Of Carmel

Clifford Fetters, M.D. Bruce Thomas, M.D. Annamarie Salyer, FNP
Jerry Weber, N.D. Amanda Patchett, FNP-C

REGISTRATION FORMS

Patient Name: ____
(Last) (First) (M)

Sex: M / F (circle) Birthdate: _____/_____/______
Address: ____
(street) (city) (state) (zip)

Telephone # Home: (_____) ______-________ Cell: (_____) _______-________ Receive Text; **Yes** **No**

E-Mail: ____ Patient Portal Access: **Yes** or **No**

Employer: ____ Work: (____) _____-_________

Employer's Address ____

Marital Status: S M D W (circle) Spouse Name: ______________________ Birthdate: ____/____/_____

Emergency Contact

Name: ___________________ Relation: ____________________Phone #: (____) _____-_________

***The government is requiring us to ask the following as a part of our new EMR system.**

What is your Race? ____________ What is your Ethnicity? _____________ Primary Language __________

Guarantor (if patient is under the age of 18)
Name: ____ Phone #: (____) _____-________

Relationship to Patient: ____

Signature: ____ Date: _____________
(☐ Self ☐ Parent ☐ Guardian)

***Primary Insurance:** ____

Subscriber's Name: __________________________________ ***Subscriber's Birthdate***: ____/____/______

Subscriber's SS#: ____________________ Subscriber's Employer: ______________________________

Insurance ID# ___________________ Group #: _________________ Effective Date: ____________

Relationship to Patient: ___________________ Mother's Name (if minor): _________________________

<u>If you have Secondary Insurance, Please Complete the Following**</u>**

***Secondary Insurance:** ____

Subscriber's Name: ___________________________________ *Subscriber's Birthdate*: ____/____/______

Subscriber's SS#: ___________________ Subscriber's Employer: ______________________________

Insurance ID# ___________________ Plan #: __________________ Effective Date: _____________

PATIENT CONSENT

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Health and Wellness of Carmel, LLC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by Health and Wellness of Carmel, LLC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Health and Wellness of Carmel, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the practice manager of Health and Wellness of Carmel, LLC.

With this consent, Health and Wellness of Carmel, LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Health and Wellness of Carmel, LLC may mail to my home or other alternative location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Health and Wellness of Carmel, LLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Health and Wellness of Carmel, LLC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Health and Wellness of Carmel, LLC to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Health and Wellness of Carmel, LLC may decline to provide treatment to me.

Signed by: ______________________________ ______________ ________________

Signature of Patient or Legal Representative Date Relationship to Patient

______________________________ ______________________________

Print Patient's Name Print Name of Legal Representative, if applicable

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION… PLEASE REVIEW IT CAREFULLY.

State and federal laws require us to maintain the privacy of your health information and to information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on January 2013 and will remain in effect until amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established “minimum necessary or need to know” standards that limit various staff members’ access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other healthcare professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide for you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may disclose your health information when the office is required to do so by the law. We will use disclose your information when requested by national security, intelligence, and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Public Health Responsibility: We will disclose your healthcare information to report problems with product, reactions to medications, product recalls, and disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters. In addition, we may contact you to inform you of health screenings, wellness events or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you about seminars or programs that we are providing.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Copies, if requested, will be given at a fee for the patient. If you want the copies mailed to you, postage will be charged.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your healthcare information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available). You have the right to a list of instances in which we or our business associates disclosed information for reasons other than treatment, payment or healthcare operations.

Complaints: If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to or amendments to your records, you may contact our office at 317-663-7123. You may also send a written complaint to U.S. Department of Health and Human Services Office of Civil Rights. **Under no circumstances will you be penalized or retaliated against for filing a complaint.**

PATIENT CONSENT FOR TREATMENT FORM

CONSENT

1. I agree that Health and Wellness of Carmel, LLC may use or release my health information as follows: to other health care providers and their staff for treatment purposes; to third party payers and other third parties as necessary for Health and Wellness of Carmel, LLC to obtain payment for services I have received; or for Health and Wellness of Carmel, LLC health care operations (such as administration and quality assurance).
2. I understand that I am responsible for paying the cost of any services at the time the services are provided and that, unless Health and Wellness of Carmel, LLC has an agreement with my health plan or insurer, Health and Wellness of Carmel, LLC is not responsible for obtaining reimbursement on my behalf or for assisting me in obtaining reimbursement from any source. If Health and Wellness of Carmel, LLC has an agreement with my health plan or insurer, I understand that I am responsible for paying any co-payment or deductible amount at the time of service. If my health plan or insurer does not pay all remaining amounts due, I shall be responsible for making payment in full to Health and Wellness of Carmel, LLC for any and all services.

