Welcome To Our Practice

Today's Date: «encDate»	JOHNSON MEMORIAL HOSPITAL PHYSICIAN PRACTICES

PATIENT INFORMATION

Patient Last Name: **«LastName»**	First: **«FirstName»**	Middle: **«MiddleInitial»**	Prefix: **«PtPrefix»**
Street Address/City/State/Zip: **«MailingAddress1»** **«PtAddress2»** **«PtCityStateZip»**	HomePhone: **«HomePhone»**	CellPhone: **«CellPhone»**	Work Phone: **«WorkPhone»**

PCP: Ref Phys:	DOB: **«DOB»** Sex: **«PtSex»** Marital Status: **«MaritalStatus»**	SSN: **«SSN»**

Race: ____African-American ____Asian ____Hispanic ____Native American ____White ____Other	**Ethnicity: _____Hispanic _____Non-Hispanic**	**Language of Preference: Email: «Email»**

Email Address:____

RESPONSIBLE PARTY INFORMATION

Person Responsible for Bill: **«GrFName» «GrLName»**	Relationship:
Address if different from Patient: **«GrAddr1»** **«GrAddr2»**	
Employer Name:	Employer Address:

INSURANCE INFORMATION

*********** PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST ***********

☐ *Check this box if you do NOT have insurance coverage*

Primary Ins: **«InsuranceName»**	Secondary Ins: **«InsuranceName1»**
Identification # **«subscriberno»**	Identification # **«subscriberno1»**
Subscriber's Name: **«Subscriber»**	Subscriber's Name: **«Subscriber1»**
Group # **«SubscriberGroupNo»**	Group # **«SubscriberGroupNo1»**
Subscriber's DOB: «SubscriberDOB»	**Subscriber's DOB: «SubscriberDOB1»**
Patients Relation to Subscriber: **«RelToPatient»**	Patients Relation to Subscriber: **«RelToPatient1»**
Subscriber's SSN:	**Subscriber's SSN:**
** If Patient is a minor: Father's Name: Date of Birth:	** If Patient is a minor: Mother's Name: Date of Birth:

ACCIDENT INFORMATION (IF APPLICABLE)

How did injury/problem occur? Date: __________ Where: ________________________

How:____

Have you had xrays for this problem? YES / NO If yes, Where: ________________________

Is this condition work related? YES / NO Auto Accident: YES / NO

If yes, date of accident or onset: ______________________________

ADDITIONAL INFORMATION

Emergency Contact Name: **«EmergencyName»** Phone: **«EmergencyPhone»**

Relationship to Patient: ______________

Pharmacy Name: **«pharmacyName»**
Phone Number: **«pharmacyPhone»**

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS ACCURATE AND CURRENT:

Signature of patient or responsible party:	Date:

Scan to: **REG/HIPAA**

New Patient Consent to the Use and Disclosure of Health Information For Treatment , Payment, or Healthcare Operations

«FirstName» «MiddleInitial» «LastName»
DOB: «DOB»

I, «FirstName» «MiddleInitial» «LastName» understand that as part of my health care, Johnson Memorial Hospital Employed Physicians originates and maintains paper and/or electronic records describing my health history, prescriptions, symptoms, examination, test results, diagnoses, treatment and any plans for future care. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party-payer can verify that services billed were actually provided, and
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a *HIPAA Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Johnson Memorial Hospital Employed Physicians are not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Johnson Memorial Hospital Employed Physicians reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Johnson Memorial Hospital Employed Physicians change their notice, we will provide you an opportunity to receive an updated policy at your next visit.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I also permit you to discuss with parties indicated below, my health and/or financial status.

Party's Name: «HIPAAPartyName1» Phone Number: «HIPAAPartyPhone1» ☐Health Only ☐Financial Only

Party's Name: «HIPAAPartyName2» Phone Number: «HIPAAPartyPhone2» ☐Health Only ☐Financial Only

I fully understand and accept the terms of this consent. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I shall also be responsible for any fees required to collect for past due balances which may include court costs, reasonable attorney fees, and collection agency fees, to which may be added pre-judgement and/or post-judgement.

