



Community
Physicians of Indiana

Lader Internal Medicine

Kenneth Lader, M.D., FACEP

461 Town Center Road
Mooresville, IN 46158
~~317-834-9858 (tel)~~
~~317-834-3290 (fax)~~

Fax Transmission
Confidential Health Information Enclosed

Confidentiality Notice

Health Care Information is personal and sensitive information related to an individual and the individual's care. This information is being faxed to you after appropriate authorization from the patient or under circumstances that don't require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

From: Laura

Date: 7/28/10

Practice Name: Lader Internal Medicine

To: Andrea

Fax:

Number of pages: 1 (including transmission sheet)

Additional comments:

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED**. If you have received this message by error, please notify us immediately and destroy the related message. **THANK YOU!!**



Lader Internal Medicine

Kenneth Lader, M.D., FACEP

461 Town Center Road
Mooresville, IN 46158

~~317-834-9858 (tel)~~

~~317-834-3290 (fax)~~

WELCOME TO LADER INTERNAL MEDICINE

HOW WERE YOU REFERRED TO US?

- | | |
|---------------------------------------|-----|
| ❖ Friend or Family Member | [] |
| ❖ Insurance Company | [] |
| ❖ Emergency Department | [] |
| ❖ Referral from a Physician _____ | [] |
| ❖ Previous Patient of a CPI Physician | [] |
| ❖ Newspaper | [] |
| ❖ Flyer in the Mail | [] |
| ❖ MedCheck | [] |
| ❖ Internet Webpage | [] |
| ❖ Sign on the Building | [] |
| ❖ A Relocation Guide | [] |
| ❖ Welcome Wagon | [] |
| ❖ Community Event/Festival | [] |
| ❖ Health Screening/Health Fair | [] |
| ❖ Other _____ | [] |



Community
Physicians of Indiana

Lader Internal Medicine

Kenneth Lader, M.D., FACEP

461 Town Center Road
Mooresville, IN 46158
317-834-9858 (tel)
317-834-3290 (fax)

Patient Registration Sheet

Patient's Name _____ Birth Date _____

Address _____ City _____ St _____ Zip _____

Home Phone () _____ Cell () _____ Work () _____

Social Security Number _____ Single ___ Married ___ Widow ___ Divorced

Employer _____ Address _____

Spouse's Name _____ Birth Date _____

Spouse's Social Security Number _____ Spouses Employer _____

Responsible Party 18 years or older Relationship _____

Name: _____ SS# _____ Birth Date _____

Address _____ City _____ St _____ Zip _____

Home Phone _____ Cell _____ Work _____

Employer _____

Emergency contact/ Health Care Representative _____

Relationship _____ Phone _____

I request that payment for authorized Medicare and/or private benefits be made to Kenneth S Lader, MD I Authorize any holder of medical or other information about me to be released to the Health Care Financing Administration, its agents, or my private carrier as needed to determine these benefits or any benefits for related services. I request that payment of authorized MediGap benefits be made to Kenneth Lader, MD for any services furnished to me by this physician/supplier. I authorize any holder of medical information about me to be released to _____ (name of insurance co. any information needed To determine these benefits or the benefits payable for related services.

I authorize the office of Kenneth S Lader, MD to release to my referring or subsequent healthcare provider, reports of my medical condition that will assist him or her in my continuing care.

I hereby agree to pay Kenneth S Lader, MD the charges for all medical services rendered. I shall also be responsible for any attorney fees required to collect for these services, court costs, and collection agency fees, to which may be added prejudgment and/or post-judgment interest at the current legal rate.

Signagture _____ Date _____



Community
Physicians of Indiana

Lader Internal Medicine

Kenneth Lader, M.D., FACEP

461 Town Center Road
Mooresville, IN 46158
317-834-9858 (tel)
317-834-3290 (fax)

Medical History

Name _____ DOB _____

Marital Status ___ Spouse Name _____ # of Children ___ Employer _____

Social History:

Tobacco yes ___ no ___ how much per day _____ Illicit drug use yes ___ no ___ how much _____

Passive smoke exposure yes ___ no ___ Caffeine yes ___ no ___ how much _____

Alcohol yes ___ no ___ how much _____ Seat Belt Use percent of time _____

Education level _____ Exercise how much per week _____

HIV or Hepatitis risk yes ___ no ___ Stree level _____

Medications (Use back of sheet if needed)