By signing below, I am confirming that I understand the information above, and that I consent to the disclosures described.

Patient Name (Please Print) Birth Date Phone

Address City State Zip

Signature Date

If signed by anyone other than the patient, check box that describes relationship to patient:

☐ Parent ☐ Guardian

☐ Health Care Agent ☐ Other (please specify) ______________________________

Notice of Privacy Practices

☐ – I acknowledge that I have received the Health and Wellness of Carmel, LLC Notice of Privacy Practices.

☐ – I decline to accept the Health and Wellness of Carmel, LLC Notice of Privacy Practices. Please initial _______ and provide the reason for refusal to accept the Notice of Privacy Practices.

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PATIENT CONSENT TO SHARE PROTECTED HEALTH INFORMATION

Patient Name: ____
(First Name) (MI) (Last Name)
Social Security # ________________________________ Date of Birth: ____________________________

I ***authorize*** Health and Wellness of Carmel, LLC to disclose medical information of the above named individual as described below. This authorization is only valid at this location and for the information designated below.

INFORMATION TO BE RELEASED: Please indicate below what types of information can be disclosed to the identified individual(s) listed below
□ All Clinical and Billing Information
If certain information is NOT to be included, please list: ____
I understand the information listed may be communicated via: fax, photocopy, verbal communication, telephone, voicemail, and/or direct mail.

PURPOSE FOR NEED OF DISCLOSURE
My medical information may be disclosed to and used by the following individual(s) or organization(s): Please list all persons you wish to receive your personal medical information.
□ Spouse ____
(Name) (Address & Phone, if different than patient)
□ Child/Children ____
(Name) (Address & Phone)
□ Child/Children ____
(Name) (Address & Phone)
□ Child/Children ____
(Name) (Address & Phone)
□ Other ____
(Name & Relationship) (Address & Phone)

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form, as provided in CFR 164.524. ***Right to Receive a Copy of this Authorization-*** I understand that if I agree to sign this authorization, which I am not required to do, I will be provided with a signed copy of the form upon request. ***Right to Withdraw this Authorization***- I understand that I have the right to withdraw this authorization at any time. I understand that if I withdraw this authorization I must do so in writing and present my written withdrawal to the health information management department of the Entity as listed above. I understand that the withdrawal will not apply to information that has already been released in response to this authorization. I understand that the withdrawal will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise withdrawn, this authorization will expire on the date, event, or condition specified below. I understand that this authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Health and Wellness of Carmel, LLC at (317) 663-7123.

____ ____________________
Signature of Patient or Legal Representative Date

____ ____________________
(If signed by Legal Representative, state relationship & authority to do so) Signature of Witness

Patient Is: □ Minor □ Incompetent □ Authorized Legal Representative
Legal Authority: □ Custodial Parent □ Disabled □ Power of Attorney for Healthcare
□ Legal Guardian □ Deceased □ Executor of Estate of Deceased

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REGISTRATION FORMS

Received by: ______________________________ Date: ____________________

FINANCIAL POLICY

The Physicians and staff of Health and Wellness of Carmel, LLC feel that all patients deserve the very best medical care. Further, we feel that everyone benefits when definite financial arrangements are clearly defined and agreed upon. **PLEASE READ CAREFULLY AND COMPLETELY.**

Insurance Classification: We are contracted with the following Provider Networks: Anthem, Cigna, Community Health Alliance, Encore, Humana, Medicare, Sagamore Health Network, Aetna, and United Health Care. Within these networks are numerous insurance companies - or payers. If we are contracted with your insurance company through one of the above networks we will accept the negotiated fee reimbursement for our services. Please note that we may bill you for non-covered services, co-pays, co-insurances, and/or deductibles as identified by your insurance company. If you have insurance through a company that is not currently utilizing one of the above networks, we do not recognize their "usual and customary" level of reimbursement. If your insurance company selects a level of reimbursement that is below our standard fees, the responsibility of the remaining balance is placed on you when applicable. Again, we may also bill you for non-covered services, co-pays, co-insurances, and/or deductibles as identified by your insurance company. We are Non-Participating with Medicaid providers. Therefore, all Medicaid and non-insured patients (self-pay) are expected to remit payment for services at the time services are provided.

