NOTICE:

If your insurance company requires a prior authorization it will be the Patients responsibility to contact their insurance company prior to any visits to start the process.

Attn: New Patients:

Medicare is not accepted at this office attached is a form that will need to be signed prior to your first visit with Dr. De Wester.

Cash prices for treatments are available upon request.

Respectfully,

6447 S. East Street Suite C and D, Indianapolis, IN 46227

Jeffrey N. De Wester, M.D.
6447 S. East St., Suite C
Indianapolis, IN 46227

Physician-Patient Private Contract ("Agreement") (Medicare Opt-Out)

Even though you, the patient, and I, the physician, are entering into a private agreement outside of Medicare, because I have opted out of Medicare, Medicare REQUIRES your agreement to the following terms MEDICARE HAS SPECIFIED, before we can proceed. This Agreement protects Medicare from payment responsibility for services you receive directly from me. If requested by Medicare, this Agreement will be provided to resolve any misunderstanding and clarify our intent. This Agreement must be signed before I can see you as a patient. Please review the following and sign this Agreement to confirm your acceptance of the terms of this Agreement:

The undersigned patient / Medicare beneficiary (or the Medicare beneficiary's legal representative) is signing this Private Contract to evidence his or her understanding and agreement regarding payment for any services to be provided by Jeffrey N. De Wester, M.D. ("Physician"). Physician's practice entity is known as DTRC, LLC or Gerald M. De Wester Treatment and Research Center).

Physician hereby certifies that physician is not and has not been excluded from participation in the Medicare program under section 1128, 1156 or 1892 of the Social Security Act.

Physician further certifies that the effective date of Physician's opt-out is July 1, 2014 and the estimated date of expiration of the opt-out period is July 1, 2016, provided that physician may extend the opt-out period further.

By executing this Private Contract, Medicare Beneficiary acknowledges and agrees as follows with respect to all items or services provided by Physician to Medicare beneficiary:

1. That Medicare Beneficiary will not submit a claim, or request Physician to submit a claim, for payment under Medicare, even if such items or services would otherwise be covered under Medicare.

2. That Medicare Beneficiary or the beneficiary's legal representative understand and agree to accept full responsibility for payment in full at the time of service whether Medicare Beneficiary is reimbursed through private insurance or otherwise, for payment for all such items or services.

3. Medicare Beneficiary understands that NO reimbursement can or will be provided by Medicare for such items or services provided by Physician.

4. The Medicare beneficiary or beneficiary's legal representative agrees not to submit a claim to Medicare and not ask the physician to submit a claim to Medicare.

5. That Physician is not limited by Medicare in the amount that he or she may charge Medicare Beneficiary for the items or services provided, and that Medicare Beneficiary will pay Physician's charges in full at time of service.

6. That Medigap plans do not make payments and other Medicare supplemental insurance plans may choose not to make payment, for items or services furnished by Physician.

7. That Medicare Beneficiary has the right to have the items or services sought from Physician to be provided by other physicians or practitioners whose items or services would be covered by Medicare. The beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out of Medicare.

8. That Medicare Beneficiary is not in an emergency or urgent health care situation.

9. That Medicare Beneficiary agrees to reimburse Physician for any costs, collection fees and reasonable attorney's fees that result from violation of this Agreement by Medicare Beneficiary.

10. That Medicare Beneficiary acknowledges a copy of this agreement has been provided to Medicare Beneficiary. This contract will be retained by the physician for the duration of the opt out period. This contract will be made available to Centers for Medicare and Medcaid Services (CMS) upon request.

11. That Medicare Beneficiary signs this Private Contract voluntarily and upon full understanding of its terms.

Date:__________________________

Patient/Medicare Beneficiary
(or Legal Representative)

X______________________________

____
(Printed Name of Medicare Beneficiary)

Date:__________________________

Physician:

X______________________________
Jeffrey N. De Wester, M.D.
DTRC, LLC

The Gerald M. De Wester
Treatment and Research Center
Jeffery N. De Wester, MD

WELCOME TO OUR PRACTICE!

Welcome to the offices of Dr. Jeffrey N. De Wester. Our office is located at 6447 S. East Street Suite D, just south of 465, at the corner of Banta Avenue & East Street (US 31)Office complex is called Banta Trails, on the East side of the street (Forrest Dentistry is also located in the same building).

