UNITED STEELWORKERS
USW
UNITY AND STRENGTH FOR WORKERS

**Mail Forms to:**
**Steelworkers Health and Welfare Fund**
**60 Blvd of the Allies, Suite 700**
**Pittsburgh, PA 15222**
**Fax to: 412-562-2276**
**Email to: arcelormittalhai@gmail.com**

ArcelorMittal

# VERIFICATION FORM FOR THE 2020 USW-ARCELORMITTAL HEALTH AWARENESS INITIATIVE

- Form to be filled out by your healthcare provider to verify that you or your spouse, if applicable, completed the Wellness Examination **from 10/1/2019 – 9/30/2020.** Separate forms are required for you and your spouse, if applicable.
- **In order to meet the 2020 Health Awareness Initiative requirement:**
  **(1) It is mandatory that you and your spouse, if applicable, submit a completed verification form, and**
  **(2) The completed form must be submitted by 11/15/2020.**

## *Section 1: Completed by Employee, Retiree or Surviving Spouse*

Check One: ☐ Active Employee ☐ Non-Medicare Retiree, Medicare Retiree for Non-Medicare Spouse, or Surviving Spouse

***Employee/Retiree:***_____
Last Name First Name M.I. Date of Birth (mm/dd/yyyy)

**Email**: _____ **Phone #** (___) _____

**Insurance Card ID#** (Numeric Portion Only) ☐☐☐☐☐☐☐☐☐☐☐☐

**Home Address**: _____
Street City State Zip

**Verification is for**: ☐ Employee, Retiree or Surviving Spouse ☐ Spouse covered through my ArcelorMittal Healthcare Plan

**If Verification Form is for your Spouse**, complete:

*Spouse:* _____
Last Name First Name M.I. Date of Birth (mm/dd/yyyy)

_____ _____
**Employee/Retiree Signature** **Date**

_____ _____
**Spouse Signature (only if spouse verification)** **Date**

## *Section 2: Completed by Healthcare Provider**

**Date of Service**_____

The above named patient was seen in my office on the date of service listed. I completed the examinations check marked below.

(**Do <u>not</u> provide examination results**.)

| | **<u>Check the box if completed on Date of Service</u>** |
|---|---|
| ***Height*** | ☐ |
| ***Weight*** | ☐ |
| ***Blood Pressure*** | ☐ |
| ***Discussion of appropriate recommended exams, screenings and procedures*** | ☐ |

***Provider is not liable if patient does not follow recommendations.***

**Healthcare Provider Name** _____ **Phone #**_____

**Healthcare Provider Signature**_____

**Date Signed**_____ *If you have an office stamp, please apply here:*

***Attention Provider**

***<u>Work Physicals</u>*: A Work Physical does not qualify as a wellness exam.**

***<u>Preventive Testing</u>*: When ordering preventive testing for your patient, please refer to the *Highmark BCBS Preventative Schedule* for covered testing when tests are ordered and coded as preventive/screening. <u>Tests not included within this schedule will not be covered without a diagnosis code other than "routine", and patient could be responsible for the entire charge.</u> Tests ordered and coded for diagnostic purposes will be processed under the diagnostic benefit, and medical policy guidelines will be used in determining benefit and payment.**

Indiana Surgical Associates P.C.

# Patient Registration Form

## Patient Information

**Patient Information: (PLEASE FILL OUT ALL SECTIONS BELOW)**

| | | | |
|---|---|---|---|
| Last Name: | First Name: | MI: | Previous Name (if applicable) |
| Mailing Address: | | | Sex: ❑ Male ❑ Female |
| Home Phone: | Cell Phone: | Work Phone: | |
| Social Security #: | Date of Birth: | Referring Physician: | Primary Physician: |
| Email Address: | | Marital Status: ☐ Married ☐ Divorced ☐ Legally Seperated ☐ Single ☐ Widowed ☐ Partner | |
| Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military ☐ F/T Student ☐ P/T Student | | Employer Name: | |
| Pereferred Pharmacy & Location: | Preferred Language (please select one): ☐ English ☐ Spanish ☐ Other (please list): ☐ Sign Language ☐ Chinese | | |
| Emergency Contact Name: | Emergency Contact Phone #: | | |
| Emergency Contact Address: | | Relationship to Patient: | |