Allergies _____

Past Medical History (check all that apply)

- Cancer Heart Attack Chronic Pain Kidney Disease Bipolar Disease Throat problem
 Asthma Hypertension Nose/sinus Skin Tags Growth Disorder Autoimmune Disease
 Arthritis Emphysema Tuberculosis Osteoporosis Blood Transfusions High Cholesterol
 Allergies Epilepsy Depression Thyroid Abnormal Bleeding
 Diabetes Moles Skin Disease Hearing Impaired Ear Problems Stroke
 Chronic Headache Thoughts of Suicide

Family History Parents and Siblings Only

Father ___ Alive ___ Deceased Cause of Death _____

Mother ___ Alive ___ Deceased Cause of Death _____

Please check any that apply and indicate who has the problem/disease

- Cancer Heart Disease Lung Problems Osteoporosis Psychological Problems
 Stroke Emphysema Eye Problems Depression Thyroid Disease
 Asthma Allergies Diabetes Arthritis High Cholesterol
 Anemia High Blood Pressure Kidney Disease Substance Abuse

Review of Symptoms

Name: _____ DOB: _____ Date: _____

Please check any of the following symptoms or conditions that you have experienced within the last 2 years.

| General | Vision | ENT | Cardiovascular | Respiratory | Digestive | Genitourinary |
|--|---|--|--|--|---|--|
| <input type="checkbox"/> fevers <input type="checkbox"/> chills <input type="checkbox"/> night sweats <input type="checkbox"/> anorexia <input type="checkbox"/> fatigue | <input type="checkbox"/> blurring <input type="checkbox"/> double vision <input type="checkbox"/> irritation <input type="checkbox"/> discharge from eye <input type="checkbox"/> vision loss <input type="checkbox"/> eye pain <input type="checkbox"/> sensitive to light | <input type="checkbox"/> earache <input type="checkbox"/> ear discharge <input type="checkbox"/> ringing in ears <input type="checkbox"/> hearing loss <input type="checkbox"/> nasal congestion <input type="checkbox"/> nose bleeds <input type="checkbox"/> sore throat <input type="checkbox"/> hoarseness <input type="checkbox"/> trouble swallowing | <input type="checkbox"/> chest pain <input type="checkbox"/> palpitations <input type="checkbox"/> fainting <input type="checkbox"/> short of breath while moving <input type="checkbox"/> pain when breathing <input type="checkbox"/> short of breath while lying down <input type="checkbox"/> swelling in hands and feet | <input type="checkbox"/> cough <input type="checkbox"/> trouble breathing <input type="checkbox"/> excessive mucous <input type="checkbox"/> cough up blood <input type="checkbox"/> wheezing | <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> change in bowel habits <input type="checkbox"/> abdominal pain <input type="checkbox"/> black stools <input type="checkbox"/> bloody stools <input type="checkbox"/> yellow skin or eyes | <input type="checkbox"/> vaginal discharge <input type="checkbox"/> wetting self <input type="checkbox"/> painful urination <input type="checkbox"/> blood in urine <input type="checkbox"/> urinate frequently <input type="checkbox"/> no periods <input type="checkbox"/> heavy periods <input type="checkbox"/> abnormal vaginal bleeding <input type="checkbox"/> pelvic pain |
| Musculoskeletal | Skin | Neurological | Mental Health | Endocrine | Blood/Lymph | Allergy/immune |
| <input type="checkbox"/> back pain <input type="checkbox"/> joint pain <input type="checkbox"/> joint swelling <input type="checkbox"/> muscle cramps <input type="checkbox"/> muscle weakness <input type="checkbox"/> stiffness <input type="checkbox"/> arthritis | <input type="checkbox"/> rash <input type="checkbox"/> itching <input type="checkbox"/> dryness <input type="checkbox"/> suspicious lumps / moles | <input type="checkbox"/> paralysis <input type="checkbox"/> weakness <input type="checkbox"/> numbness / tingling <input type="checkbox"/> seizures <input type="checkbox"/> black outs <input type="checkbox"/> tremors / shaking <input type="checkbox"/> vertigo | <input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> memory loss <input type="checkbox"/> mental disturbance <input type="checkbox"/> thoughts of suicide <input type="checkbox"/> hallucinations <input type="checkbox"/> paranoia | <input type="checkbox"/> cold intolerance <input type="checkbox"/> heat intolerance <input type="checkbox"/> excessive thirst <input type="checkbox"/> eating abnormal amounts of food <input type="checkbox"/> frequent urination <input type="checkbox"/> weight change | <input type="checkbox"/> abnormal bruising <input type="checkbox"/> abnormal bleeding <input type="checkbox"/> swelling under arms, in neck or groin | <input type="checkbox"/> hives <input type="checkbox"/> hay fever <input type="checkbox"/> persistent infection <input type="checkbox"/> HIV exposure |

