PRIMARY INSURANCE POLICY	HOLDER NAME:			
		LATIONSHIP:		
SECONDARY INSURANCE POLICE	CY HOLDER NAME:			
DOB: SSN:	REL	ATIONSHIP:		
EMERGENCY CONTACT INFORI	MATION:			
NAME:		RELATIONSHIP:		
		NE:		
	ADVANCED DIRECTIVE? YES			
	REFERRING YOU:			
DDIMADY CADE DD	CAPDIOLOGIST			

AUTHORIZATION FOR TREATMENT - I hereby authorize the physician/nurse practitioner to conduct such examinations, perform such procedures as are medically required, and administer such treatment and medication as deemed necessary or advisable. I hereby certify that I have read and fully understand this Authorization form. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

RELEASE OF INFORMATION/MEDICAL RECORD DIAGNOSIS - I hereby authorize the physician(s)/nurse practitioner(s) providing services and any other authorized person to release to its authorized billing agents, any physician who treated me, my insurance carrier, employer's workmen's compensation insurance company, or other category of third party payor, the Social Security Administration under Title XVIII(18) of the Social Security Act, the Professional Review Organization, or other intermediaries responsible for payment of my charges, a complete report of services rendered. I understand that I may revoke this consent at any time by giving written notice. I understand that if I refuse to consent to the release of information, I will be held personally responsible for payment of all charges for services rendered. I give my consent to Munster Orthopaedic Institute, LLC and all clinical providers who have provided care to me, along with any billing service, collection agencies, attorney or other agents who may work on their behalf, to contact me on my cell phone and/or home phone using automatic telephone dialing systems or other computer assisted technology.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/FINANCIAL OBLIGATION - In consideration of medical services provided, I hereby assign and transfer to the physician all of my rights, title and interest to medical reimbursement, including but not limited to, the right to designate a beneficiary, add dependent eligibility and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by my physician/nurse practitioner, including Medicare Part B. I understand that I will be fully responsible for payment of any and all charges no covered by my medical insurance. I understand that if I do not pay the balance in full my account will be placed for collection and I will be responsible for all collection expenses including reasonable attorney's fees and court costs. It is our policy to charge a fee for any check that is returned due to Insufficient Funds.

CO-PAYMENTS - I understand that if my medical insurance required a co-pay or encounter fee the payment is **DUE AT THE TIME OF SERVICE.**

NO SHOW POLICY - Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences. Due to high patient demand, and limited availability of appointments we have instituted a \$25.00 no show fee for doctor appointments and \$25.00 no show fee for physical therapy appointments. By signing below, I acknowledge that I have read and understand this policy.

PRECERTIFICATION - If my insurance requires precertification it is my responsibility to make sure it is obtained. I will be held financially responsible if the precertification is not obtained.

H.H.S. Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of <u>NOTICE OF PRIVACY PRACTICES:</u>

Patient Signature	Date	Responsible Party Signature	Date
Witness Signature	Date	Relationship to Patient	
I give consent & authoriza information regarding my		or billing staff of my physician's o	ffice to release
Name		 Relationship	
Name		 Relationship	
I understand that I may revoke this	,	time by submitting in my request in writing	to this office.

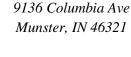
Office Location:

Community Outpatient-St. John 9660 Wicker Avenue St. John, IN 46373

> 9132 Columbia Avenue Munster, IN 46321

Office: (219) 836-2225

Billing and Remit Address:



Fax: (219) 836-3158

Jeffrey M. Tioco, M.D. Michael D. Dichoso, DPM Christina Graham, NP-C

Institute, LLC

PATIENT CONTRACT REGARDING NARCOTICS AND MEDICATIONS

- Your Physician at Munster Orthopaedic Institute, LLC does not prescribe narcotics as a general pain treatment. These must be prescribed by your primary care or pain management physician.
- Munster Orthopaedic Institute, LLC Physicians and Nurse Practitioners will prescribe post-operative pain
 medications in the form of narcotics, non-narcotic pain relievers, muscle relaxants, and non-steroidal medications
 for patients in the immediate pre and post-operative period for a predetermined period of time not to exceed more
 than 3 months after your surgery.
- Patients who are taking methadone, OxyContin, Fentanyl patches, MSContin, Kadian and other long acting narcotics need to have prior arrangements with their pain management or primary care physicians.
- Munster Orthopaedic Institute, LLC Physicians and Nurse Practitioners will not prescribe sedatives, sleep medicines, anxiety or general medications. These need to be filled by your primary care physician.
- Prescriptions will not be called in between 5:00 pm and 9:00 am nor on weekends. All postoperative medication refill requests must be submitted two business days prior to their expiration/run out for the staff to authorize refills.
- Refills will not be given for lost or stolen prescriptions for narcotics.
- Requests for medications made after noon on Friday will not be called in until Monday.
- When calling for a medication, leave the pharmacy name and phone number, as well as your phone number. If you have changed the medications you are taking, we need to know those changes.
- Any request for prescriptions needs a two business day response time.

PRINT NAME

- All pain medications must be sent electronically.
- Most importantly: DO NOT WAIT UNTIL THE LAST MINUTE TO REQUEST MEDICATIONS. It is your responsibility to keep up with your medications. DO NOT WAIT UNTIL YOU RUN OUT TO CALL FOR MEDICATIONS.

RECEIVED A SIGNED COPY OF THIS CONTRACT.			
I UNDERSTAND THE ABOVE STATEMENTS. I AGREE T	O ABIDE BY A	AND FOLLOW	THEM. I

A copy of this form was given to the patient. MOI Staff Initials	