Michael Frampton, M.D., P.C.,

American Board Certified in Psychiatry
9120 Connecticut, Suite A, Merrillville, IN 46410
Phone: 219-793-1233 Fax: 219-793-1244

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient's Name: _____ Birthdate _____
(Ex: 01/01/2000

Signature: _____

Relationship: _____

Today's Date: _____

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PRIMARY INSURANCE INFORMATION

LEGAL NAME: _____ SS#: _____

Street Address: _____ City: _____ State:____ Zip: _____

Mailing Address: _____ City: _____ State:____ Zip: _____

HOME PHONE #: _____ WORK PHONE #: _____

MOBILE PHONE #: _____ Call this number first: _____

DATE OF BIRTH: _____ AGE: _____ GENDER: MALE: ☐ FEMALE: ☐ NON-BINARY: ☐
(Ex: 01/01/2000
PREFER NOT TO SAY: ☐

Email Address: _____

MARITAL STATUS: (Check One) MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ OTHER ☐

EMPOLYER NAME: _____ PHONE #: _____

EMPOLYER ADDRESS: _____
Street/City/State/Zip

EMERGENCY CONTACT PERSON

NAME: _____ PHONE #: _____

RELATIONSHIP TO PATIENT: FATHER ☐ MOTHER ☐ SPOUSE ☐ OTHER ☐

REQUIRED: SPOUSE OR FINANCIAL PARTY INFORMATION

LEGAL NAME: _____ SS #: _____

RELATIONSHIP TO PATIENT: FATHER ☐ MOTHER ☐ SPOUSE ☐ OTHER ☐

Street Address: _____ City: _____ State:____ _____

Mailing Address: _____ City: _____ State:____ Zip: _____

HOME PHONE #: _____ DATE OF BIRTH #: _____

EMPOLYER NAME: _____ PHONE #: _____

EMPOLYER ADDRESS: _____
Street/City/State/Zip

_____ _____
SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN DATE

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PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____

PHONE NUMBER: _____ POLICY NUMBER: _____

INSURED/POLICYHOLDER:NAME: _____ SS#: _____

RELATIONSHIP TO PATIENT: FATHER ☐ MOTHER ☐ SPOUSE ☐ OTHER ☐

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ DATE OF BIRTH #: _____

EMPOLYER NAME: _____ PHONE #: _____

EMPOLYER ADDRESS: _____
Street/City/State/Zip

EMPLOYER PHONE: _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____

PHONE NUMBER: _____ POLICY NUMBER: _____

INSURED/POLICYHOLDER:NAME: _____ SS#: _____

RELATIONSHIP TO PATIENT: FATHER ☐ MOTHER ☐ SPOUSE ☐ OTHER ☐

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ DATE OF BIRTH #: _____

EMPOLYER NAME: _____ PHONE #: _____

EMPOLYER ADDRESS: _____
Street/City/State/Zip

EMPLOYER PHONE: _____

_____ _____

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN DATE

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TREATING PRIMARY CARE PHYSICIAN

NAME: _____ PHONE: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

REFERRING THERAPIST OR PHYSICIAN

NAME: _____ PHONE: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

RECORD OF PREVIOUS TREATMENT

Physician, Hospital or Facility	Address	City & State	Phone	Dates

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CONSENT FOR TREATMENT

I, the undersigned, _____ Re: Patient: _____
(Please print your name) (Please print your patient name)

request treatment as a patient of Michael Frampton M.D., P.C. and/or other providers and voluntarily consent to such care and routine diagnostic procedures and medical treatment by the physician and his assistants or designee as is necessary in the physician's judgement.

I am aware that the practice of psychiatry is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment or examination in the clinic.

I understand that if the patient appears to be dangerous to himself/herself or others the staff will exercise the necessary interventions in order to protect the patient or others.

_____ _____
Patient Signature Date

_____ _____
Patient Signature Date

_____ _____
Responsible Person's Signature Date

_____
Relationship

_____ _____
Witness Signature Date

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STATEMENT OF FINANCIAL RESPONSIBILITY

AUTHORIZATION TO RELEASE INFORMATION TO THIRD PARTY PAYERS
I have provided Michael Frampton M.D., P.C. and/or other providers with the information regarding eligibility and benefits. I understand that this authorization will be used by Michael Frampton M.D., P.C. and named insurance company to determine the eligibility and benefits under the existing policy. Any information obtained will not be released by the insurance company without authorization. This authorization shall be valid during the pending of the claim unless specifically revoked in writing.

ASSIGNMENT OF INSURANCE BENEFITS
I hereby authorize payment of benefits others payable to me to be paid to Michael Frampton M.D., P.C. I authorize insurance companies providing coverage for services to make payment directly to Michael Frampton M.D., P.C. The insurance will be verified but is not guaranteed.

GUARANTEE OF PAYMENT
I guarantee payment of the bill for services provided. I understand that I am financially responsible to Michael Frampton M.D., P.C. for charges not covered or paid by the insurance company. I agree to pay my out of pocket money at the time of my visits. If my insurance needs to be pre-certified I will be responsible for pre-certifying my insurance. I understand that if I do not pre-certify I will be responsible for the bill.

CHANGE OF INSURANCE
If your insurance policy changes, please notify our office immediately. We mush have enough advance notice in order to verify your benefits prior to your next scheduled visit. If we are unable to verify your benefits or you fail to give us reasonable time to call on your benefits, you will be responsible for the entire charge of the visit(s).

NO-SHOW FEE
Failure to cancel at least 24 hours before your scheduled appointment will result in a no-show fee. This fee will not be billed to your insurance company and must be paid before your next appointment with Michael Frampton M.D., P.C. and all other providers associated with Michael Frampton M.D., P.C.

Time spent with Dr. Frampton and/or other providers outside of scheduled session answering patient phone calls, writing prescription renewals or letters, completing forms, etc, will be billed directly to the patient and not to the insurance company.

Patient Signature _____ Date _____

Responsible Person's Signature _____ Date _____

Witness Signature _____ Date _____

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New Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I, the undersigned, _____ Re: Patient: _____
(Please print your name) (Please print your patient name)

understand that as part of my healthcare, Michael Frampton M.D., P.C., originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basics for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that the services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Privacy Practices* effective 4/1/03 that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand that Michael Frampton M.D., P.C. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the code of Federal Regulations.

I further understand that Michael Frampton M.D., P.C.reserves the right to change their notice and practices and will document changes prior to implementation, in accordance with Sections 164,520 of the Code of Federal Regulations. Should Michael Frampton M.D., P.C. change their notice, they will send a copy of any revised notice to the address I have provided (whether U.S. mail or, if I agree, email).

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I wish to have the following restrictions to the use of my health information:

_____

_____

_____

I hereby consent to verbal communication to the following spouse, or other relative(s) or person(s) regarding billing, appointments, prescriptions, lab results and treatment plans:

_____

_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may be necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____ _____

Patient Signature Date

_____ _____

Responsible Person's Signature Date

_____

Relationship. to Patient

FOR OFFIC USE ONLY

[ ] Consent received by _____

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____