



When you get scheduled for an appointment with Aspire, you'll receive an email prompting you to fill out your registration paperwork online to save time.

Forms from Aspire Indiana Health

Aspire Indiana Health <surveyadmin@clinectsurvey.com>

to me ▾

Wed, May 24, 12:29 PM

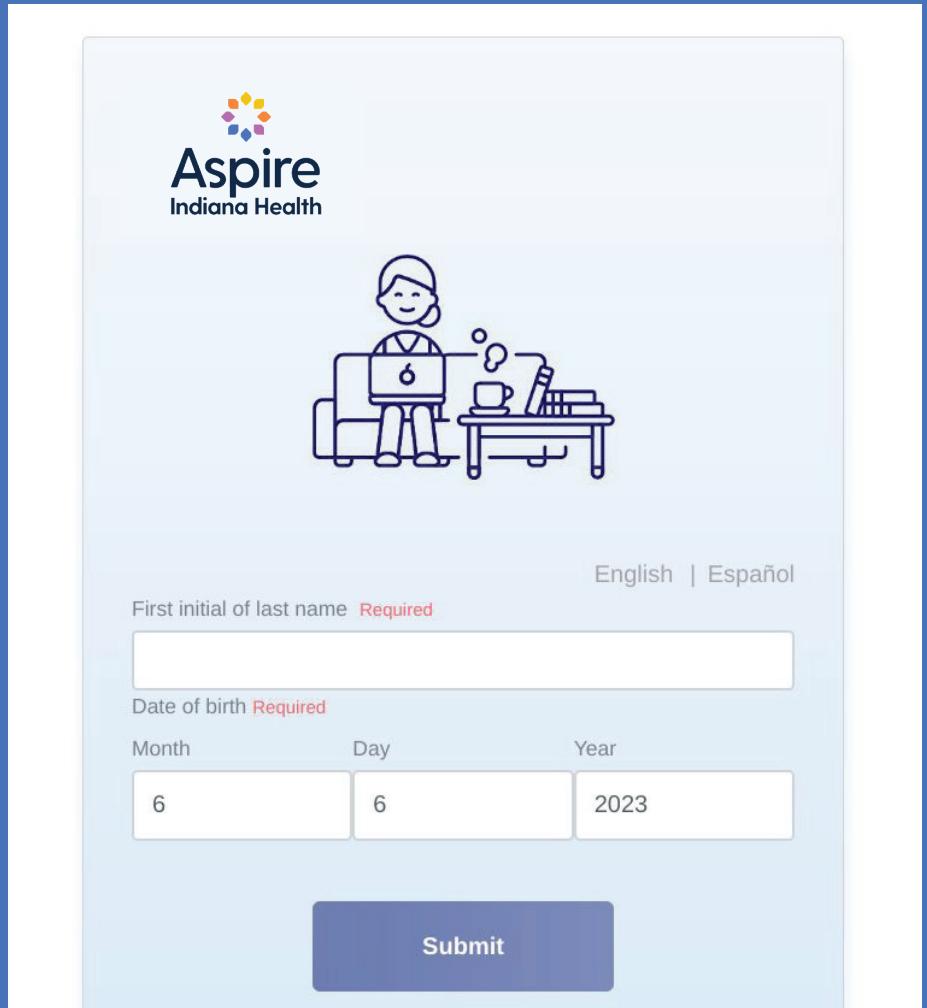
Dear [REDACTED],

Thank you for choosing Aspire Indiana Health as your healthcare provider, we greatly appreciate you allowing us to care for and serve you and your family. In order to provide you with the best service possible, please take a few moments to complete the **forms** that are linked to this invitation.

Please follow this link to your **forms: Patient Forms**

CONFIDENTIALITY NOTICE: The information contained in this transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email and destroy all copies of the original message.

When you click on the link, you'll be prompted to login with the first initial of your last name and your Date of Birth.



The image shows the login page for Aspire Indiana Health. The page has a light blue header and a white main content area. At the top left is the Aspire Indiana Health logo, which includes a stylized sunburst icon above the text "Aspire" and "Indiana Health". Below the logo is a line drawing of a person sitting on a couch, facing a laptop, with a coffee cup and books on a nearby table. At the bottom of the page are language selection links for "English | Español". The main form area contains fields for "First initial of last name" (marked as required) and "Date of birth" (also marked as required). The date of birth fields are labeled "Month", "Day", and "Year", with the value "6" entered for each. A large blue "Submit" button is located at the bottom of the form.

