DAMAR
HEALTH SERVICES

DAMAR Health Services New Patient Information

PATIENT INFORMATION		
First Name:	Middle Initial:	Last Name:
Date of Birth:	SSN:	
Sex Assigned at Birth: ❑ Male ❑ Female	Gender: _____ ❑ Prefer not to say	
Race: ❑ White ❑ Black/African American ❑ Multi-Racial ❑ American Indian/Alaska Native ❑ Hispanic ❑ Asian ❑ Pacific Islander ❑ Native Hawaiian ❑ Other _____		
Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino		
Home Address:		
City, State	Zip Code:	
Phone Number:		
May leave voice message: ❑ Yes ❑ No	Email:	
Preferred Pharmacy:	**Pharmacy Zip Code:**	

GUARDIAN INFORMATION	
Client is at least 18 years of age or emancipated (does NOT have a legal guardian or medical decision maker) ❑ Yes ❑ No (Continue to fill out guardian information below)	
Guardian Name:	Phone Number:
Relation to Patient: ❑ Parent/Guardian ❑ Foster Parent ❑ Other	
Home Address:	
City, State	Zip Code:

FAMILY INCOME INFORMATION
Family Income: ☐Below $10,000 ☐$10,001 - $20,000 ☐$20,001 - $30,000 ☐$30,001 - $40,000 ☐ $40,001 - $50,000 ☐$50,001 - $60,000 ☐$60,001 - $70,000 ☐$70,001$80,000 ☐ Greater than $80,000
Family Size: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Other _____

EMERGENCY CONTACT	
Emergency Contact:	Phone Number:
Relation to Patient: ❑ Parent/Guardian ❑ Foster Parent ❑ Other	
I authorize the disclosure of personal health information to this person: ❑ Yes ❑ No	

INSURANCE INFORMATION	
Insurance Provider:	Medicaid # (If applicable):
Insured Name:	Insured D.O.B:
Group #:	Insurance ID # (if applicable):

Signature: _____ Date: _____

5715 Decatur Blvd., Indianapolis, IN 46241 (317) 455-2366 Phone (317) 455-9351 Fax
E-mail : Medschedule@damar.org

DAMAR
HEALTH SERVICES

No-Show and Late Cancellation Policy

Our no-show and cancellation policy applies to missed appointments, which include:

- No-show: You don't arrive for your appointment, and you don't reach out to cancel.
- Late arrival: You arrive 30 or more minutes past your appointment time.
- Late cancellation: You cancel your appointment less than 24 hours before your appointment time.

To ensure all patients have the appointment access they need, please:

- Arrive on time for your appointments.
- Understand that if you arrive 30 or more minutes after your appointment time, we may need to reschedule your appointment.
- Notify the clinic at least 24 hours in advance if you can't make it to your appointment.

We understand there are times when you must miss a medical appointment due to emergencies. If you have a history of three or more missed appointments with a clinic or provider in a 12-month period, the clinic may decide not to treat or see you in the future.

Signature:_____ **Date:**_____

HIPAA RELEASE FORM

Patient Name: _____ Date of Birth: ____/____/_____

Release of Information

Privacy regulations require providers to have a release signed by our patients so we may speak with family members, friends and other relations regarding protected health information. This information includes but is not limited to medical appointments date/time, medical treatment (lab results, medications, etc.) and financial obligations.

I authorize the release of information to the following person(s):

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

_____ I do not authorize my release of information to anyone.

This authorization will remain in effect until terminated by you, your personal representative or other individual(s) of legal entity authorized to do so by court order or law. You can request to terminate this authorization by submitting a written request to our practice in person, fax or by mail.

Signature: _____ Date: _____

5715 Decatur Blvd., Indianapolis, IN 46241 (317) 455-2366 Phone (317) 455-7143 Fax

DAMAR
HEALTH SERVICES

STATEMENT OF DAMAR HEALTH SERVICES PATIENT RIGHTS AND RESPONSIBILITIES

Employees of Damar Services, Inc. shall ensure that all patients are afforded the special rights defined below through either their interactions or the interactions of others.

You have certain rights when receiving medical services through Damar Services, Inc. Most important is your own knowledge and understanding of the treatment you are to receive. Prior to initiating treatment, your provider will explain the reason for the proposed treatment, the benefits of the proposed treatment, the risks of the proposed treatment, and alternative treatment options. The provider will allow time to answer all questions thoroughly before obtaining your verbal consent. This consent acknowledges your voluntary participation and your understanding of the treatment plan. You maintain the right to request a change in, refuse, or stop treatment. By signing this form, you are providing Damar Health Services the right to use the phone number provided to receive SMS.

Your Responsibilities Include: Setting and keeping appointments with your provider, notifying your provider within the identified timelines presented in the Damar Health Services Cancellation Policy, and paying for the services you receive.

Professional Standards. The right to receive services in accordance with standards of professional practice, appropriate to your needs, and which are meant and designed to give you a reasonable opportunity for improvement. This includes being informed of the qualifications of your provider. The provision of services shall be responsive to each person's age, gender, social supports, cultural orientation, psychological characteristics, sexual orientation, physical situation, and spiritual beliefs.

