Harmony Medical Associates
Envision, Empower, Excel

11956 Fishers Crossing Drive, Fishers, IN 46038
Phone: 317.842.5555
http://www.harmonymed.com

Patient Demographics

First Name | Last Name | Gender

Home Address | City/Town | State | Zip

Home Phone | Cell Phone | Work Phone | Email Address

Date of Birth | Social Security Number | Marital Status | Spouses' Name

Emergency Contact | Emergency Contact Phone Number | Relationship

Reason For Visit | Referring Physician | Primary Care Physician

Pharmacy Name | Pharmacy Address

Primary Insurance Carrier | Policy Number | Effective Date

Secondary Insurance Carrier *(if applicable)* | Policy Number | Effective Date

Patient Medical History

List any **Medical Conditions** you have been treated for.

List any **Surgeries or Procedures** you have had.

Procedure | Date | Procedure | Date

List any **Medications and Supplements** you are ***currently taking***. Please include **dosage** and **frequency**.

Do you have any known **food** or **drug** allergies? ○ No ○ Yes
If yes, please list:

Family Medical History

List any **Medical Conditions** present in your family. Include parents, siblings, maternal and paternal grandparents.

Medical Condition	Family Member	Medical Condition	Family Member

Social History

Tobacco Use: ○ Current ○ Former ○ Never

*If **Current** or **Former**:* Number per day: Number of years:

Alcohol Use: ○ Current ○ Former ○ Never

*If **Current**:* Have you ever felt you should cut down on your drinking? ○ Yes ○ No

Have people annoyed you by criticizing your drinking? ○ Yes ○ No

Taken a drink first thing in the morning to steady nerves or get rid of a hangover? ○ Yes ○ No

Have you ever felt bad or guilty about your drinking? ○ Yes ○ No

Recreational Drug Use: ○ Current ○ Former ○ Never

How many days per week do you exercise? Duration: *hours*

How many caffeinated drinks do you consume on a daily basis?

Sexually Active? ○ No ○ Yes

Social History *continued*

Employment Status: ○ Full Time ○ Part Time ○ Retired ○ Student ○ Unemployed

*If **Employed**:* Activity Level: ○ Desk/Office ○ Occasional physical work ○ Moderate physical work

Employer's Name:

Patient Health Questionnaire

How often have you been bothered by the below symptoms during the last two week?

Feeling down, depressed, hopeless	○ Not at all	○ Several days	○ More than half the days	○ Never
Little interest or pleasure in activities	○ Not at all	○ Several days	○ More than half the days	○ Never
Trouble falling asleep or staying asleep	○ Not at all	○ Several days	○ More than half the days	○ Never
Feeling tired or little energy	○ Not at all	○ Several days	○ More than half the days	○ Never
Poor appetite or overeating	○ Not at all	○ Several days	○ More than half the days	○ Never
Feeling bad about yourself	○ Not at all	○ Several days	○ More than half the days	○ Never
Trouble concentrating	○ Not at all	○ Several days	○ More than half the days	○ Never
Moving or speaking slowly	○ Not at all	○ Several days	○ More than half the days	○ Never
Thoughts better off dead or hurting self	○ Not at all	○ Several days	○ More than half the days	○ Never

SIGNATURE DATE

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PATIENT RELEASE

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agents, for purpose of filing and payment of medical claims.

I understand that if I am using insurance for treatment, I directly assign my insurance benefits to my provider.
I hereby authorize the use of this signature on all insurance submissions on my behalf. I understand in the event that payment is not submitted directly to HMA, it is my responsibility to submit any payment I receive for services rendered by HMA, directly to this office.

EXTERNAL RX HISTORY CONSENT:
I authorize HMA to view my external prescription history via the electronic health record systems, I understand that prescription history from multiple other medical providers, insurance companies, and pharmacies may be viewable by my providers and authorized staff here, and it may include prescriptions from previous years.

CONSENT TO TREAT:
I give consent to my physician to provide the medical care, perform tests, prescription of medications and other services that are considered necessary or beneficial for me or my child's health and wellbeing.
I acknowledge that no representations, warranties or guarantees related to results or cures have been made to me or relied upon by me.

Your signature below indicates that you have read this agreement and agree to abide by its terms. You have the right to revoke this agreement in writing at any time.

_____ _____
SIGNATURE DATE

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FINANCIAL POLICY

Thank you for choosing HMA as your mental health care provider. We are committed to building a successful physician-patient relationship with you and your family. Please understand that payment for service is a part of that relationship. The following is a statement of our Financial Policy, which we require you to read and sign prior to your treatment.

PATIENT INFORMATION:
A fully completed, current patient registration will be on file in the patient chart during the time in which the patient is considered an active patient. Patient registration will be updated by the patient yearly and will include where the patient can be reached by phone. A signature by the responsible party is required.

INSURANCE CLAIMS:
Primary Insurance: We will file claims with the patient's insurance upon the patient's submission of proof of insurance (i.e., insurance card indicating coverage, identification number and group number). In the event the patient has insurance coverage but cannot provide documentation, payment is due at the time of service. Upon receipt of the insurance card, we will submit the health insurance claim form indicating patient payment at the time of service.

Secondary Insurance: Claims will be filed with secondary insurance if adequate information is received at the time of service. However, if payment is not received in our office within 45 days after filing, the responsibility will be transferred to the patient and due upon receipt.

PATIENT FINANCIAL RESPONSIBILITY:
If no insurance is to be filed by us, or if we are not a participating provider in your insurance plan, **full payment is expected.** Co-payments, deductibles, co-insurance and payment for non-covered services are due at the time of service. We accept cash, checks and credit cards.

PAST DUE ACCOUNTS:
Any outstanding balance, after insurance has paid, will be invoiced to you on a statement. Payment is due upon receipt of the statement. Prolonged delinquency in payment will result in preparation of account to be sent to a collection agency. This may result in a discharge from the practice.

METHOD OF PAYMENT:
Acceptable methods of payment are cash, check, VISA, MasterCard and Discover. Credit cards payments can also be accepted by phone or fax. There will be a $25.00 fee for returned checks.

CANCELLATION/NO SHOW/RESCHEDULE POLICY:
It is essential you are on-time for your appointment and call at least 24 hours in advance when you are unable to keep your scheduled appointment. Failure to show up for your appointment or cancel without 24 hours notice will result in a $50.00 charge.

MINORS/DEPENDENTS:
Children under the age of 18 will require the signature of a responsible party on the registration form.

ACKNOWLEDGEMENT OF RECEIPT:
I have reviewed the financial policy, and I accept financial responsibility of collection.

_____ _____

SIGNATURE DATE