Please fill out the enclosed forms completely, & return to our office at least two days prior to your appointment (**Note:** ***Please make sure the patient history form is filled out completely, if not we will not be able to see you until it is completed***). Also enclosed you will find information on our office policies and procedures. Please read over the enclosed information and let us know if you have any questions.

Upon arrival for your first appointment, please check in at our front office. We will need to copy your insurance card and driver's license so please bring them with you. If you don't have insurance or don't have your card with you, we require payment in full at the time of your visit. If your insurance has a deductible, you will be required to pay toward the deductible. Co-pay's are due at the time of service. If you are unable to keep a scheduled appointment, we ask that you call the day before to cancel that appointment.

Please bring with you or have your doctor (s) fax to DTRC before your appointment the results of any past cardiac (heart) testing;

Examples:

- Echocardiogram
- Stress Testing
- Cardiac Catheterization
- Heart Scan "Coronary calcium CT Scan
- Carotid ultrasound
- Any cardiac screening performed at a heath fair

We look forward to serving you. If you have any questions please feel free to contact us at (317)807-0247 or 317-735-1809.

Thank you.

The Gerald M. De Wester
Treatment and Research Center
Jeffery N. De Wester, MD

IMPROTANT IMFORMATION FOR ALL PATIENTS!

1. APPOINTMENTS:
   - We will attempt to call you the day before your scheduled appointment. There are times however, when we are unable to make reminder calls. Ultimately, it is your responsibility to know when your appointments are scheduled.
   - We now require that you call one business day prior to your scheduled appointment if you cancel. This allows time to schedule other patients who need to be seen. This policy is necessary in order to free unused appointment times for other patients. Patients who don't call to cancel will be charged a fee proportional to the length / type of appointment. (Non- business days are Wednesdays, Saturdays and Sundays)
   - Due to the number of patients seen each day, WE ARE UNABLE TO SEE PATIENTS WITHOUT AN APPOINTMENT. If you feel you need to see a doctor immediately, please CALL our office before coming in. We will make every effort to schedule you to be seen the same day. If no appointments are available, your doctor will notify you as soon as possible with instructions.
   - If you have an emergency, please go to a facility equipped to handle emergency situations.

   Please keep in mind that there is more involved in seeing a doctor than just "seeing the doctor". Appointments are necessary to insure that every patient who needs to be seen CAN be seen in a timely manner. Remember, if you demand to be seen without an appointment, you make someone else wait past his/her appointment time. Please call before coming in!

2. Prescription refills and/or samples:
   - We are now required by law to send your pellets to your home prior to your appointment please make sure to bring them with you to your appointment if you forget them we will not have supplies on hand. If you need to return home to get them we may require you to reschedule your appointment depending on the patient load that day.
   - We now require 72 hours to fill your prescription and/or sample request. We will no longer call to confirm that you prescriptions have been called in. You will need to call your pharmacy for confirmation.
   - No pain, nerve or sleeping medications will be called in after hours or on weekends, nor will they be called in by a doctor other than the one who originally prescribed them.
   - If you are written a Controlled substance prescription please take special care of it and the medication , if script or medication is lost another script will not be written until the previous script date as expired (this is do to the new federal laws)

- Routine prescriptions are filled during business hours with the exception of surgery day (Non hormone scripts will not be written). The information listed below is required to be left on our prescription phone line in order to process your refill request within 72 hours:

  - Patient's Name, Date of Birth & Phone Number
  - Name of Medication (Spelling), Dosage, & Direction
  - Prescription Number on bottle
  - Pharmacy Phone Number
  - Doctor (s) Name
  - Next Appointment Date

- If you have not been seen by your doctor within the last 6 months, an office visit will be required before a routine refill can be called to a pharmacy.
- Office visit or Teleconference is required before new medications can be prescribed for new illnesses'. There will be a *$15.00 fee* for any refills written without a routine or medication office visit. Be sure to ask for any refills at the time of your appointments, (Reminder non-hormonal scripts will not be written on surgery days).