Insurance Claims Processing: All charges incurred are the responsibility of the individual patient from the date services are rendered. We courteously file your insurance claim for you, when applicable. An initial 60 day grace period will be allowed for insurance payment, provided copayments are made at the time of service. We cannot accurately file an insurance claim for any patient without an updated insurance identification card. If you do not present a current insurance card, payment will be expected at the time of service. If your insurance company has not paid your claim by the end of the two 60 day grace periods, the balance then becomes your responsibility. Beyond this point, payment from your insurance company is between you and them.

Holistic Functional Medicine: Many of our services and products are not covered by insurance companies. The cost of these services and products are to be paid by the patient at the time of service. We routinely perform a Holistic Functional Assessment. This assessment costs $150 to $250 depending on the provider you choose. This is a non-covered service and will be billed to the patient. Prices can change without notice. Double-length appointments are naturally double and Cancer consult fees are higher as well. Cancer fees will be discussed with our Cancer Program Director.

Minor Patients: The adult accompanying a minor and the parents (or guardians) are responsible for payment.

NSF Checks: All checks returned for non-sufficient funds will incur a $30.00 service fee.

Delinquent Accounts: If your account becomes delinquent (60 days) the patient, parent or guardian if patient is a minor, will be responsible for all collection costs, including agency fees, attorney fees, court costs or any other fees incurred to collect this debt.

Missed Appointments: Unless canceled at least 72 hours in advance (96 hours for Monday appointments), it is our policy to charge $100.00 for missed appointments. Please help us serve you better by keeping scheduled appointments.

Portal Messaging: Portal messages should be used in between office visits for refill requests and questions that pertain to your last visit only. Any reason beyond that will require an existing appointment to be moved up or for a new appointment to be scheduled. Excessive portal use will likely result in a $50 charge.

Agreement: I have read and fully understand the Financial Policy as stated above and all of my questions have been answered. I agree to be liable for any of the above fees associated with the visit and/or subsequent services.

Name ____ Date ____________________________

Authorization and Release: I authorize the release of any medical information necessary to process my claim(s). I authorize and request payment of insurance benefits to my provider of services otherwise payable to me. I have read and agree to the above financial policy. I will be responsible for myself and those listed below.

Name ____ Relationship ______________________

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What is the Functional Fee?

Many of our services and products are not covered by insurance companies. The cost of these services and products are to be paid by the patient at the time of service. The Functional Fee is dependent upon the provider, the appointment duration, and the diagnosis. This is a non-covered service for all insurance companies which we contract with and will be billed to the patient.

Functional Fee

The Functional Fee is comprised of a number of components including what is considered holistic medicine; analysis of various natural supplements, vitamins and dietary products, an extensive and ongoing review of diagnostic tests such as the Bio 101 or, Flow Systems Analysis, naturopathy, applied kinesiology, and orthomolecular therapy.

The Flow Systems Analysis medical device is used to evaluate the biological terrain of a human being. It measures the internal environment of the body giving the practitioner valuable information on balance and overall health. We know that the cells of our body thrive in an ideal environment and deteriorate in a hostile environment. The most important parameters that regulate cell health are measured by the Bio 101. This dynamic form of physiological biofeedback helps uncover the underlying cause or causes of a patient's imbalance or illness, rather than treating a list of "symptoms".

Naturopathy, or naturopathic medicine, is a system of medicine based on the healing power of nature. Naturopathy is a holistic system, meaning that naturopathic doctors (N.D.s) or naturopathic medical doctors (N.M.D.s) strive to find the cause of disease by understanding the body, mind, and spirit of the person. We use a variety of therapies and techniques (such as nutrition, behavior change, herbal medicine, and homeopathy).

These are two areas of focus in naturopathy: one is supporting the body's own healing abilities, and the other is empowering people to make lifestyle changes necessary for the best possible health. While we treat short bouts of illness and chronic conditions, our emphasis is on preventing disease and educating patients.

