CHHABRA MEDICAL CORPORATION PC

Portage Health Center
6375 U S Hwy 6
Portage. IN 46368
219.762.3196 / 219.763.6438 Fax

Hobart Health Center
7835 Grand Blvd
Hobart, IN 46342
219.769.2258 / 219.769.2743 Fax

B. Chhabra, MD Family Practice
M. Geeta, MD Family Practice

S. Meeks, NP Family Nurse Practitioner
K. Kozub, NP Family Nurse Practitioner
S. Wojcik, NP Family Nurse Practitioner

ACCT: _____

PATIENT INFORMATION ***PLEASE PRINT***

LAST NAME_____ FIRST_____ MI_____

DOB: _____ SEX_____

ADDRESS: _____CITY_____STATE_____ZIP_____

EMPLOYED YES___NO___ EMPLOYER/SCHOOL _____ HOME PHONE: (__)_____ CELL PHONE: (__)_____ WORK PHONE: (__)_____

RACE_____ SOCIAL SECURITY#_____-_____-_____ MARITAL STATUS (M) (S) (W) (D) (O)

LANGUAGE SPOKEN_____EMAIL_____SMOKE Y/N

PARENT/INSURANCE POLICY HOLDER INFORMATION

LAST NAME FIRST MI SEX

_____

ADDRESS_____CITY_____STATE_____ZIP_____

DATE OF BIRTH ___/___/___ SOCIAL SECURITY# ___-___-___ EMPLOYED YES__NO___ EMPLOYER _____ HOME/CELL PHONE # _____

RESPONSIBLE PARTY STATEMENT

AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.

RESPONSIBILITY PARTY SIGNATURE **TODAY'S DATE**

X_____ _____/_____/_____

FOR EMERGENCIES-PLEASE NAME NEAREST RELATIVE NOT LIVING WITH YOU

LAST NAME_____FIRST NAME_____MI_____

ADDRESS_____CITY_____STATE_____ZIP CODE_____

HOME ( ) _____WORK PHONE ( ) _____
RELATIONSHIP_____

REFERRED BY – CHECK HERE IF REFERRED BY DOCTOR ( )

LAST NAME_____FIRST_____ADDRESS_____TELEPHONE_____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE NAMED INDIVIDUAL FOR PROFESSIONAL SERVICES RENDERED. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE TO CHHABRA MEDICAL CORP ON MY BEHALF FOR ANY SERVICES FURNISHED ME BY THEIR PHYSICIANS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENT ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I REQUEST THAT PAYMENT OF MEDIGAP BENEFITS BE MADE ON MY BEHALF TO CHHABRA MEDICAL CORP FOR ANY SERVICES FURNISHED ME BY THEIR PHYSICIANS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO _____ (MEDIGAP INSURANCE) ANY MEDICAL INFORMATION NEEDED TO DETERMINE THESE BENEIFTS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNED: _____ DATE: _____

AUTHORIZATION AND ACKNOWLEDGEMENT

I RECOGNIZE AND ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL SERVICES RENDERED AND FUTHER AUTHORIZE THE INSURANCE COMPANY TO PAY BENEFITS DIRECTLY TO THE PHYSICIAN. ALL COSTS OF COLLECTION INCURRED FOR OVERDUE ACCOUNTS ARE AGREED TO BE PAID BY RESPONSIBLE PARTY; INCLUDING, BUT NOT LIMITED TO COURT COSTS, REASONABLE ATTORNEY FEES, AND ALL OTHER LITIGATION EXPENSES.

SIGNED: _____ DATE: _____

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Family Nurse Practitioner

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Family Nurse Practitioner

S. Wojcik, NP
Family Nurse Practitioner

PEDIATRIC HISTORY QUESTIONNAIRE (5-13 Years)

Name: _____ Date: _____

Age: _____ Sex: _____ DOB: _____

Menstruation		
Age Started: _____ Last Menstrual: _____		
Irregular Menstrual Cycle	Yes	No
Surgical History		
Tonsillectomy and/or Adenoidectomy	Yes	No
Ear Tubes	Yes	No
Appendectomy	Yes	No
Other (please specify)	Yes	No
Habit		
Exposure to Second-Hand Smoke	Yes	No
Refusing to Eat	Yes	No
Use of Alcohol	Yes	No
Use of Drugs	Yes	No
Use of Tobacco Products (cigarettes, vapes, chew, etc)	Yes	No
Medical History		
Problem with Eyes or Vision	Yes	No
Frequent Ear Infections	Yes	No
Chickenpox	Yes	No
Hospitalization (explain, when/where:_____)	Yes	No
Diabetes Mellitus	Yes	No
Convulsions or other Neurological Problems	Yes	No
Chronic or Recurring Skin Problem (acne, eczema, etc)	Yes	No
Bladder or Kidney Infection, Serious Injury, or Accident	Yes	No
Serious Injury or Accident (if yes, explain: _____)	Yes	No
Frequent Abdominal Pain	Yes	No
Anemia or Bleeding Problem	Yes	No
Thyroid or Other Endocrine Problems	Yes	No