Treatment Plan Involvement. The right to participate in the development and review of your treatment plan, including known effects of receiving or not receiving such treatment and alternative treatment as may be available. You retain the right to refuse treatment.

Least Restrictive Setting. The right to receive treatment in the least restrictive setting that responds to your treatment needs. The right to receive services in a safe, secure, and supportive environment. The right not to be placed in a room or area where exit is prevented.

Confidentiality. The right to confidential maintenance of information about yourself and treatment received. We may not tell a person outside this agency that you receive health care from our provider or discuss any information identifying you as a patient within our services without your written authorization or as allowed by law (including court orders, medical emergency, suspected abuse or neglect, to report a crime or a threat to harm someone, etc.). Suspected violations of these confidentiality requirements may be reported to appropriate authorities in accordance with federal regulations. For legal references see: IC 16-14 & 16-4 (Indiana statutes), C42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 (federal laws), and 42 CFR Part 2 (federal regulations).

Access to Records. The right to inspect your own record and, under most conditions, the right to have a copy of your own record at your expense.

Freedom of Religion. The right to practice the religion of your choice or to abstain from religious practices.

Constitutional/Civil Rights. The right to exercise constitutional, statutory, and civil rights, except those denied or limited by court action. No person shall, on the grounds of race, religion, ethnicity, color, national origin, ancestry, age, handicap, or sexual preference, be excluded from participation in, be denied the benefit of, or be otherwise subjected to discrimination under any program or activity of Damar Services Inc Outpatient Clinic in the provision of its services.

Consumer Conduct. All consumers shall conduct themselves in an appropriate manner. Rule violations may lead to a limitation or termination of service. In some cases the police may be called. Visitors and staff shall not: 1) carry or be under the influence of intoxicating beverages or illegal substances; 2) steal, attempt to steal, or deface property of Damar Services, Inc or visitors to Damar

Services, Inc; 3) assault or sexually harass anyone; 4) possess firearms or dangerous weapons; 5) threaten, intimidate, coerce, or interfere with other people; 6) falsify information provided to Damar Services,

Inc; 7) smoke inside any Damar Services, Inc facility. Services may also be limited or terminated if a consumer fails to keep their scheduled appointments.

Reinstatement. If your services have been terminated, you may request a review of the situation and reinstatement of those services from the Director of Nursing. The Director of Nursing will provide you with information about if and how reinstatement can occur based upon the circumstances of the termination.

Protection From Abuse. The right to humane care and protection from harm. All instances of abuse or neglect of an adult should be reported to Adult Protective Services Unit (Adult Abuse Hot Line) at 1-800-992-6978. Circumstances of child abuse and neglect should be reported to the local County Division of Family and Children's Services or to the local Police Department. There are two other Indiana agencies that help clients in securing their rights to appropriate care, freedom from harm, and appropriate treatment – the Indiana Advocacy Service (also known as Indiana Protection and Advocacy Services) at 1-800-622-4845 and, for eligible consumers, Legal Services Organization (LSO) at 1-800-382-2018.

Waivers. At no time will admission to services be conditional upon a person's waiver of their rights. However, you retain the option to waive any of your rights. Such a waiver must be given voluntarily, knowingly, and in writing and can be withdrawn at any time.

Access to Information. The right to access information in sufficient time to facilitate your decision making.

Informed Consent. The right to have informed consent, refusal, or expression of choice regarding: 1) the delivery of services; 2) release of confidential information; or 3) any concurrent services.

Copy of Rights. The right to receive a copy of the Patient Rights Statement upon your request.

Legal Counsel. The right to contact or consult with legal counsel of your choice at your own expense.

Consumer Advocate; Questions, Concerns, or Grievances. The right to have your questions answered or to make complaints about services you receive or violations of these rights and to have those complaints heard and decided promptly. If you have a grievance or complaint, you may contact the Director of Nursing at 317-856-5201. The Director of Nursing will contact you within 5 days to discuss the complaint and update you as to the status of the investigation. Any complaint should be taken initially to your provider, then the Director of Nursing.

Accommodations. You have the right to request information be presented to you in your primary mode of communication.
I have received a copy of Damar Services' statement of medical services patient rights and responsibilities.

☐ By checking this box, I agree to receive SMS from Damar Health Services to the phone number provided.

_____ Date _____

Signature of Patient or Guardian Date

Damar Services, Inc.
Summary – Notice of Privacy Practices

This notice provides a summary of how health information about you may be used and disclosed and how you can get access to this information. You may request a complete copy of this privacy notice from Damar Services, Inc. at any time. If you have any questions about this notice, please contact Damar at 317-455-2366.

Damar Services, Inc. is required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices.

