LEESTMA HEALTHCARE

519 N. Halleck
DeMotte, IN 46310
Phone: 219-987-7750, Fax: 219-987-5750

AUTHORIZATION AND RELEASE OF MEDICAL INFORMATION

I hereby authorize Leestma Healthcare to release any of the following requested information for the purpose of payment of office charges for any treatment received, or to another facility or physician for further medical care. Any and all information contained in my medical records may be released to any of the following: third party payer, peer review organization, pre-certification organization, managed care plans or health facilities or physicians.
Excluding Medicare patients, I understand that I am ultimately responsible for any and all charges not paid by my medical insurance. I understand that I am responsible for all fees regardless of insurance coverage, and that payment is due at time of service.

Patient (Guardian) Signature_____ Date_____

AGREEMENT FOR THE ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT OF ANY BALANCE DUE

I hereby authorize the assignment of any insurance benefits to Leestma Healthcare. I also agree that I am liable for the payment of all medical services not paid by my insurance or other benefits. In addition, any balance left due and owing after 150 days, will be turned over to our attorney for collections. I then will be responsible for any court costs, costs of collections, attorney fees and any pre and post collections interest.

Patient (Guardian) Signature_____ Date_____

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by Leestma Healthcare, including my physician services. I authorize any holder of medical and or other information about me to be released to the Health Care Financing Administration and its agents for any information needed to determine these benefits or any benefits for related services.

Patient Signature_____ Date_____

DISCLOSURE OF PHYSICIAN OWNERSHIP

I acknowledge that my signature on this form is evidence of my receipt of the following disclosure pertaining to a Physician's ownership or financial interest, or both in Pinnacle Healthcare, LLC at Connecticut Drive, Crown Point IN 46307. The following Physician(s) maintain an ownership or financial interest, or both at Pinnacle Healthcar, LLC.

Eric J. Leestma, DO
519 N Halleck
DeMotte, IN 46310

Micah J. Leestma, DO
519 N Halleck
DeMotte, IN 46310

I understand that I may choose to be referred to another facility or healthcare entity. For further information concerning such ownership interest, I understand that I can contact the physician or medical administrator at the address shown above.

Patient Signature_____ Date_____