Indiana Surgical Associates P.C.

PATIENT CONSENT, ACKNOWLEDGMENT, AND AUTHORIZATION FORM

RELEASE OF MEDICAL RECORD:
In order to ensure proper follow-up and continuity of care, I hereby authorize all physicians, hospitals and other medical facilities to release to Indiana Surgical Associates, my medical history, laboratory reports, x-rays, films, and any other material regarding medical consultations I received.

INSURANCE AUTHORIZATION/ASSIGNMENT RELEASE:
I request that payment of authorized medical benefits be made to Indiana Surgical Associates for any services provided to me. This assignment of benefits includes Medicare, state medical assisted agency programs, commercial insurance, managed care plans, and any third party payer benefits that I may have. I authorize the use of this signature on all my insurance claim submissions.

I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information required to determine these benefits for related services.

I authorize a copy of this authorization to be used in place of the original.

FINANCIAL RESPONSIBILITY:
I am responsible for all the financial obligations of health services, and for the reimbursement and payment of claims from my insurance company. I understand that I am responsible for any amount not covered by insurance. I also understand that if a payment becomes more than 90 days past due, I will be responsible for the balance due on my account as well as any and all reasonable attorney fees and costs of collections in the event of default.

ELECTRONIC HEALTH RECORD ACCESS/COMMUNICATION INFORMED CONSENT:
I hereby request access to Indiana Surgical Associate's (ISA) Patient Portal and understand that in order to gain access to ISA Patient Portal I will be given a confidential password. I agree to keep it confidential and not share it with anyone else. I understand that my use of ISA Patient Portal is subject to certain terms and conditions. I agree to review ISA Patient Portal terms and conditions before accessing ISA Patient Portal and further agree that by accessing ISA Patient Portal I am agreeing to abide by the ISA Patient Portal terms and conditions.

I agree to abide by the guidelines for the ISA Patient Portal electronic communication, as outlined below. ISA Patient Portal is not intended for critical or time sensitive communication. I understand that I am to contact the hospital, office, or physician directly for any urgent or emergent situations. My failure to adhere to the following guidelines may result in termination of the ISA Patient Portal access. When using ISA Patient Portal I agree to never use ISA Patient Portal to communicate information related to behavioral/mental health, chemical dependence, such as alcohol and substance abuse or workers' compensation injuries or disabilities.

I understand that the hospital, office, or provider or a designated staff member will maintain certain activities with ISA Patient Portal as part of the practice medical record, use reasonable and appropriate security practices to protect electronic patient information and prevent unauthorized access (password protection, encryption, proxy authorizations, etc.) and share ISA Patient Portal communications with hospital or office staff and other healthcare providers as needed.

I understand that e-mail is not a confidential means of communication. I agree to waive any rights that I may have against Indiana Surgical Associates, P.C., any affiliated organization, or physician, or the supplier or operator of ISA Patient Portal, for any loss of information due to technical failures and/or unintended breach of confidentiality, due to unauthorized access to my information, as a result of my decision to communicate with my physician in this manner.

RECEIPT OF NOTICE OF PRIVACY PRACTICES:
I have received the Notice of Privacy Practices from Indiana Surgical Associates, P.C.

_____ _____
Patient Name (Print) Patient Date of Birth

_____ _____
Patient/Guardian Signature Today's Date