LEESTMA HEALTHCARE
OUR FAMILY CARING FOR YOURS
519 N. HALLECK ST DEMOTTE, IN 46310
PHONE: 219-987-7750 FAX: 219-987-5750

PATIENT REGISTRATION

PATIENTS NAME: _____ DATE: _____

SS: _____ DOB: _____ HOME/CELL PHONE: _____

EMAIL FOR PORTAL ACCESS: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

MARITAL STATUS (CHECK ONE):

SINGLE____ MARRIED ____ WIDOWED____ DIVORCED____

PATIENT'S SEX: MALE _____ FEMALE _____

INSURANCE SUBSCRIBER INFORMATION

POLICYHOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICYHOLDER DOB: _____

EMERGENCY CONTACT – RELEASE INFORMATION Y / N

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

HOME PHONE: _____ CELL PHONE: _____

PATIENT SIGNATURE: _____ DATE: _____

All services provided in the office are due and payable at the time of service. Please give the receptionist your insurance card & a valid identification card.

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Demotte, IN 46310
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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 the 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 (Guardian) 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 Dr, crown Point, IN 46307. The following physician(s) maintain ownership or financial interest, or both at Pinnacle Healthcare, LLC.

Eric J. Leestma	Micah J. Leestma
519 N Halleck St.	519 N Halleck St.
Demotte, IN 46310	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 (Guardian) Signature_____ **Date** _____

LEESTMA HEALTHCARE
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HIPPA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing the consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information by the practice does not have to agree to those restrictions.
- The practice has the right to revoke this consent in writing at any time and all full disclosures will then cease.

The practice may condition receipt of treatment upon execution of this consent,

May we phone, e-mail, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by _____

Signature:_____ Date:_____

Witness:_____ Date:_____

Disclosure of Physician Ownership in Pinnacle Healthcare LLC

I acknowledge that my signature on this form is evidence of my receipt of the following disclosure pertaining to a Physician's or medical practice's ownership or financial interest, or both, in the hospital or Pinnacle Healthcare LLC. The following Physician(s) and/ or medical practice's maintain an ownership interest or financial interest, or both, in the hospital or Pinnacle Healthcare LLC:

Name of Physician/Practice: Dr. Micah Leestma/ Dr. Eric Leestma

Address/City/State/Zip Code: 519 N. Halleck St./DeMotte/IN/46310

Telephone number: (219) 987-7750

I understand that I may choose to be referred to another facility or health care entity. For further information concerning such ownership interest, I understand that I can contact the Physician or medical practice administrator at the addresses and telephone numbers shown above.