**Additional Information:**

**Race:** ☐ White ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Hispanic ☐ American Indian or Alaska Native ☐ Asian ☐ Decline to Specify

**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

## Responsible Party

**Responsible Party:** *If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor*

☐ **PUT AN "X" IN THIS BOX IF INFORMATION IS SAME AS PATIENT**

| | | |
|---|---|---|
| Last Name: | First Name: | |
| Date of Birth: | Social Security #: | Phone: |
| Address of Person Responsible: | | Relationship to Patient: |

## Insurance Information

| Primary Medical Insurance | Secondary Medical Insurance |
|---|---|
| Insurance Co. Name: | Insurance Co. Name: |
| Policy Holder Name: | Policy Holder Name: |
| Policy #: | Policy #: |
| Group ID: | Group ID: |
| Policy Holder's Date of Birth: | Policy Holder's Date of Birth: |
| Policy Holder's Social Security #: | Policy Holder's Social Security #: |
| Patient Relationship to Policy Holder: | Patient Relationship to Policy Holder: |

## Communication Preferences

**Communication with Others:** *These communications may include information such as test results, medications, appointments, instructions regarding treatments, and billing information.*

Please check one of the boxes below:

☐ **YES**, you may share my health information with the following individuals *(list names)*:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

☐ **NO**, I prefer that my doctor or staff speak to only myself, personally, regarding any medical information.

**Message Preferences:** *These messages may include information such as test results, medications, appointments, instructions regarding treatments, and billing information.*

Please check one of the boxes below:

☐ **YES**, you may leave messages on my answering machine or voicemail: ☐ at Home ☐ on Cell Phone ☐ at Work

☐ **NO**, Please do not leave messages on my answering machine or voicemail.

**Signature of Patient or Guardian:** X _____ **Date:** _____

Indiana Surgical Associates P.C.

# PATIENT CONSENT, ACKNOWLEDGMENT, AND AUTHORIZATION FORM

**RELEASE OF MEDICAL RECORD:**
In order to ensure proper follow-up and continuity of care, I hereby authorize all physicians, hospitals and other medical facilities to release to Indiana Surgical Associates, my medical history, laboratory reports, x-rays, films, and any other material regarding medical consultations I received.

**INSURANCE AUTHORIZATION/ASSIGNMENT RELEASE:**
I request that payment of authorized medical benefits be made to Indiana Surgical Associates for any services provided to me. This assignment of benefits includes Medicare, state medical assisted agency programs, commercial insurance, managed care plans, and any third party payer benefits that I may have. I authorize the use of this signature on all my insurance claim submissions.

I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information required to determine these benefits for related services.

I authorize a copy of this authorization to be used in place of the original.

**FINANCIAL RESPONSIBILITY:**
I am responsible for all the financial obligations of health services, and for the reimbursement and payment of claims from my insurance company. I understand that I am responsible for any amount not covered by insurance. I also understand that if a payment becomes more than 90 days past due, I will be responsible for the balance due on my account as well as any and all reasonable attorney fees and costs of collections in the event of default.

**ELECTRONIC HEALTH RECORD ACCESS/COMMUNICATION INFORMED CONSENT:**
I hereby request access to Indiana Surgical Associate's (ISA) Patient Portal and understand that in order to gain access to ISA Patient Portal I will be given a confidential password. I agree to keep it confidential and not share it with anyone else. I understand that my use of ISA Patient Portal is subject to certain terms and conditions. I agree to review ISA Patient Portal terms and conditions before accessing ISA Patient Portal and further agree that by accessing ISA Patient Portal I am agreeing to abide by the ISA Patient Portal terms and conditions.