Name: _____ Date: _____

Heart Problem or Heart Murmur	Yes	No
Pneumonia	Yes	No
Bronchitis	Yes	No
Nasal Allergies	Yes	No
Constipation	Yes	No
Problems with Ears or Hearing	Yes	No
Bed-Wetting	Yes	No
Frequent Headaches	Yes	No
Social History		
Oppositional Behavior	Yes	No
Sibling Interaction	Yes	No
Cooperation at Home	Yes	No
Parent/Teacher Concern	Yes	No
School Performance	Yes	No
Parent Smoker	Yes	No
Concern or Problem with Physical Development	Yes	No
Concern or Problem with Mental or Emotional Development	Yes	No
Family History		
Bronchial Asthma	Yes	No
High Cholesterol	Yes	No
Epilepsy or Convulsions	Yes	No
Liver Disease	Yes	No
Deafness	Yes	No
Bleeding Disorder	Yes	No
Anemia	Yes	No
Immune Problem	Yes	No
Mental Illness	Yes	No
HIV or Aids	Yes	No
Drug Abuse	Yes	No
Alcohol Abuse	Yes	No
Diabetes Mellitus	Yes	No
Kidney Disease	Yes	No
High Blood Pressure	Yes	No
Heart Disease	Yes	No
Other:		

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MEDICATIONS

NAME: _____ DOB: _____

Pharmacy:_____ Pharmacy Phone Number: _____

Address: _____

ALT Pharmacy: _____

PRESCRIPTIONS:		
Name:	Dosage:	Frequency:
NON-PRESCRIPTIONS:		
Name:	Dosage:	Frequency:
ALLERGIES:		
Medications:		
Other:		

Medications List updated 08/01/2021

CHHABRA MEDICAL CORPORATION

Acknowledgment of Receipt and/or Review of Privacy Policies

In effort to communicate with you more effectively and keep your Protected Health Information confidential, we are asking you to complete this form. This form lets you decide how we can release your information to-and for what reason. If you have any questions about this form, please ask.

I have received a paper copy of/have reviewed the office copy of Chhabra Medical Corporation's Notice of Privacy Policies.

_____(Initial)

Chhabra Medical Corporation staff may discuss or leave information about my Protected Health Information and/or financial matters to the following people:

Name_____Relation_____Phone_____

Name_____Relation_____Phone_____

Name_____Relation_____Phone_____

In addition to the above, how may we contact you regarding health issues or concerns which may be confidential? **PLEASE ANSWER EVERY QUESTION BELOW!**

Via Mail (sealed privacy mail only)	YES ( )	NO ( )
Home Phone_____	YES ( )	NO ( )
Cell Phone_____	YES ( )	NO ( )
Can we leave a message on your answering machine	YES ( )	NO ( )
Work Phone_____	YES ( )	NO ( )
Can we leave a voicemail at work	YES ( )	NO ( )

Other_____

_____

Patient /Responsible Party (PRINTED) Date **D.O.B.**

_____

Patient/Responsible Party (SIGNED) Date Relationship to Patient

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PATIENT OFFICE POLICIES

We welcome you to our medical offices. For your convenience we have two facilities to meet your healthcare needs. Some of our office policies are stated below for your information. Please read and sign at the bottom of the second page.

Office Hours:

Portage Health Center
Monday- 8 a.m. to 5 p.m.
Tuesday- 8 a.m. to 5 p.m.
Wednesday-8 a.m. to 5 p.m.
Thursday- 8 a.m. to 5 p.m.
Friday- 8 a.m. to 1 p.m.

Saturday- 8 a.m. to 12 p.m.
(Every 1st Saturday of the month)

Hobart Health Center
Monday- 8:30 a.m. To 4:30 p.m.
Tuesday- 9 a.m. to 5 p.m.
Wednesday- 8 a.m. to 4 p.m.
Thursday- 9 a.m. to 5 p.m.
Friday- 8:00 a.m. to 1 p.m.