______________________________ ______________

Patient's Signature (authorized representative signing for the patient) Date

FOR OFFICE USE ONLY

☐ Consent received by:_________(initials)

☐ Consent refused by patient, and treatment refused as permitted.

☐ Consent added to the patient's medical record

Scan to: **REG/HIPAA**

Welcome to our Office!

To ensure the highest quality service and care to our patients, we have policies and procedures we ask you to observe. If you have any questions or concerns, please address them with the staff prior to your office visit.

We require that you always bring the following to your visit:

- Insurance card
- Identification Card
- Co-pay/Deductible for insurance patients
- Full payment for self-pay patients (cash, check or visa/mastercard)
- An Authorization or referral (if your insurance requires it)

Please be aware that without these items, the Johnson Memorial Hospital Health Affiliates has the right to have you reschedule or cancel your appointment.

Patient Information: A complete patient registration is kept on file in the patient chart. The patient registration will be updated by the patient every year. A signature of the responsible party is required.

Insurance Cards: All patients who will be utilizing insurance coverage are required to bring a current insurance card to each office visit. If the patient does not have an insurance card, the patient will be expected to pay for service at the time it is rendered.

Identification Cards: ID cards will be required at each office visit. If the patient does not have the proper information the appointment may be cancelled and a cancellation fee may be charged.

Co-pays: Patients who have a co-pay as part of an agreement with her insurance carrier will be required to pay prior to meeting with the provider for each visit. It is the patient's responsibility to bring cash, check or visa/mastercard with them. The appointment will be cancelled if the patient does not bring appropriate means of payment. A cancellation fee may be charged for failure to provide this information.

Deductibles: Any deductible due indicated by you insurance company will be collected prior to surgery or procedures.

NSF: There will be a charge of $25.00 for all returned checks due to non-sufficient funds.

Authorizations/Referrals: Authorizations and referrals are an arrangement between patient and her insurance carrier. Contact your insurance company prior to your visit to ensure you have the proper paperwork in place. If a patient does not have the proper information the appointment may be cancelled. The patient will have to reschedule or proceed as self-pay. A cancellation fee may be charged for failure to provide this information.

Legal Guardians: All minors are required to have a Parent or Guardian present with them. If a Parent or Guardian is not able to come to the appointment then arrangements with the office need to be made prior to the visit.

Late Patients: Patients are required to be on time for an appointment. If possible, patients should arrive a few minutes early to check in and fill out any required paperwork. If a patient is more than 15 minutes late for an appointment, the appointment may be cancelled. It will be at the discretion of the provider to determine if there will be enough time to see the patient without making other patients wait. A cancellation fee may be charged if your appointment has to be cancelled.

New Patients: New patients must arrive 15 minutes prior to their scheduled appointment in order to complete paperwork. If you do not arrive 15 minutes prior, you will be asked to reschedule.

Cancellations/No Shows: As a courtesy, our staff will attempt to confirm your appointment the day prior to your visit. There are occasions when we are unable to provide this courtesy. If you are unable to keep your appointment, you are required to give 24 hours notice. If you fail to provide notice, you will be charged $25.00. When a patient has 3 no shows/3 late cancellations in a 1 year period, you will be discharged from the practice.

Self-Pay Patients: Patients who are self-pay are expected to pay at the time of service. Arrangements must be made in advance for any other situations. If you do not bring payment at time of service, you will have to reschedule and will be charged a $25.00 fee.

Past Due Accounts: Payment is due upon receipt of billing statement. Non-payment may result in dismissal from the practice. In the event your account is turned over to collections, the person financially responsible for the account will be responsible for all collection costs including attorney fees and court costs.

Copy of Medical Records: We are happy to provide copies of your medical records, however; we require you to complete an Authorization to Release Medical Records. Unless we are forwarding your information to another provider, you will be assessed a fee.

Disability Forms: We will complete your disability forms; there is a $20.00 charge due prior to the forms completion.

I have read and understand your office policies:

____________________________________ ____________________

Patient Signature Date

«FirstName» «MiddleInitial» «LastName»

____________________________________ ____________________

Witness Signature Date