Applied kinesiology is a system using muscle testing as a functional neurological evaluation. The methodology is concerned, primarily, with neuromuscular function as it relates to the structural, chemical and mental physiologic regulatory mechanisms.

Orthomolecular medicine, as conceptualized by double-Nobel laureate Linus Pauling, aims to restore the optimum environment of the body by correcting imbalances or deficiencies based on individual biochemistry, using substances natural to the body such as vitamins, minerals, amino acids, trace elements and fatty acids.

Insurance companies consider these various components alternative or complementary medicine and, as such, do not provide benefits. Many times this determination is made by their Medical Director and typically does not vary across companies. Thus, it is very important you call your insurance company and understand the benefits provided. We try very hard to file every claim with your insurance company as directed in our contract with them. It is mandated we utilize certain codes and nomenclature when billing them. However, the American Medical Association provides the Current Procedural Terminology (CPT) codes for our use. There is no CPT code for many of the different holistic and functional medicine procedures we utilize. Therefore, when we attempt to file your claim through the electronic clearing houses most insurance companies use, our claims are rejected by the system due to lack of the proper codes. Again, as there are no codes established, it is impossible to receive payment for services rendered but we do make that attempt on your behalf. It is paramount you understand what benefits your insurance company provides for you as you will be responsible for this fee. We are permitted by our agreement with most insurance plans to bill the beneficiary of the plan for any non-covered services.

Functional services are an integral part of your health care here at Health & Wellness of Carmel. It truly is what sets your care apart from conventional medicine and why functional medicine succeeds where others fail. In addition to working with insurance companies, we also set our fees lower than other groups to provide more people access to Functional Medicine. Your health and well-being is extremely important to us. If you have any other questions about the fee please feel free to inquire.

Health & Wellness of Carmel, LLC
11900 N Pennsylvania St. Suite 200
Carmel, IN 46032 (317)
317-663-7123

By signing this document below, I am giving Health & Wellness of Carmel, LLC my permission to leave a detailed message at the number(s) provided below in regards to my personal health information including, but not limited to, any appointment reminders, billing inquiries, and test results. Any changes must be submitted to Health & Wellness of Carmel, LLC in writing. This document will remain effective unless otherwise specified by patient.

Primary#:____

☐ Home ☐ Cell ☐ Work

Alternative#: ____

☐ Home ☐ Cell ☐ Work

Print Name: ______________________________________

Signature: ____

Relation to Patient if applies: ___________________________

Date: ____

☐ **PLEASE DO NOT LEAVE DETAILED MESSAGED ON MY VOICEMAIL OR ANSWERING MACHINE**
(This does not include appointment reminders)

Clifford Fetters, M.D. Bruce Thomas, M.D. Annamarie Salyer, FNP
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REGISTRATION FORMS

A NOTICE REGARDING INSURANCE CLAIMS

The staff at Health & Wellness of Carmel is happy to file your insurance claims for services provided by our doctors on behalf of Health & Wellness of Carmel. We currently accept most insurance plans. Please note, we do not accept Medicaid. For your convenience, we also file secondary claims and Medicare supplement claims.

Health & Wellness of Carmel is not a traditional doctors' office; it is a doctors' office that specializes in Holistic and Functional care. This specialization routinely includes services, procedures, and products that are not covered by insurance plans.

We will file Insurance based claims (i.e. office visits) to your plan. However, our care for you includes several services and products that are not covered by your insurance. There are no applicable codes for filing for these procedures and tests and they are rejected by the insurers thus adding only a very costly administrative burden. We do not wish to add that expense on to the cost of providing care to you. In order to forego this needless expense, we will not prepare a claim for your insurance company and will not file a claim with your insurance company for these non-covered services and products. The non-covered services and products are the financial responsibility of the patient and payment is anticipated at the time of service.

Services, procedures and products not covered by insurance include, but are not limited to:

- Physician Grade Supplements
- Specialty Lab Testing and Procedures (i.e. Heavy Metal Testing, Bio101, IV Therapy…etc.)
- Holistic Functional Assessments ($145-$240 per office visit)

We also have an independent phlebotomy lab on-site for patient convenience. This lab is not affiliated with Health & Wellness of Carmel and remains independent. Insurance claims and patient billing are conducted by Lab Corp and patients will receive billing directly from Lab Corp and not from Health & Wellness of Carmel.