I agree to abide by the guidelines for the ISA Patient Portal electronic communication, as outlined below. ISA Patient Portal is not intended for critical or time sensitive communication. I understand that I am to contact the hospital, office, or physician directly for any urgent or emergent situations. My failure to adhere to the following guidelines may result in termination of the ISA Patient Portal access. When using ISA Patient Portal I agree to never use ISA Patient Portal to communicate information related to behavioral/mental health, chemical dependence, such as alcohol and substance abuse or workers' compensation injuries or disabilities.

I understand that the hospital, office, or provider or a designated staff member will maintain certain activities with ISA Patient Portal as part of the practice medical record, use reasonable and appropriate security practices to protect electronic patient information and prevent unauthorized access (password protection, encryption, proxy authorizations, etc.) and share ISA Patient Portal communications with hospital or office staff and other healthcare providers as needed.

I understand that e-mail is not a confidential means of communication. I agree to waive any rights that I may have against Indiana Surgical Associates, P.C., any affiliated organization, or physician, or the supplier or operator of ISA Patient Portal, for any loss of information due to technical failures and/or unintended breach of confidentiality, due to unauthorized access to my information, as a result of my decision to communicate with my physician in this manner.

**RECEIPT OF NOTICE OF PRIVACY PRACTICES:**
I have received the Notice of Privacy Practices from Indiana Surgical Associates, P.C.

_____ _____
Patient Name (Print) Patient Date of Birth

_____ _____
Patient/Guardian Signature Today's Date

# Indiana Surgical Associates P.C.
# NOTICE OF PRIVACY PRACTICES

*EFFECTIVE DATE: January 1, 2017*

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

**YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.**

Your health record is the physical property of Indiana Surgical Associates, P.C. The information contained in the record, however, belongs to you. You have the right to:

A. Request a restriction or limitation on the medical information we use or disclose about you for your treatment, payment or health care operations. For example, you may request that a particular procedure be kept confidential and not shared with other providers. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend or when we notify a family member, personal representative or other person responsible for your care to inform them of your location and general condition. We are not required to agree to your requested restrictions. If we disagree, we will comply with your request unless the information is needed to provide you emergency treatment.

B. Obtain a copy of this Notice by requesting one from the Indiana Surgical Associates, P.C.

C. Inspect and obtain a copy of your health care record by submitting a request in writing to Indiana Surgical Associates, P.C.

D. Amend your healthcare record if you feel that medical information that we have about you is incorrect or incomplete by requesting, in writing, that an amendment be made. You must provide a reason that supports your request.

E. Obtain a report of all of the disclosures of your health information that we have made.

F. Request that we communicate with you about your medical information in a certain way or at a certain location within reasonable time limits.

G Revoke your authorization to use and disclose medical information about you, except to the extent that we already used or disclosed your medical information.

**OUR RESPONSIBILITES REGARDING YOUR MEDICAL INFORMATION**

We are required by law to:

A. Maintain the privacy of your health information.

B. Provide you with this Notice, which describes our legal duties and privacy practices with respect to information we collect about you and a revised copy of the Notice if it is amended or otherwise changes.

C. Abide by the terms of this Notice.

D. Notify you if we are unable to agree to a requested restriction.

E. Accommodate reasonable requests that you have made to have us communicate your health information to you in a certain way or at a certain location.

WE RESERVE THE RIGHT TO CHANGE THIS NOTICE. We reserve the right to make the revised and changed notice effective for medical information that we already have about you, as well as any information we receive in the future. We will post a copy of the current notice in the Indiana Surgical Associates, P.C. office. The notice will contain the effective date on the first page. Each time you register at Indiana Surgical Associates, P.C. for health care services, we will offer you a copy of the current Notice in effect.