UNITED STEELWORKERS
USW
UNITY AND STRENGTH FOR WORKERS

Mail Forms to:
Steelworkers Health and Welfare Fund
60 Blvd of the Allies, Suite 700
Pittsburgh, PA 15222
Fax to: 412-562-2276
Email to: arcelormittalhai@gmail.com

ArcelorMittal

VERIFICATION FORM FOR THE 2017 USW-ARCELORMITTAL HEALTH AWARENESS INITIATIVE

USE THIS FORM IF **HIGHMARK** ADMINISTERS YOUR MEDICAL INSURANCE IN 2017.

Form to be filled out by your healthcare provider to verify that you or your spouse, if applicable, completed the Wellness Examination from 10/1/16 – 9/30/17. Separate forms are required for you and your spouse, if applicable.

Section 1: Completed by Employee/Non-Medicare Retiree or Surviving Spouse

Check One: ☐ Active Employee ☐ Non-Medicare Retiree or Surviving Sposue

Employee/: _____
Retiree Last Name First Name M.I. Date of Birth (mm/dd/yyyy)

Email: _____ **Phone #** (___) _____

Insurance Card ID# (Numeric Portion Only) ☐☐☐☐☐☐☐☐☐☐☐

Address: _____
Street City State Zip

Verification is for: ☐ Employee/Retiree or Surviving Spouse ☐ Spouse covered under my ArcelorMittal Healthcare Plan

If Verification Form is for your Spouse, complete:

Spouse: _____
Last Name First Name M.I. Date of Birth (mm/dd/yyyy)

_____ _____
Employee/Retiree Signature **Date**

_____ _____
Spouse Signature (only if spouse verification) **Date**

Section 2: Completed by Healthcare Provider

Date of Service_____

The above named patient was seen in my office on the date of service listed. I completed the examinations check marked below. (**Do not provide examination results.**)

Check the box if completed on Date of Service

Height ☐

Weight ☐

Blood Pressure ☐

Discussion of appropriate recommended exams, screenings and procedures ☐
Provider is not liable if patient does not follow recommendations.

Healthcare Provider Name _____ **Phone #**_____

Healthcare Provider Signature_____

Date Signed_____ *If you have an office stamp, please apply here:*

USE THIS FORM IF **HIGHMARK** ✓ADMINISTERS YOUR MEDICAL INSURANCE IN 2017.

PATIENT INFORMATION **(Please Print)**

INDIANA SURGICAL ASSOCIATES

Patient Registration Form

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) ___ Previous Name _____

Address _____ City, State _____ Zip _____

Home Phone _____ Cell # _____ Work Phone _____ Ext. _____

Family Doctor _____ Referring Doctor _____

Doctor you are seeing at this practice _____ Email Address: _____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M – Male ☐ Transgender

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name _____

Employment Status ☐ 1- Full time ☐ 2- Part time ☐ 3- Not Employed ☐ 4- Self Employed ☐ 5- Retired ☐ 6- Active Military

Student Status ☐ F – Full Time Student ☐ P – Part Time Student ☐ N- Not a Student

Emergency Contact: Last Name _____ First Name _____

Phone Number _____ Emergency Contact relationship to Patient _____

Address _____ City, State _____ Zip _____

Alternate Phone # _____ Do you have a living will? ☐ Yes ☐ No

RESPONSIBLE PARTY INFORMATION ***(information used for patient balance statements)***

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self Check here if information is same as patient ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM _____ /DD_____ /YYYY _____

Social Security Number _____-_____-_____ Telephone _____ Sex ☐ F- Female ☐ M- Male

E-mail Address _____

Address _____ City, State _____ Zip _____

Employer _____ Employer Phone # _____

PRIMARY INSURANCE INFORMATION ***(provide your insurance card to the front desk at check-in)***

Insurance Company/Phone Number _____ (_____)_____

Name of Insured _____ Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount $_____

Effective Date _____ Date of Birth MM_____/DD_____/YYYY_____

SECONDARY INSURANCE INFORMATION ***(provide your insurance card to the front desk at check-in)***

Insurance Company/Phone Number _____ (_____)_____

Name of Insured _____ Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount $_____

Effective Date _____ Date of Birth MM_____/DD_____/YYYY_____

***** I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.**

***** Patient (or Responsible Party) Signature** _____ **Date** _____

Indiana Surgical Associates, P.C.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS FORM
FINANCIAL RESPONSIBILITY

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.

_____ _____

Patient or Guardian Signature Date

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.

_____ _____

Signature of Insured/Beneficiary Date

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.

