Indiana Health GROUP

NEOSSIA PATIENT REFERRAL

PATIENT NAME:

LAST:_____ FIRST:_____ MI:____ NICKNAME: _____

DATE OF BIRTH: _____/_____/_____ AGE: _____ SEX: MALE / FEMALE

(Not required if patient is a minor) SSN: _____ OR DRIVERS LICENSE NUMBER: _____

EMAIL ADDRESS: _____

STREET ADDRESS: _____ APT NUMBER: _____

CITY: _____ STATE: _____ ZIP: _____

*Primary Telephone: _____ Secondary Telephone: _____

** You will receive a courtesy appointment reminder call at your primary number unless you notify our staff otherwise.*

PARENT / GUARDIAN INFORMATION

NAME: _____ DATE OF BIRTH: _____

SSN: _____ OR DRIVERS LICENSE NUMBER: _____

ADDRESS: _____

Primary Telephone: _____ Secondary Telephone: _____

NEOSSIA REFERRAL / AUTHORIZATION

Name of Neossia Staff Making Referral: _____

Primary Telephone: _____ Email Address: _____

I, _____, an authorized representative of Neossia, Inc.:
(printed name)

- Authorize Indiana Health Group to run the Neossia credit card on file for all charges incurred for above patient including but not limited to initial exam = $255.00, medication management appointments and telephone consults = $151.00.
- Appointments missed or not cancelled with at least a 24-hour notice will be charged full fee according to the type of appointment that was scheduled. *It is the responsibility of Neossia to ensure patient has a valid credit card on file to cover failed appointments. Neossia is ultimately responsible for all charges incurred if patient card is not on file or valid.
- Agree to assist the patient in completing the required registration forms prior to their scheduled visit at IHG. Required Forms: *Release of Information and New Patient Registration including signature forms.*
- Understand that the initial exam visit must be face-to-face with the physician.
- Responsible for notifying IHG when Neossia is no longer financially responsible for services.

Neossia Authorized Signature _____ Date: _____

Patient / Legal Guardian: [ ] I understand that I am responsible for missed appointments or appointments not cancelled with at least a 24-hour notice. I have provided a valid credit card and authorize IHG to charge this card for all failed appointments.

Patient / Legal Guardian Signature: _____ Date: _____

[ ] Neossia, Inc will no longer be financially responsible for services rendered.

Signature: _____ Effective upon submission date of email/fax.

Please email form to newpatients@indianahealthgroup.com or fax to 317.581.3918.