H.H.S. Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of NOTICE OF PRIVACY PRACTICES:

INITIAL _____

DATE _____

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

INITIAL _____

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INS BENEFITS: I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

INITIAL _____

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician who treats me, to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

INITIAL _____

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

INITIAL _____

PATIENT'S SIGNATURE _____

DATE _____

Parent/Guardian _____

DATE _____

ADVANCED DIRECTIVE

1. Do You Have A Living Will? Yes _____ No _____
A copy may be needed for your chart.
A Copy Was Received By This Office. Date _____

2. Have You Appointed A Health Care Representative? Yes _____ No _____ Read and Sign Below
I give my consent and authorization for this person or persons I list below to act as my Health Care Representative to receive any and all information from my medical records, or discuss any and all aspects of my medical care. I also give consent, and authorization for the person, or persons to be notified any time I have an appointment. I also understand that I may revoke this privilege at any time by submitting my request in writing to this office.
Name of your Health Care Representative _____ Date _____
Name of your Health Care Representative _____ Date _____
Signed By: _____ Date _____
Witnessed By: _____ Date _____

3. Have You Given Anyone Your Power Of Attorney? Yes _____ No _____ Please list below
A copy may be needed for your chart.
A Copy Was Received By This Office. Date _____
Name _____ Relationship _____ Date _____

Release of Protected Health Care Information Via Telephone To Answering Machine, Or Voice Mail
I give my consent and authorization for the Medical, or Billing Staff of my Physician's Office to leave protected Health Care Information about me or for me on my answering machine or voice mail via the telephone at the number I have listed below. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

Number _____

Initial _____



Community Physicians of Indiana

KENNETH LADER, M.D.

461 TOWN CENTER ROAD, MOORESVILLE, TN 46158

OFFICE # (317) 834-9858 FAX# (317) 834-3290

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ SS# _____

Street Address _____

City _____ ST _____ Zip Code _____

Birth Date _____ Phone Number _____

- I agree to the release of health records and/or information as stated below.
- I understand that I may refuse to sign this form and that not signing this form will not affect my services, treatment or payment for services: unless the services are research related and your signature is required so that your results can be used for research.
- I understand that I may see and copy the information described in this form if I ask for it.
- Unless limited below, I understand that this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR Part 2) or State Law (IC 16-39-2) concerning hospitalization or treatment, including but not limited to information regarding alcohol abuse, substance abuse, communicable disease documentation, human immunodeficiency virus (HIV), or mental health treatment or counseling.

I authorize Lader Internal Medicine to release information to:

Name _____ Phone _____

Street Address _____ Fax _____

City _____ ST _____ Zip Code _____

I authorize Lader Internal Medicine to obtain information from:

Name _____ Phone _____

Street Address _____ Fax _____

City _____ ST _____ Zip Code _____

The purpose or need for the disclosure: At the request of the individual Other (Specify) _____

Date (s) of information to be disclosed (please circle) past year, past 2 years, past 3 years, past 4 years, past 5 years, All Records
Other _____ (list)

Information to be disclosed:

Office Notes X-Ray report Labs Emergency Room All Record Other _____

I understand that this authorization is voluntary and that I have the right to revoke it at any time prior to its expiration date by written notification to Lader Internal Medicine. This revocation will not have any effect on the information released pursuant to this Authorization before the revocation. I understand that the information released may be subject to redisclosure by any recipient and no longer protected by federal privacy laws.

The expiration date for this release is 60 days from the signature date.

PLEASE DO NOT FAX RECORDS WITHOUT PRIOR APPROVAL CALL ~~317-834-9858 ext. 6~~

Information to be released Verbally Photocopy Other _____

Signature _____ Date _____

Witness _____ Date _____

Parent/Guardian/Representative Signature _____ Date _____

Legal Authority of Representative _____

Released by _____ Date _____

Copy of Auth. provided by _____ Date _____