3. INSURANCE:
   - Co-pays: Co-pays are due at the time of service unless prior arrangements are made with our office.
   - Deductibles: If you have an insurance deductible to meet for the year, you will be asked to pay toward your deductible at each office visit until it has been met.
   - Non Covered items: If your insurance does not cover pellets, pellet procedure and try you will be expected to pay this at the of services.
   - Restrictions: Each patient is responsible to know the restrictions of his/her insurance, such as:
     - **Physicians you're allowed to see**
     - **If there is a special lab to which you must go**
     - **Where your test can be done**
     - **Prior- Authorization**

   You will be responsible for any and all portions of unpaid balance outside of what your insurance pays.

4. MEDICAL RECORDS:
   - If copies of your medical records are required for an appointment with a specialist, we will copy those records; however, you will need to pick them up from our office and take them with you to your appointment. We will no longer fax these records to the specialist. Please check with the specialist's office in advance of your appointment to see if any records or test results will be needed. Please request copies at least 2 days prior to your appointment. Please be aware that if multiple requests are made a fee may be associated with it, if the request is for yourself a fee may apply. Please make sure to ask the front desk prior to having making the request.

5550 South East Street Suite G
Indianapolis, IN 46227
(317)807-0247
Fax (317)882-1415

Acknowledgement of Prescription refills and/ or Samples Protocol

Prescription are written at non-surgical appointments, please advise the Nurse if you need refills and if you are in need of, 30 day or 90 day scripts.

- Any type of controlled substance (i.e. Pain, Sleeping, ED, etc.) will not be called in after hours or on weekends.
- If you have not been seen by the doctor within the last 6 months, an office visit will need to be scheduled before a refill can be called to a pharmacy. (if the scheduled appointment is not kept no further refills will be called in or written until you have been seen by the doctor.
- If seen within the last six months have a follow-up visit schedules, but your medication will run out before this visit, refills will be provided in the amount needed to cover you until your office visit.
- Office visit or Teleconference is required before new medications can be prescribed for "new illnesses' or an illness that a script has not been written for in this calendar year.
- There will be a ***$15.00 fee*** for any refills written without a routine or medication office visit.
- We do not accept phone calls or faxes from pharmacies for script refills.
- We require 72 hours to fill your prescription and/or sample request. We will no longer call to confirm that your prescriptions have been called in. You will need to call your pharmacy for confirmation.
  - Please do not stop by the Nurses station when you are in for your lab appointment.
  - Please do not drop by the office to request refills please call the script line at 317-807-0247 option 2. The information listed below is required to be left on our prescription phone line in order to process your refill request within 72 hours or less:
    - Patient's Name, Date of Birth & Phone Number
    - Name of Medication (Spelling), Dosage, & Direction
    - Prescription Number on bottle
    - Pharmacy Phone Number
    - Doctor (s) Name
    - Next Appointment Date
    - Indicate 30-day or 90 day

Patients Signature ____________________ Date ____________

The Gerald M. DeWester Treatment and Research Center

5550 South East Street Suite G
Indianapolis, IN 46227
(317)807-0247
Fax (317)882-1415

NOTICE OF POSSIBLE DENIAL OF CHARGES BY INSURANCE

Some insurance companies have informed us that certain services done in this office have been deemed not a covered benefit. Subsequently, your insurance company will deny payment for these services. As your physicians, we feel that these are in your best medical interest.

Because of the insurance companies policies on in-office visits/testing/procedures, we are forced to ask our patients to sign the waiver below, which states that should your insurance company not cover the charges outlined below, you agree to be personally and fully responsible for payment not made by your insurance company. The lists below are items outside of the normal NP code 99205 which is standard for the first visit.

Date	Service	CPT Code	Patient Signature
______ Date	**Extended Visit** NP consultation	**99354 $225.00** CPT Code	______ Patient Signature
______ Date	**Extended Visit** No-Face to Face NP Consultation	**99358 $130.00** CPT Code	______ Patient Signature
______ Date	**Extended Visit** Face to Face Every 30 thereafter	**99355 $111.00** CPT Code	______ Patient Signature
______ Date	**Teleconference** 5-10 min	**99441 $50.00** CPT Code	______ Patient Signature
______ Date	**Teleconference** 11-20	**99442 $75.00** CPT Code	______ Patient Signature
______ Date	**Teleconference** 21-30	**99443 $100.00** CPT Code	______ Patient Signature

5550 South East Street Suite G
Indianapolis, IN 46227
(317)807-0247
Fax (317)882-1415

PHONE CONSULTATION INFORMED CONSENT FORM

I ____, have requested to have phone consultations with Dr. Jeffrey De Wester for those visits where it is deemed medically appropriate. I understand that these will be paid for by cash basis as they are an uncovered services by both medical insurers and Medicare. I accept full financial responsibility to pay the fees incurred for such telephone consultations.

