



Mail Forms to:  
UMR  
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## VERIFICATION OF A WELLNESS EXAMINATION FORM

### FOR THE 2016 USW-ARCELORMITTAL HEALTH AWARENESS INITIATIVE

**USE THIS FORM IF UMR ADMINISTERS YOUR MEDICAL INSURANCE IN 2016.**

Form to be filled out by your healthcare provider to verify that you or your spouse, if applicable, completed the Wellness Examination from 10/1/15 – 9/30/16. 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 Spouse

*Employee/:* \_\_\_\_\_

Retiree Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Date of Birth (mm/dd/yyyy) \_\_\_\_\_

ArcelorMittal Location/Plant: \_\_\_\_\_

Insurance Card ID# \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_

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*

  
  
  

Healthcare Provider Name \_\_\_\_\_ Phone # \_\_\_\_\_

Healthcare Provider Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

*If you have an office stamp, please apply here*

USE THIS FORM IF UMR ✓

ADMINISTERS YOUR MEDICAL INSURANCE IN 2016.

## MEDICAL QUESTIONNAIRE

Tom N Galouzis, MD FACS  
 Mark A. Mueller, MD FACS  
 James Siatras, DO

Thomas W Shin, MD FACS

Brendan P Frawley, MD FACS  
 Jonathan G Patterson, DO  
 Eric Woo, DO

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Age: \_\_\_\_\_ Sex:  Female  Male

Who is your family doctor? \_\_\_\_\_

Please list name and address of the pharmacy you use: \_\_\_\_\_

What is the reason for your visit? Please list chief complaints: \_\_\_\_\_  
 \_\_\_\_\_.

PLEASE (X) SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR.

GENERAL	GENITO-URINARY	CARDIOVASCULAR	SKIN
Chills	Blood in urine	Chest pain	Bruise easily
Depression	Frequent urination	High blood pressure	Hives
Dizziness	Lack of bladder control	Irregular heart beat	Itching
Fainting	Painful urination	Low blood pressure	Change in moles
Fever	<b>GASTROINTESTINAL</b>		Rash
Forgetfulness	Appetite poor	Rapid heart beat	Sore that won't heal
Headache	Bloating	Swollen feet/ankles	Anemia
Loss of sleep	Bowel Changes	Varicose veins	<b>MEN ONLY</b>
Nervousness	Constipation	EYE, EAR, NOSE and THROAT	Breast lump
Numbness	Diarrhea	Bleeding gums	Erection difficulties
Sweats	Excessive hunger	Blurred vision	Lump in testicles
Weight loss	Excessive thirst	Difficulty swallowing	Other
<b>MUSCLE</b>	Gas	Double vision	
<b>JOINT/BONE</b>	Hemorrhoids	Earache	<b>WOMEN ONLY</b>
Pain, weakness, Or numbness in:	Indigestion	Hay fever	Abnormal pap smear
Arms	Nausea or Vomiting	Hoarseness	Bleeding between periods
Hands	Rectal bleeding	Loss of hearing	Extreme menstrual pain
Back	Abdominal/stomach pain	Nosebleeds	Hot flashes
Feet	Vomiting blood	Persistent cough	Painful intercourse
Hips	<b>RESPIRATORY</b>		Vaginal discharge
Legs	Cough w/phlegm? Dry?	Ringing in the ears	
Neck	Shortness of breath	Sinus problems	Other
Shoulders	Wheezing	Vision-Flashes/Halos	

PLEASE (X) CONDITIONS YOU HAVE OR HAD IN THE PAST.

AIDS	Chemical Dependency	High Cholesterol	Prostrate Problems
Alcoholism	Chicken Pox	HIV Positive	Psychiatric Care
Anemia	Diabetes	Kidney Disease	Rheumatic Fever
Anorexia	Emphysema	Liver Disease	Scarlet Fever
Appendicitis	Epilepsy	Measles	Stroke
Arthritis	Glaucoma	Migraine Headaches	Suicide Attempt
Asthma	Goiter	Miscarriage	Thyroid Problems
Bleeding Disorder	Gonorrhea	Mononucleosis	Tonsillitis
Breast Lump	Gout	Multiple Sclerosis	Tuberculosis
Bronchitis	Heart Disease	Mumps	Typhoid Fever
Bulimia	Hepatitis	Pacemaker	Ulcers
Cancer	Hernia	Pneumonia	Vaginal infections
Cataracts	Herpes	Polio	Venereal disease

