CLOVIS E MANLEY, MD LLC
4943 Rosebud Lane
Newburgh, IN 47630

PATIENT DEMOGRAPHIC FORM **Please present your driver's license or other photo ID, most recent insurance card(s) and copay if applicable.**

Please PRINT

PATIENT INFORMATION

Last Name:_____ **First Name**:_____ **MI**:_____

Date of Birth:_____ **Social Security Number**:_____ **Gender**: ☐ Male ☐ Female

Address:_____ **City**:_____ **State**:_____ **Zip**:_____

Cell Phone #:(_____)_____ **Home Phone #**:(_____)_____ **Email Address**:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment Status: ☐ Employed Full-Time ☐ Employed Part-Time ☐ Self Employed ☐ Not Employed ☐ Disabled ☐ Retired ☐ Active Duty Military

Employer Name: _____ **Phone #**:(_____)_____ **Occupation**: _____

EMERGENCY CONTACT

Name:_____ **Phone #**:(_____)_____ **Relationship to Patient**:_____

PRIMARY INSURANCE

Insurance Name:_____ **Policy/ID #**:_____ **Effective Date**:_____

Policy Holder's Relationship to Patient: ☐ Self **(DO NOT complete shaded section below)** ☐ Spouse ☐ Parent ☐ Other **(specify)**:_____

Name of Policy Holder:_____ **DOB**:_____ **SSN #**:_____

Address (if different than the patient):_____ Phone #:(_____)_____

SECONDARY INSURANCE (if applicable)

Insurance Name:_____ **Policy/ID #**:_____ **Effective Date**:_____

Policy Holder's Relationship to Patient: ☐ Self **(DO NOT complete shaded section below)** ☐ Spouse ☐ Parent ☐ Other **(specify)**:_____

Name of Policy Holder:_____ **DOB**:_____ **SSN #**:_____

Address (if different than the patient):_____ Phone #:(_____)_____

I certify the above information is correct to the best of my knowledge.

Signature:_____ **Date**: _____

Verified Date/Initials _____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____
_____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____

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Patient's Name_____ **DOB** _____ **Date** _____

AUTHORIZATIONS, ASSIGNMENT OF BENEFITS, FEES AND PRIVACY NOTICE

1. Treatment authorization. I expressly authorize this practice to provide me with reasonable and proper care by the standard of care in the community.

2. Medicare lifetime signature on file (applies to Medicare patients only). I request payment of authorized Medicare benefits be made to Clovis E. Manley, MD, LLC for any services furnished to me by this practice. I authorize any holder of medical information about me to release required information to the Center for Medicare and Medicaid Services (CMS) and its agents as needed to determine benefits and payment for benefits for services rendered. Our office accepts assignment on fees for our Medicare patients. We will submit your Medicare claims to CMS for you.

3. Assignment of benefits. I request payment of authorized medical insurance benefits be made on my behalf to Clovis E. Manley, MD, LLC. I understand that the office does not accept all forms of insurance. I understand the office will file my insurance claim to accepted insurance plans as a courtesy to me. I am responsible for payment of co-pays, coinsurance, and deductibles for covered services. Services that are not covered by insurance are my responsibility and I agree to pay in full. I authorize the release of my medical information needed to process my insurance claims.

4. Non-acceptance of Medicaid. I understand that Clovis E. Manley, MD LLC and its business entities do not accept Medicaid benefits or Medicaid-funded insurance plans. I understand that my medical claims will not be filed to Medicaid for processing.

5. Insurance cards. I agree to inform the office of any changes in my insurance coverage in advance of obtaining any additional services. I will bring my insurance card to every visit.

6. Contact information. I agree to inform the office of any changes in my contact information, including name, phone number, and mailing address.

7. Record copying fee. I understand I have a right to the information in my medical records, but the original records belong to the practice. I understand it is expensive and time consuming to copy medical records. I understand that a reasonable copying fee will be charged anytime I request a copy of my records or transfer my records to another provider. However, **I will not be charged** for: (1) copies of recent lab/imaging tests, (2) records sent to a specialist that the office refers me to, or (3) a copy of my most recent office visit.

8. Missed appointment fee. I understand my credit card will be placed on file to hold my appointment or procedure time. **My credit card will not be charged unless**: I no show or fail to cancel or reschedule within 24 hours. A missed appointment fee is $50.00. A missed procedure fee is $100.00.

9. Collection fees. I agree that if any unpaid balance is assigned to a third-party collection agency for collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of 33% will be added to my account. I agree to pay any attorney fees or court costs incurred in the course of the collection of my fees. I agree to pay pre-judgment and/or post judgment interest on any overdue balance at the current legal rate.

10. Notice of AIAssisted Documentation. Clovis E. Manley, MD, LLC uses an AIassisted clinical documentation tool ("AI scribe") to help create medical notes during some office visits. This technology processes spoken clinical conversations solely for documentation purposes and does not make medical decisions or replace your provider's judgment. All notes are reviewed, edited and finalized by your provider. Any protected health information is handled in compliance with HIPAA and the AI vendor operates as a HIPAA-compliant business associate of the practice. Audio is not used for marketing or AI training and is not retained beyond what is necessary to generate the note. Indiana law permits audio recording with the consent of at least one party. By continuing with a visit that uses AI scribing you acknowledge this use. If you prefer not to have AI-assisted documentation used during your visit, please inform the staff – your care will not be affected and an alternative documentation method will be used.

11. Privacy policy. I received a copy of the Notice of Privacy Practices for Clovis E. Manley, MD, LLC.

Signature _____