The time of these hours are subject to change without notice. Please call the office to confirm appointments and location.

APPOINTMENTS: Appointments are scheduled in advance. In an emergency situation, we will be able to see you in either of our two offices or you may go to the emergency room at the nearest hospital. If it becomes necessary to cancel an appointment, please give our office a 24-48 hour notice so we may offer your appointment to another patient. If a 24-hour notice is not given there will be a failed appointment service charge added to the account. **1st occurrence $50.00, 2nd occurrence $75.00, and 3rd occurrence $100.00.** This charge shall be the responsibility of the patient and is not insurance billable.

TELEPHONE: In order to reduce interruptions to patients being examined, our receptionist and or nursing staff will handle the phone calls. Messages taken between, 8 a.m. and 1:00 p.m. shall be most likely handled within 12-24 hours. Most messages taken after 1 p.m. will be handled by the end of the next business day. The doctors or their associates will return your calls as soon as possible. This, on occasions, may take up to 48-72 hours. When the offices are closed, our answering service will take **urgent messages only** and transmit them to the doctor on call. All refill requests shall be accommodated only during business hours.

IN OFFICE TESTING: We are equipped to do some basic blood and urine tests in our office. An outside laboratory does more complicated testing. As a convenience to you, frequently will draw the blood for these tests in our office. When this is done, there is a nominal charge for drawing the blood and preparing the specimen. Any other tests done will be billed according to the test performed. Testing results shall be discussed at the time of your next follow-up visit.

X_____
Signature of Responsible Party/Guarantor/Patient

X_____
Print Name
D.O.B._____

HEALTH INSURANCE: Health insurance is designed to help the patient meet the cost of medical service, but the basic responsibility for payment is the patient's. Your insurance contract defines to what extent the company can reimburse you. We are prepared to help you recover the portion of your medical expenses that are covered by your contract by filling out the form from the patient before submitting the form to us for completion. There shall be a nominal charge for completion of disability forms, insurance forms and workman's compensation forms. It is your responsibility to familiarize yourself with your insurance policy. Your insurance dictates if you need referrals for diagnostic testing and specialty visits. If referrals are needed, please inform our offices before your diagnostic testing and/or for specialist visits. This could take up to 4-5 business days.

CREDIT AND GUARANTEE AGREEMENT: We hope you understand that our credit and collection policies are a necessary part of assuring the financial resources needed to maintain the medical offices for our patients and the community. By signing below you signify your understanding and agreement to be responsible for any and all reasonable charges incurred for medical services provided to the patient. **Charges for medical services at our offices are due and payable at the time services are rendered.** All co-pays, deductibles, and co-insurance as dictated by your health policy, are payable at the time of service. For your convenience, we accept cash, check, or credit card. All Co-Pays not paid at time of office visit shall entail a $20 administrative and collection charge.

If unusual circumstances should make it impossible to meet our credit terms, please call or personally discuss the matter with our billing manager. This will avoid misunderstandings and enable you to keep your account in good standing. Accounts 60 days past due are referred to our attorney, unless prior arrangements have been made with my office. If we must retain an attorney in order to collect and overdue amount owed by you, you will be responsible for not only the original debt, but also for all costs of collection incurred by this office, including court costs, attorney fees incurred, and any and all other costs reasonable and necessarily incurred in litigating the matter.

If you have health insurance, please understand that this is an agreement between you and your insurance company to pay your certain amounts for medical care. Our bill for medical services is an agreement between you and us. You are responsible for the payment of your bill regardless of the status of your insurance claim.
If you should have any questions regarding any of the above, please feel free to discuss it with my staff.

Sincerely,
CHHABRA MEDICAL CORPORATION, P.C.

This agreement also serves as a formal consent to treatment for myself and/or my dependents.

X_____
Signature of Responsible Party Guarantor/Patient

X_____
Witness Signature

X_____
Print Name

X _____
Witness Name

X_____
Date

X_____
Date

_____
D.O.B.

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, D.O.B_____HAVE BEEN OFFERED TO READ/VIEW A COPY OF CHHABRA MEDICAL CORPORATION'S PC NOTICE OF PRIVACY PRACTICES.

_____ _____
SIGNATURE OF PATIENT **DATE**

_____ _____
WITNESS NAME/SIGNATURE **DATE**