We hope this information is useful, and helps you to understand the insurance benefits as they relate to our specialization.

Thank You,

Health and Wellness of Carmel

Patient Printed Name: ____ Date: ________________

Patient Signature: ____

Electronic Communication Consent

Email, text, or other electronic communication provides a fast and easy way to communicate with Health and Wellness of Carmel, LLC for those issues that are non-emergent, non-urgent or non-critical. It is not a replacement for the interpersonal contact that is the very basis of this medical practice; rather it can support and strengthen an already established relationship.

The following summarizes the information you need to determine whether you wish to supplement your experience at our practice by electronically communicating with Health and Wellness of Carmel.

General Considerations:

- Electronic communication will be considered and treated with the same degree of privacy and confidentially as written medical records.
- Messaging through the Patient Portal will create the most secure way of contacting Health and Wellness of Carmel staff.
- Your email address will not be used for external marketing purposes without your permission.

Provider Responsibilities

- Every attempt will be made to respond to your electronic message within 2 business day. If you do not receive a response from the practice within 2 business days, please contact practice by phone.

Patient Responsibilities

- Patient Portal Messaging should not be used for emergencies or time-sensitive situations. In the event of an emergency, you should immediately call 911. For time-sensitive situations, you should contact the practice by phone.
- Electronic messages should be concise. Please arrange for an office appointment if the issue is too complex or sensitive to discuss via patient portal messaging.
- Extensive use of, or over-utilization of the Patient Portal may result in additional fees. However, you will be notified if we feel over-utilization is occurring. All legitimate questions and concerns are always answered as quickly as possible. Many questions can be answered during your next visit so please be respectful of the system.

- ○ I wish to have Patient Portal access

  Within the Portal:

- ○ I wish to send and receive messages through the portal.
- ○ I wish to view lab reviews through the portal.
- ○ I wish for past labs and medical history to be available through the portal.

I wish to receive text messages for:

- ○ Appointment Confirmations
- ○ General Notifications

I wish to receive voice messages for:

- ○ Appointment Confirmations
- ○ General Notifications

**If yes for voice/texting, please provide best number for contact below

Patient Name: ____
Date of Birth: ________________ Phone: ___________________
Email: ____

I agree to be held accountable and to comply with what is outlined in this consent. By signing below, I am agreeing to the above statements and my approval for the services I wish to participate in.

Signature: ______________________________ Date: ___________

In the event of an emergency who may we contact regarding your care? This information will only be used in the event of a true medical emergency.

Name: ___________________________ Relationship: ______________

Phone: ___________________________

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Advance Directives

If you need further information on Advance Directives, please ask our staff. We can provide State of Indiana forms for you.

Please mark any that apply:

- ○ I have a *Medical Power of Attorney (MPOA).* I will provide a copy of this legal document to **Health and Wellness of Carmel** as soon as possible. Please be sure to mark this person in the HIPPA agreement.
  - Name of MPOA: ________________________________
  - Phone ___________________________
- ○ I have a *Living Will* outlining my wishes. I will provide a copy of this to **Health and Wellness of Carmel** as soon as possible. If this document is not provided, I understand that lifesaving procedures such as cardiopulmonary resuscitation (CPR) will be performed.
- ○ I want cardiopulmonary resuscitation (CPR) and the use of an automated external defibrillator (AED) if my heart should stop or if I stop breathing.
- ○ *Do Not Resuscitate (DNR):* I do NOT want any lifesaving actions such as cardiopulmonary resuscitation (CPR) or the use of an automated external defibrillator (AED) in the event my heart should stop or if I stop breathing.

If you do not have any Advance Directives but would like to put an Advanced Directive in place, please ask our staff for the necessary forms. For further information, go to https://www.in.gov/isdh/25880.htm.

_______________________________　　　　　　　　__________________
Patient Signature　　　　　　　　　　　　　　Date

____
Patient Printed Name

Consent for Receiving of Protected Health Information via Email

I, ____________________________, consent to receive Protected Health Information (PHI) via the personal email address I have provided in the New Patient Paperwork/portal. I understand that documents and information sent via email are not 100% secure and may result in a breach of PHI.

I am of legal age and freely sign this release, which I have read and understood.

____

Email address

____

Signature

____

Print Name

____

Date