________________________________ PATIENT SIGNATURE

________________ DATE

In order to provide maximum service to our patients, we may need to contact you at home.

To insure confidentiality, please indicate how you want to be contacted.

_____ Please call me at this number: ______________________.
You may leave a message.

_____ I DO NOT want a message left; therefore please
follow these arrangements to contact me:
____
____

______________________ Signature

______________________ Date

5550 South East Street Suite G
Indianapolis, IN 46227
(317)807-0247
Fax (317)882-1415

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM.

I,______________________________, have received a copy of Central Indiana Medical Group's Notice of Privacy Practices.

____________________________ ________________

Signature of Patient Date

____________________________ ________________

Witness Signature Date

The Gerald M. DeWester Treatment and Research Center

Patient Name: ____

LAST FIRST MI

AUTHORIZATION FOR MEDICAL, SURGICAL, DIAGNOSITC, AND/OR THERAPEUTIC TREATMENT & RELEASE OF INFORMATION & FINANCIAL ARRANGEMENTS

MEDICAL CONSENT:

Permission is hereby granted to the attending physician and nursing personnel under their supervision to administer such medical and surgical examinations, anesthesia, treatments, and procedures as are deemed necessary for myself and/or the patient named above.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the release of information necessary to substantiate any insurance claims.

FINANCIAL RESPONSIBILITY:

The undersigned accepts full responsibility for the payment of charges not paid by insurance and agrees to notify this office within 10 days of any change of address. The undersigned assumes and agrees to pay for all collection agency fees paid or incurred by us for the collection of the undersigned patient's debt. The undersigned agrees to pay reasonable attorney fees, court fees, and other fees paid to incurred by this office or our collection agency while collection the amount due.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize payment directly to Central Indiana Medical Group from my health insurance. I understand that I am financially responsible for charges not paid by this assignment. This authorization is in effect until rescinded.

Signature: ______________________________ Date: ____________________

MEDICARE PATIENTS:

Name: ______________________________ Medicare# ____________________

I request that payment of authorized Medicare benefits be paid directly to Central Indiana Medical Group for any services furnished to me. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or benefits for related services.

Signature: ______________________________ Date: ____________________

Effective Date of this Notice: April 14, 2003

Gerald M. De Wester, MD
Jeffery N. De Wester, MD
5550 South East Street Suite G
Indianapolis, IN 46227
(317)807-0247
Fax (317)882-1415

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

The Gerald M. De Wester Treatment and Research Center
Drs. Gerald & Jeffery De Wester
5550 S. East St. Suite G
Indianapolis, IN 46227

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment. We may leave a message on your answering machine if we cannot talk to you personally. We may also send you a postcard or letter if you miss an appointment.

5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a relative or guardian may ask that a relative/friend take a patient to the cardiologist's office for treatment. In this example, the relative/friend may have access to this patient's medical information. A custodial parent and non-custodial parent of a child have equal access to the parents' child's health records. This applies generally for patients under the age of 18 provided that the patient is not married or emancipated or for certain circumstances provided for by Indiana State Law. Our practice may not allow a non-custodial parent access to the child's health records if: (1) a court has issued an order that limits the non-custodial parent's access to the child's health records; and (2) the provider has received a copy of the court order or has actual knowledge of the court order.

8. **Disclosures Required By Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for purposes such as:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative,

and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain a court or administrative order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. Health records of a deceased patient may be requested by the personal representative of the patient's estate.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the IIHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the IIHI. We may also release IIHI to the tumor registry at the hospital for cancer patients.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Privacy Officer, The Gerald M. De Wester Treatment and Research Center, 5550 S. East St, Suite G, Indianapolis, IN 46227, (317) 807-0247**, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to: **Privacy Officer, The Gerald M. De Wester Treatment and Research Center, 5550 S. East St. Suite G, Indianapolis, IN 46227, (317) 807-0247.** Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: **Medical Records Clerk, The Gerald M. De Wester Treatment and Research Center, 5550 S. East St. Suite G, Indianapolis, IN 46227, (317) 807-0247**, in order to obtain a copy of your IIHI. Our practice will charge a fee approved by the State of Indiana for the costs of copying, mailing, labor and supplies associated with your request. A copy of the "Charges Permitted for Providing Copies of Medical Records" is available upon request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.

Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Privacy Officer, The Gerald M. De Wester Treatment and Research Center, 5550 S. East St. Suite G, Indianapolis, IN 46227, (317) 807-0247.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures. An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Privacy Officer, The Gerald M. De Wester Treatment and Research Center, 5550 S. East St. Suite G, Indianapolis, IN 46227, (317) 807-0247.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Privacy Officer, The Gerald M. De Wester Treatment and Research Center, 5550 S. East St. Suite G, Indianapolis, IN 46227, (317) 807-0247.**

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Privacy Officer, Privacy Officer, The Gerald M. De Wester Treatment and Research Center, 5550 S. East St. Suite G, Indianapolis, IN 46227, (317) 807-0247.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the purposes described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Privacy Officer, The Gerald M. De Wester Treatment and Research Center, 5550 S. East St. Suite G, Indianapolis, IN 46227, (317) 807-0247.**

2015 PATIENT INFORMATION SHEET

PLEASE PRINT

HOME PHONE______________________ CELL PHONE______________________

PATIENT INFORMATION

THIS FORM MUST BE COMPLETELY FILLED OUT

NAME____ SOC SEC#______________________
(LAST) (FIRST) (MI)

ADDRESS____

CITY______________________ STATE__________ ZIP CODE__________

EMAIL____

Gender ( )M ( )F AGE____BIRTHDAY__________( )SINGLE ( )MARRIED ( )WIDOWED ( )SEPERATED ( ) DIVORCED

PATIENT EMPLOYED BY______________________ OCCUPATION______________________

BUSINESS ADDRESS______________________ BUSINESS PHONE______________________

INCASE OF EMERGENCY WHO SHOULD WE NOTIFY?__________________ PHONE______________

PRIMARY CARE PHYSICIAN

PHYSICIANS NAME____

ADDRESS______________________CITY______________STATE ___ ZIP CODE _____

PHONE: ____

INSURANCE INFORMATION

POLICY HOLDER'S NAME ____
(LAST) (FIRST) (MI)

RELATIONSHIP TO PATIENT______________ BIRTHDATE__________ SOC SEC#______________

ADDRESS (IF DIFFERENT FROM PATIENT'S)______________________ PHONE______________

CITY______________________ STATE______________ ZIP CODE______________

POLICY HOLDER EMPLOYED BY______________________ OCCUPATION______________

PRIMARY INSURANCE______________________ SECONDARY INSURANCE______________________

NAMES OF OTHER DEPENDENTS COVERED UNDER THIS PLAN______________________________

ASSIGNMENT & RELEASE

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH ______________ AND ASSIGN DIRECTLY TO DR De WESTER ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE, I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUMISSION.

______________________ ______________________ ______________
(RESPONSIBLE PARTY'S SIGNATURE) (RELATIONSHIP) (DATE)

Patients Name: ______________________________ Account# ____________________

DTRC
PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES REQUESTED BY THE PRACTICE

By signing this authorization, I authorize DTRC to use and/or disclose certain protected health information (PHI) about me to:

Name: ______________________________ Relationship: ____________________

Address: ____

Phone # ______________________________ Fax# ____________________

This authorization permits Central Indiana Medical Group to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, types of services, level of detail to be released, origin of information, etc. or specify any/all information requested by the party above):

____

____

This information will be used or disclosed for the following purpose:

____

____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire when revoked in writing.

The Practice will ☐ will not ☐ receive payment or other reimbursement from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from Central Indiana Medical Group. In fact, I have the right to refuse to sign this authorization. I also have the right to inspect or copy the information to be used or disclosed. When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the:

Privacy Officer
DTRC
6447 S. East Street Suite C /D
Indianapolis IN 46227

Signed by: ______________________________ ______________________________
Signature of Patient of Legal Guardian — Relationship to Patient

______________________________ ______________________________
Print Name of Patient or Legal Guardian — Date

______________________________ ______________________________
Witness Signature — Print Witness Signature

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION
I reaffirm this authorization:

Date:	Initials:	Date:	Initials:
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________
________	________	________	________
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