



Dr. Ziya Toper, M.D. & Dr. Sibel Toper, M.D.
6301 University Commons, Suite 320 • South Bend, IN 46635

Patient Name Last First Middle Initial Nickname

Social Security # - - Date of Birth / / Age Sex: Male / Female

Address City State Zip

Home () Cell () Work ()

Preferred Contact: (Please Circle) Home / Cell / Work / Other:

Patients Marital Status: (Please Circle) Minor/ Married / Single /Divorced / Separated / Widowed

Primary Language Spoken: (Please Circle) English / Spanish / Other:

Religious Beliefs: Are you a Student?: (Please Circle) Yes / No High School / College

Who may we thank for referring you?: Another Physician: / Internet / Insurance Co. /

Television / Phone book / Hospital: /Other:

Emergency Contact: Phone() Relationship:

Parents Employer: Occupation:

Employer Address: City State Zip

PRIMARY INSURANCE/ADDITIONAL INSURANCE

Name of Policy Holder: Relationship To Patient:

Date of Birth: / / Social Security Number of Policy Holder: - -

Address(if different from patient) City State Zip

Insurance Co. ID# Group#

Is the patient covered by additional insurance? Yes / No

Name of Policy Holder: Relationship To Patient:

Date of Birth: / / Social Security Number of Policy Holder: - -

Address(if different from patient) City State Zip

Insurance Co. ID# Group#

WORKER'S COMPENSATION/LIABILITY

Workman's Comp/Liability Carrier: _____

Billing Address: _____ City _____ State _____ Zip _____

Contact Person _____ Claim# _____ Date Injury ____/____/____

Contact Phone # () _____ Contact Fax # () _____

PARENT(S)/ GUARDIAN INFORMATION

(if patient is a minor)

Name: _____ Relationship _____

Address _____ City _____ State _____ Zip _____

(if different from minor)

NOTICE TO OUR PATIENTS

As required by the HIPAA Privacy Regulations, all patients who received health care service in our office must: Receive the attached "Notice of Privacy Practices" form, and sign the "acknowledgement" form below. A complete list of this policy is available in our office at your request.

Please note that the attached notices are not a consent form. This form must be read in full by the patient and signed before treatment can be provided, the Notice provides each patient with a summary description of how each patient can exercise their rights with regard to this medical information. IN ORDER FOR US TO REMAIN HIPAA COMPLIANT PLEASE LIST ANY PERSON(S) OR COMPANIES THAT YOU GIVE YOUR PERMISSION TO OBTAIN WRITTEN OR VERBAL INFORMATION ON YOUR BEHALF (YOU DO NOT NEED TO LIST OTHER PHYSICIANS OR THE PATIENT):

Name Relationship Phone Number

Name Relationship Phone Number

PEDIATRIC ASSOCIATES OF MICHIANA POLICIES & PROCEDURES

You must allow five to seven business days for completion of all forms. There will be a \$5.00 charge per form. If you need the form filled out immediately there will be an additional \$5.00 per form charge.

Please allow 24 hours for medication refills to be called in. Medication refill requests must be made during normal business hours.

A charge of \$20.00 may be assessed to your account for broken appointments unless 24 hour notice is given. This charge is not billable to insurance companies and must be paid by the responsible party.

ASSIGNMENT & RELEASE

I certify that I, and /or my dependant(s) have insurance coverage with the above named insurance company and assign directly to Pediatric Associates of Michiana and all insurance 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 authorize the use of my signature on all insurance admissions. The above named facility may use my health care information and may disclose such information to the above named insurance company and agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I acknowledge that I have received a current copy of the Privacy Notice. I have also acknowledged that I have read and understand all other policies and agree to the terms set above.

Signature of patient/guardian/personal representative

Date