We may use and disclose health information under these conditions:

- For Treatment
- For Payment
- For Business Operations
- To Business Associates
- For Research Purposes
- For Treatment Alternatives
- For Health-Related Services
- To Individuals Involved in Your Care
- Payment for your Care

Law requires disclosure of health information for the following:

- To Avoid a Serious Threat to Health or Safety
- Organ and Tissue Donation
- Military and Veterans
- Lawsuits and Disputes
- Protected Services for the President and Others
- Worker's Compensation
- Law Enforcement
- Coroners, Medical Examiners and Funeral Directors
- National Security and Intelligence Activities
- Inmates/Prisoners

Your rights as it relates to your personal health information:

- The Right to Inspect
- The Right to Amend
- The Right to Disclosure Information
- The Right to Request Restrictions
- The Rights to Request Confidential Communications
- The Right to a Copy of this Notice

*Other uses and disclosures of health information not covered by this notice or law will be made only with your written permission. You may request a complete copy of this notice at any time. If you believe your privacy rights have been violated, you may file complaint with Damar Services, Inc. by contacting us at 317-548-7221.

***I have received a copy of Damar Services' Notice of Privacy Practices and understand I may request a complete version of this privacy notice at any time.**

_____ _____

Signature of Client or Guardian **Date**

Financial Policy

Welcome to Damar Health Services and thank you for choosing us for your medical needs. We are committed to providing quality medical care for you, your children, and family. In order to reduce potential misunderstandings, our office has adopted the following Financial Policy.

Insurance

We will file claims to those plans with which we have a contractual agreement as long as we have valid information and insurance card(s). We will confirm eligibility prior to the appointment but familiarizing yourself with the benefits and limitations of your plan such as: deductible, copay, coinsurance prior to your appointment will be beneficial to you. **We will require copays and self- pay balances to be paid at time of service for office visits.** If your health plan determines that a service is "not covered" you will be responsible for the entire charge.

Please note that all insurance companies and plans do not pay the same. If you do not agree with how your insurance provider processed the claim for your services, you will need to contact your insurance company regarding their decision. This office is not responsible for disputing decisions made by your insurance carrier regarding coverage.

Forms of Payment

Damar Health Services will accept cash, checks, and debit cards. Any payment returned from our financial institute could be assessed for additional fees by Damar Health Services as well as your banking institute. *You will not be able to use that form of payment in the future.*

Payment for Account Balance

If you need to setup a payment plan for an account balance, our staff can assist you.

Patients will receive treatment at Damar Health Services regardless of their ability to pay for services rendered.

I have read and agree to the above policy.

Printed Name: _____ Date: _____

Signature: _____

PATIENT MEDICAL HISTORY FORM

Damar Health Services, Inc.
5715 Decatur Blvd., Indianapolis, IN 46241
Phone: 317-856-5201

HEALTH CARE PROVIDERS

Primary Care Provider:		❑ Pediatric ❑ Adult/Family	Phone:
Street Address:			Last seen:
City:	State:		ZIP Code:

Specialist Information (name and specialty)		Last Appt	Phone Number
Primary Care:			
Specialist:			
Specialist:			
Specialist:			
Specialist:			
Psych / Behavior:			

FAMILY HISTORY

Condition	Who?	Condition	Who?	Condition	Who?
Heart Disease		Hypertension (HTN)		Diabetes (DM)	
Lipids		Cancer Type:		Genetic	
Psychiatric		Other:			

PAST MEDICAL HISTORY

Has the patient ever been hospitalized?	❑ Yes ❑ No
If yes, when and for what?	
Has the patient ever had surgery?	❑ Yes ❑ No
If yes, when and for what?	

For children under the age of 18: Has the patient ever required treatment for any of the following:

❑ ADD/ADHD	❑ Ear Infections	❑ Reflux
❑ Allergies	❑ Eczema	❑ Seizures
❑ Anxiety	❑ Feeding Problems	❑ Urinary Problems (including UTIs)
❑ Asthma	❑ Genetic Disorder	❑ Vaccine Reactions
❑ Concussion	❑ Hearing Loss	❑ Other (Please explain below)
❑ Constipation	❑ Heart Disease	
❑ Depression	❑ Heart Murmur	
❑ Diabetes	❑ Immune Disorder	
❑ Diarrhea	❑ Rashes	

For patients 18 and older: Has the patient ever required treatment for any of the following:

❑ Angina	❑ Diabetes	❑ Visual Impairment
❑ Anxiety	❑ Hearing Impairment	❑ Allergies
❑ Arthritis	❑ Heart Attack	❑ Bleeding Disorders
❑ Asthma	❑ Osteoporosis	❑ Bowel/Bladder Concerns
❑ COPD	❑ Stroke/TIA	❑ Cancer
❑ Congestive Heart Failure	❑ Stomach ulcers	❑ Seizures
❑ Depression	❑ Acid Reflux	❑ High Blood Pressure
❑ Immune Disorder	❑ Other (Please explain below)	
❑ Genetic Disorder		
❑ Kidney Problems		
❑ Liver Problems		

CURRENT MEDICATIONS			
	Name	Dose	Purpose
1.			
2.			
3.			
4.			
5.			
6.			
ALLERGIES:			
Preferred Pharmacy:			

CURRENT DIAGNOSES	
1.	
2.	
3.	
4.	
5.	
6.	

_____

Patient Name (If under 18: Parent/Guardian Name)

_____ Date: _____

Patient Signature (If under 18: Parent/Guardian Signature)