Patient Name: \_\_\_\_\_

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Please list any medications you are now taking. Be sure to indicate the dosage and frequency:

Do you have any ALLERGIES to medications?       NO       YES  
If yes, list the drug(s) and describe the reaction:

HEALTH HABITS: Check (x) which substances you use and describe how much you use:

Caffeine/How much \_\_\_\_\_  Tobacco/How much \_\_\_\_\_  
 Drugs/How much \_\_\_\_\_  Alcohol \_\_\_\_\_

Have you ever had a blood transfusion?  NO       Yes (Give approximate date \_\_\_\_\_)

\*\*\*\*MEDICAL HISTORY\*\*\*\*

YEAR	TYPE OF MEDICAL PROBLEM	TREATMENT	DOCTOR	HOSPITALIZED?

\*\*\*\*PAST SURGERY (OPERATIONS) – Please list in order

YEAR	TYPE OF OPERATION	REASON FOR SURGERY	DOCTOR	HOSPITAL

Patient name: \_\_\_\_\_

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\*\*\*\*RADIATION THERAPY PATIENTS\*\*\*\*

STARTED? MONTH/YEAR	STOPPED? MONTH/YEAR	AREA OF BODY TREATED	DOCTOR	HOSPITAL OR FACILITY

\*\*\*\*FAMILY HISTORY\*\*\*\*

RELATION	AGE	STATE OF HEALTH	AGE OF DEATH	CAUSE OF DEATH
FATHER				
MOTHER				
BROTHERS				
SISTERS				

Check (x) if you or your blood relatives had any of the following:

Disease	You	Relationship to you
Breast Cancer		
Ovarian Cancer		
Other Cancers/List below		
Diabetes		
Heart Disease or stroke		
High Blood Pressure		
Kidney Disease		
Tuberculosis		
Family history of other diseases: List Below:		

## \*\*\*\*\*WOMEN ONLY\*\*\*\*\*

## Breast Health History:

Past breast problems (list): \_\_\_\_\_

Last mammogram: Date: \_\_\_\_\_ Where: \_\_\_\_\_

Are you now taking hormones or birth control pills? \_\_\_\_ NO \_\_\_\_ YES

Have you ever taken birth control pills or hormones? \_\_\_\_ NO \_\_\_\_ YES TYPE: \_\_\_\_\_

HOW LONG? \_\_\_\_\_ WHEN STOPPED? \_\_\_\_\_

Do you perform self-breast exams? \_\_\_\_ NO \_\_\_\_ YES Frequency? \_\_\_\_\_

Age at onset of periods: \_\_\_\_\_ Number of pregnancies: \_\_\_\_\_

Number of births: \_\_\_\_\_

Number of abortions: \_\_\_\_\_

Age at first childbirth: \_\_\_\_\_

Have you gone through menopause? \_\_\_\_ NO \_\_\_\_ YES

Are you pregnant? \_\_\_\_ NO \_\_\_\_ YES



## PATIENT INFORMATION

(Please Print)

## 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  TransgenderRace  American Indian/Alaska Native  Asian  Native Hawaiian/Other Pacific Islander  African American  White  DeclinedEthnicity  Hispanic or Latino  Not Hispanic or Latino  DeclinedLanguage  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 MilitaryStudent 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  NoRESPONSIBLE 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.

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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 Email: \_\_\_\_\_

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, M.D., F.A.C.S.  
Jonathan G. Patterson, D.O.

Brendan P. Frawley, Jr., M.D., F.A.C.S.  
Eric Woo, D.O.

Mark A. Mueller, M.D., F.A.C.S.  
James V. Siatras, D.O.

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 CAREFULLY.

## 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 RESPONSIBILITIES 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.

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Hobart, IN 46342  
Telephone: 219-947-1910  
Fax: 219-947-3117

101 E. 87<sup>th</sup> Avenue  
Merrillville, IN 46410  
Telephone: 219-769-2041  
Fax: 219-769-2313