

Sandra Aspy, M.D.

**Patient Information Sheet**

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ SSN: \_\_\_\_\_

Sex: Male Female Marital Status: Single Married Divorced Widowed Separated Other  
Employment Status: Full-time Part-time Self-employed Retired Student Unemployed

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact (other than spouse): \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Primary Policy Holder's Name: \_\_\_\_\_

SSN#: \_\_\_\_\_ DOB: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Secondary Policy Holder's Name: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RESPONSIBILITY**

Payments, co-payments, and insurance deductibles are due at the time of service, unless other arrangement have been made in advance. For those patients that we file insurance for please be advised that the insurance contract is between you and your company, not the insurance company and the doctor. The doctor agrees to see and treat you and to file an insurance claim for you. If you're insurance company doesn't pay in a timely manner (60 days) you will be held responsible for the money due to the doctor for services rendered. We will work with you should this happen. After three notices of payment due (90 days) and your account are still not paid, we will be forced to turn your account over to our collection agency for collection. Should this happen, please be advised that you will also be held responsible for the full amount due plus any interest charged by the collection company.

I authorize the release of any medical information necessary to process my insurance and also my insurance to directly pay the provider of service: (Initials): \_\_\_\_\_

I authorize Dr. Sandra Aspy's office to leave phone messages on my answering machine. Yes or NO

I acknowledge that I have received the Community Hospitals of Indiana, Inc. and The Indiana Heart Hospital Notice of Privacy Practices: (Initials): \_\_\_\_\_

I authorize Dr. Sandra Aspy's office to share my Private Health Information to these family members only:

I have read and understand the above statements: (Initials): \_\_\_\_\_

Patient/Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**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 as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

**Patient Initials:** \_\_\_\_\_

**Medicare Certification:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act are correct. I authorize my physician who treats me, to release information from my medical records to the Social Security Administration and/ or Medicare program or its intermediaries or carriers, or to the Professional Standards Review Organization for processing of claims for medical benefits. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

**Patient Initials:** \_\_\_\_\_