_____ _____

Signature of Patient/Guardian Date

Indiana Surgical Associates P.C.
Instructions for Communication Preferences

I authorize Indiana Surgical Associates P.C. doctors or staff to **leave messages** and/or **communicate with certain individuals** regarding my health information:

☐ YES May leave messages on my answering machine or voicemail:
☐ at HOME ☐ at WORK ☐ on my MOBILE/CELL Phone

May share my health information with the following individuals:
☐ My Spouse or Significant Other_____
☐ My Son or Daughter_____
☐ Relative_____Relation:_____
☐ Other_____Relation:_____

These messages or communications may include information such as test results, prescription refills, appointments, instructions regarding treatments or medications, and billing information.

☐ NO Please do not leave messages on my answering machine or voicemail and I prefer that my doctor or staff speak to only myself personally regarding any medical information.

I understand that I must notify Indiana Surgical Associates P.C. any time there are changes to this request, which would require a new form to be completed.

Patient Name (*Please Print*):_____

Date of Birth:_____

Signature:_____ Date:_____

Under the privacy protection act, we are not calling and releasing any of your health information to the individuals listed; this form allows us to speak to who you specifically indicate has your permission to contact us concerning you and your private health information. If someone contacts us, and they are not listed above, we will not be able to speak to them about you.

Acknowledgement of Receipt of Notice of Privacy Practices

Print:

I,_____, have received the Notice of Privacy Practices from Indiana Surgical Associates, P.C.

Sign:

X_____ Date _____

FOR OFFICE USE ONLY

In lieu of patient signature, I, _____, a staff member of Indiana Surgical Associates, P.C., state that _____ has been given our current Notice of Privacy Practices.

X_____ Date _____

Indiana Surgical Associates, P.C. Patient Portal

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.

For minors ages 12 to 18 this acknowledgment and approval expires on my eighteenth birthday or my written notice to ISA that I have obtained the right to consent on my own behalf.

Patient Acct#:_____

Patient Name:_____

Date of Birth:_____

Last 4 digits of Social Security Number:_____

Patient Signature:_____ Date:_____

*If Minor, Parent/Guardian Signature:*_____

INDIANA SURGICAL ASSOCIATES, PC

Tom N. Galouzis, MD, FACS Brendan P. Frawley Jr., MD, FACS Mark A. Mueller, MD, FACS Eric Woo, DO
Jonathan G. Patterson, DO James V. Siatras, DO Thomas W. Shin, MD, FACS Sha-Ron Jackson-Johnson, MD

EFFECTIVE DATE: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CARFULLY.

I. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Your health record is the physical property of Indiana Surgical Associates, P.C. The information contained in the record, however, belongs to you. You have the right to:

A. Request a restriction or limitation on the medical information we use or disclose about you for your treatment, payment or health care operations. For example, you may request that a particular procedure be kept confidential and not shared with other providers. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend or when we notify a family member, personal representative or other person responsible for your care to inform them of your location and general condition. We are not required to agree to your requested restrictions. If we disagree, we will comply with your request unless the information is needed to provide you emergency treatment.

B. Obtain a copy of this Notice by requesting one from the Indiana Surgical Associates, P.C.

C. Inspect and obtain a copy of your health care record by submitting a request in writing to Indiana Surgical Associates, P.C.

D. Amend your healthcare record if you feel that medical information that we have about you is incorrect or incomplete by requesting, in writing, that an amendment be made. You must provide a reason that supports your request.

E. Obtain a report of all of the disclosures of your health information that we have made.

F. Request that we communicate with you about your medical information in a certain way or at a certain location within reasonable time limits.

G Revoke your authorization to use and disclose medical information about you, except to the extent that we already used or disclosed your medical information.

II. OUR RESPONSIBILITES REGARDING YOUR MEDICAL INFORMATION

We are required by law to:

A. Maintain the privacy of your health information.

B. Provide you with this Notice, which describes our legal duties and privacy practices with respect to information we collect about you and a revised copy of the Notice if it is amended or otherwise changes.

C. Abide by the terms of this Notice.

D. Notify you if we are unable to agree to a requested restriction.

E. Accommodate reasonable requests that you have made to have us communicate your health information to you in a certain way or at a certain location.

WE RESERVE THE RIGHT TO CHANGE THIS NOTICE. We reserve the right to make the revised and changed notice effective for medical information that we already have about you, as well as any information we receive in the future. We will post a copy of the current notice in the Indiana Surgical Associates, P.C. office. The notice will contain the effective date on the first page. Each time you register at Indiana Surgical Associates, P.C. for health care services, we will offer you a copy of the current Notice in effect.