Aspire
Indiana Health



English | Español

First initial of last name Required

Date of birth Required

Month	Day	Year
6	6	2023

Submit

Patient Registration

Aspire Indiana Health

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

Patient Registration

Aspire Indiana Health

Health History Form

What seems on the form will help your health care provider better understand your medical history, conditions, if you are comfortable with very limited, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. All questions contained in this questionnaire are optional and will be kept strictly confidential.

What seems on the form will help your health care provider better understand your medical history, conditions, if you are comfortable with very limited, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. All questions contained in this questionnaire are optional and will be kept strictly confidential.

Patient Consent for Treatment and Payment Responsibility

Aspire Indiana Health

Treatment Consent Release of Information Treatment Plan Review/Attention Health History

Patient Consent for Treatment and Payment Responsibility

I, **First Name**, hereby consent to receive evaluation and/or treatment by Aspire Indiana. I understand that treatment may be provided by a primary care health professional, physician, physician's assistant, medical and primary health evaluations, medication, psychotherapy, and other modes of treatment available and related to my needs including hospitalization. I understand in order to be safe for additional services, I must provide health history or some specimens for analysis. I understand that my personal information will be maintained only by claim number and that name. I also understand that this consent does not waive my rights to decline treatment by medical doctors.

I understand that medical health services will be provided by a qualified provider within the scope of licensure, certification and licensing.

I understand that integrated health services will be provided by a primary care health professional directly supervised by a qualified provider within the scope of licensure, certification and licensing. I am aware that the practice of medicine and other health care professions is not an exact science and I acknowledge that no guarantees have been made to me as to the results of any treatment.

I understand that the Aspire Notice of Privacy Practices, a copy of my rights as a patient, on Confidentiality of Medical and Drug Abuse Client Records, Telecommunications and DHSS registration and submission information are available to me in paper form in Aspire offices, via Aspire's website, or may request copies to be made to me. All that has been explained to me and I understand that I may withdraw my dissatisfaction at any time. I have the right to request to complete an Advisor Directive or Opt-Out Directive.

In order to provide the most efficient and accessible services to our customers and to help us meet the regulatory requirements of our service, we may collect, use, store and disclose any personal information that we reasonably believe is necessary to provide services to you or to protect the rights and property of Aspire or its customers. There are certain risks associated with using internet based services which will be explained to you should you choose to register for any particular service.

I understand and agree that failure to provide accurate or up to date insurance information at the time of my appointment may result in me being responsible for payment. The Sliding Fee Scale. This form is valid for 30 days from the date it is signed. 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 or every 32 months.

I authorize my insurance company to make payments directly to Aspire Indiana for the cost of services.

I understand that Aspire Indiana will bill my insurance company on the first release of information necessary to process claims for any and all the services that may receive including substation above insurance coverage.

I understand that in the event that I do not pay for services rendered to me by Aspire Indiana and any amounts that become due/owed, that I shall be obliged to Aspire Indiana not only for the value of those services, but also for payment of all reasonable attorney fees incurred by and costs associated with Aspire Indiana's collection of such disputed 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 for services that I have. Unless indicated on this form, this release will expire when all related filing issues, including payment audits, have been resolved to the satisfaction of Aspire Indiana. Other release termination described in termination conditions.

Patient Acknowledgment and Confirmation

I understand that I am giving consent for treatment.

I authorize Aspire Indiana to bill my insurance company on the first release of information necessary to process claims for any and all the services that may receive including substation above insurance coverage.

I understand that I do not bring and/or I consent to Aspire Indiana's collection of my personal information for the purpose of filing my claim.

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

Patient or Legal Representative, Signature _____

Print Name _____

Relationship _____

Customer Registration:

Past Surgical History

Aspire Indiana

Please list all your past surgeries.

These forms can be filled out on a computer or on your mobile device.

When you have completed your packet of requested paperwork you will see a completion page:

