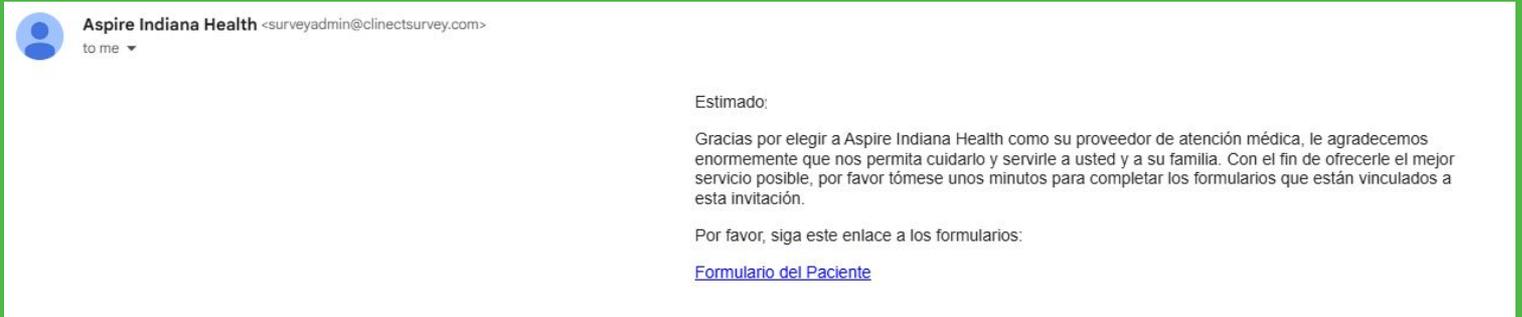


Cuando programe una cita con Aspire, recibirá un correo electrónico solicitándole que complete su documentación de registro en línea para ahorrar tiempo.



Cuando haga clic en el enlace, se le pedirá que inicie sesión con la primera inicial de su apellido y su fecha de nacimiento.



English | Español

Primera letra del apellido **Necesario**

Fecha de Nacimiento **Necesario**

Mes

Día

Año

10

22

2024

Enviar

Puede completar los formularios en su computadora o en su dispositivo móvil.



Aspire Indiana Health

English | Español

Patient Registration Additional Demographics Treatment Consent Release of Information Treatment Plan Review Attribution Health History

Patient Registration

Aspire Indiana Health

First Name: [Text] Last Name: [Text]

Gender: [Dropdown] Sex: [Dropdown]

Date of Birth: [Text] Day: [Text] Year: [Text]

Height: [Text] Weight: [Text]

Medical History

Aspire Indiana Health

English | Español

Health History Form

This consent on this form will help your health care provider understand your medical history and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details please approximate. We ask you to use English. All questions contained in this questionnaire and OPTIONAL ADD-ONS WILL BE STRICTLY CONFIDENTIAL.

What reason for today's visit?

Aspire Indiana Health

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Treatment Consent Release of Information Treatment Plan Review Attribution Health History

Patient Consent for Treatment and Payment Responsibility

I, the below named patient, hereby consent to receive evaluation and/or treatment by Aspire Indiana. I understand that such evaluation and treatment may consist of psychiatric, psychological, psychological, medical and primary health evaluations, medication, psychotherapy, and other modes of treatment available and subject to my needs including hospitalization. If required, I understand in order to be seen for additional services I may provide leave services or other accommodations for employees at the time requested. I am responsible for the cost of the testing and other expenses and/or a co-payment for services and will be responsible for any charges incurred. I also understand that this consent does not waive my civil rights and reserve the right to decide treatment against medical advice.

I understand that mental health services will be provided by a behavioral health professional directly supervised by a qualified provider within the scope of licensure, certification and training. I understand that emergency health services will be provided by a primary care health professional directly supervised by a qualified provider within the scope of licensure, certification and training. I am aware that the practice of medicine and other health care professions is not an exact science and I acknowledge that no guarantee has been made to me as to the results of any treatment, examination, procedure or other services provided by Aspire.

I understand that the Aspire Indiana Privacy Practices, a copy of my rights as a patient, statement on Confidentiality of Alcohol and Drug Abuse Client Records, Tobacco Use Information and DNA Information and submission information are available to me in paper form in Aspire offices, Aspire's website, or I may request copies to be mailed to me. All have been reviewed to me and I understand that they cover my classification at any time. I have the right to request to complete an Advance Directive or Psychiatric Advance Directive.

In order to provide the most consistent and accessible services to the customers, and to help us meet the regulatory requirements of our services, Aspire offers, directly or through third party products to implement and enhance our services including Tele-Health. Each product or service is provided for compliance with various requirements for safety and security of Protected Health Information. These services may be associated with using internet based services which will be required to use internet you choose to register for any particular service.

I understand and agree that failure to provide accurately or false insurance information or the true or my government may result in me being responsible for payment. The Ability to Scan Document that Aspire offers will be applied to my account as long as I provide income verification within 30 days, whether I have insurance coverage or not. Income verification will take place if I have changes in my income status at every 30 months.

Aspire or its related company or their agents directly to Aspire Indiana for the cost of services. Aspire Indiana Indiana will bill my insurance company on file and release all information necessary to process claims for any and all the services that I may receive including substance abuse screening, drug and alcohol testing information, HMO/DCO and other insurance related information.

I understand that the consent that I am giving to Aspire Indiana is not only for Aspire Indiana and any services that become subsequent, that I shall be obligated to Aspire Indiana not only for the value of those services, but also for payment of all reasonable attorney fees incurred by and cost associated with Aspire Indiana's collection of such delinquent amounts.

This release may be revoked by me in writing and further disclosure will not occur, except to the extent that Aspire Indiana has already acted in reliance on it. At that point I will be responsible for any costs to services that incur charges indicated on this form. This release will expire when all issues being billed have been resolved by Aspire Indiana. Other release termination date: 12/31/2025.

Patient Acknowledgment and Confirmation

- I understand that I am giving consent for treatment
- I understand my rights to the above financial and payment obligation
- I understand that I will not be eligible for income based payment eligibility for staying for 30 days.

Relationship to select (Patient): [Dropdown]

By signing your name, you are electronically signing this form. This acknowledgment and understanding that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.

Name in legal form: [Text] Aspire Indiana

Consent Registration

Aspire Indiana Health

English | Español

Past Medical History

#	ICD9	ICD10	ICD9-CM	ICD10-CM
1	300.00	Anxiety Disorder		F41.00
2	600.00	Alcohol Disorder		F10.00
3	250.00	Diabetes		E11.00
4	290.00	Depression		F32.00
5	250.00	Diabetes		E11.00
6	250.00	Diabetes		E11.00
7	250.00	Diabetes		E11.00
8	250.00	Diabetes		E11.00
9	250.00	Diabetes		E11.00
10	250.00	Diabetes		E11.00
11	250.00	Diabetes		E11.00
12	250.00	Diabetes		E11.00
13	250.00	Diabetes		E11.00
14	250.00	Diabetes		E11.00
15	250.00	Diabetes		E11.00
16	250.00	Diabetes		E11.00
17	250.00	Diabetes		E11.00
18	250.00	Diabetes		E11.00
19	250.00	Diabetes		E11.00
20	250.00	Diabetes		E11.00
21	250.00	Diabetes		E11.00
22	250.00	Diabetes		E11.00
23	250.00	Diabetes		E11.00
24	250.00	Diabetes		E11.00
25	250.00	Diabetes		E11.00
26	250.00	Diabetes		E11.00
27	250.00	Diabetes		E11.00
28	250.00	Diabetes		E11.00
29	250.00	Diabetes		E11.00
30	250.00	Diabetes		E11.00
31	250.00	Diabetes		E11.00
32	250.00	Diabetes		E11.00
33	250.00	Diabetes		E11.00
34	250.00	Diabetes		E11.00
35	250.00	Diabetes		E11.00
36	250.00	Diabetes		E11.00
37	250.00	Diabetes		E11.00
38	250.00	Diabetes		E11.00
39	250.00	Diabetes		E11.00
40	250.00	Diabetes		E11.00
41	250.00	Diabetes		E11.00
42	250.00	Diabetes		E11.00
43	250.00	Diabetes		E11.00
44	250.00	Diabetes		E11.00
45	250.00	Diabetes		E11.00
46	250.00	Diabetes		E11.00
47	250.00	Diabetes		E11.00
48	250.00	Diabetes		E11.00
49	250.00	Diabetes		E11.00
50	250.00	Diabetes		E11.00
51	250.00	Diabetes		E11.00
52	250.00	Diabetes		E11.00
53	250.00	Diabetes		E11.00
54	250.00	Diabetes		E11.00
55	250.00	Diabetes		E11.00
56	250.00	Diabetes		E11.00
57	250.00	Diabetes		E11.00
58	250.00	Diabetes		E11.00
59	250.00	Diabetes		E11.00
60	250.00	Diabetes		E11.00
61	250.00	Diabetes		E11.00
62	250.00	Diabetes		E11.00
63	250.00	Diabetes		E11.00
64	250.00	Diabetes		E11.00
65	250.00	Diabetes		E11.00
66	250.00	Diabetes		E11.00
67	250.00	Diabetes		E11.00
68	250.00	Diabetes		E11.00
69	250.00	Diabetes		E11.00
70	250.00	Diabetes		E11.00
71	250.00	Diabetes		E11.00
72	250.00	Diabetes		E11.00
73	250.00	Diabetes		E11.00
74	250.00	Diabetes		E11.00
75	250.00	Diabetes		E11.00
76	250.00	Diabetes		E11.00
77	250.00	Diabetes		E11.00
78	250.00	Diabetes		E11.00
79	250.00	Diabetes		E11.00
80	250.00	Diabetes		E11.00
81	250.00	Diabetes		E11.00
82	250.00	Diabetes		E11.00
83	250.00	Diabetes		E11.00
84	250.00	Diabetes		E11.00
85	250.00	Diabetes		E11.00
86	250.00	Diabetes		E11.00
87	250.00	Diabetes		E11.00
88	250.00	Diabetes		E11.00
89	250.00	Diabetes		E11.00
90	250.00	Diabetes		E11.00
91	250.00	Diabetes		E11.00
92	250.00	Diabetes		E11.00
93	250.00	Diabetes		E11.00
94	250.00	Diabetes		E11.00
95	250.00	Diabetes		E11.00
96	250.00	Diabetes		E11.00
97	250.00	Diabetes		E11.00
98	250.00	Diabetes		E11.00
99	250.00	Diabetes		E11.00
100	250.00	Diabetes		E11.00

Aspire Indiana Health

English | Español

Past Surgical History

Aspire Indiana Health

English | Español

Cuando haya completado su paquete de documentación solicitada, verá una página de finalización:



Gracias,

Sus formularios son completo. Por favor, devuelva la tableta al frente. escritorio y un miembro de nuestro personal estará con usted en breve.

