JOHNSON MEMORIAL HEALTH

Welcome to **JMH Gastroenterology and Hepatology**. 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 before your office visit. Our goal is to ensure that your experience at all Johnson Memorial Physician Network is exceptional. We've outlined pertinent information that is needed to make sure your visit runs smoothly. Please be aware that without these items, the Johnson Memorial Hospital Physician Network reserves the right to reschedule your appointment.

Patient Information: Enclosed is a Patient Registration and Medical History Form for you to complete. Please have these forms completed before your arrival and ready to give your medical team.

Insurance Cards: To bill your insurance, we require a copy of your current insurance card(s) at each visit. If you are unable to provide your insurance information at the time of your office visit, we will consider you uninsured and will bill you as a private pay patient.

Photo Identification: To protect the identity of each of our patients and comply with federal laws, we are required to view a photo ID or valid driver's license, at *every visit*. JMH Physician Network reserves the right to reschedule your appointment if you do not present a photo ID.

Current Medication List: To help your provider understand your overall health status and to expedite entering your medical history we require our patients to bring with them, a current medication list, including medication name, dosage, and frequency. Controlled substances that are used as a maintenance medication will not be called in after hours or on weekends. These medications may require a hand-written prescription.

Late Arrival: Patients are required to be on time for their scheduled appointments. New patients are required to arrive 20 minutes early with their new patient packet. You may be required to complete additional paperwork before being seen. In the event of late arrival, it will be at the discretion of the provider if they will be able to see you. You may be asked to reschedule your appointment to maintain the integrity of the provider's schedule.

Cancellations/No Shows: If you are unable to keep your appointment, you are required to give 24 hours' notice. If you no-show or fail to provide sufficient notice of cancellation, you may be dismissed from the practice.

Co-Pays and Uncollected Balances: Our Patient Service Representative will collect your insurance co-pay at the time of check-in. If you have a previous balance for services performed at Johnson Memorial Health, payment will be required. Unpaid balances may result in bad debt collections and possible dismissal from our practice. In the event an account is sent for collection proceedings, the guarantor of the account will be responsible for all collection costs.

Medical Records: Upon written request and signature, a copy of your medical records will be released to you. This process can take up to 5 business days. The state of Indiana has imposed a pre-defined fee schedule for copying medical records that will be charged accordingly to the patient.

Prescriptions: Prescription refills must be authorized by the provider and may take anywhere between 24-48 hours for approval. Refills will not be authorized after regular business hours.

We look forward to meeting you and establishing a relationship to meet your healthcare needs!
The Physicians and Staff at Johnson Memorial Health Physician Network

Patient Signature: _____ **Date:** _____/_____/_____

COLONOSCOPY QUESTIONNAIRE

I have been informed by **JMH Gastroenterology and Hepatology** that I am responsible for obtaining benefit information from my insurance company regarding coverage of colonoscopies. I am aware that insurance companies pay according to their own policies set forth for screening vs. diagnostic colonoscopies. I understand I am fully responsible for any and all charges for my colonoscopy that my insurance company may deny or not pay in full.

Patient Name: _____ Date of Birth:____ / ____ / ____

Please answer all questions completely.

1. Please list any previous colonoscopies you have had, where they were performed and who performed them.

_____

_____

2. If you are an established patient with our practice, please list any surgical procedures you have had since your last visit with us.

_____

_____

3. Have you recently had a positive cologuard test or a positive hemoccult test?
No _____ Yes_____ **If yes, when _____ Cologuard / Hemoccult**

4. Do you have any problems with your bowels including rectal pain, bleeding, chronic diarrhea, constipation, or change in bowel habits? Yes / No **If yes, Please specify:**

_____

5. Do you have a **PERSONAL** history of colon polyps or colon cancer?
No _____ Yes_____ **If yes, Polyps / Cancer**

6. Do you have a **FAMILY** history of colon polyps or colon cancer?
No _____ Yes_____ **If yes, Polyps / Cancer**

7. Please check if you have or have had any of these conditions:
Hypertension _____ Diabetes_____ Stroke _____ Heart attack_____

Kidney Disease_____ Other_____

8. Do you have kidney failure or follow a sodium restricted diet? No _____ Yes_____

9. List all current medications and dosages:

_____

_____

_____

10. Are you currently taking any blood thinners including aspirin? No _____ Yes_____

Name of blood thinner and prescriber: _____

_____ _____

PATIENT SIGNATURE **DATE**

DEMOGRAPHICS

Today's Date:	**JMH Gastroenterology and Hepatology**

PATIENT INFORMATION

Patient Last Name:	First:	Middle:	Prefix:
Street Address/City/State/Zip:	Home Phone:	Cell Phone:	Work Phone:

Primary Care Physician: Referring Physician:	DOB: Sex: Marital Status:	SSN:

Race: ___ African-American ____Asian ___Hispanic _____ Native-American ___ White _____ Other	Ethnicity: ___Hispanic ___ Non-Hispanic	Language of Preference:

PATIENT PORTAL

[ ] I want access to the JMH Patient Portal (email address required)
[ ] I do **NOT** want access to the JMH Patient Portal
Personal Email Address: _____

RESPONSIBLE PARTY INFORMATION

Person responsible for bill:	Relationship to Patient (If other than self)
Address if different from Patient:	
Employer Name:	Employer Address & Phone:

INSURANCE INFORMATION
☐ ***Please check this box if you do NOT have insurance coverage***

Primary Ins:	Secondary Ins:
Identification #	Identification #
Subscriber's Name:	Subscriber's Name:
Group #	Group #
Subscriber's DOB:	**Subscriber's DOB:**
Patients Relation to Subscriber:	Patients Relation to Subscriber:
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:

ADDITIONAL INFORMATION

Emergency Contact Name:	Phone: Relationship to Patient:
Pharmacy Name: Phone Number:	
I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS ACCURATE AND CURRENT:	
Signature of patient or responsible party:	**Date:**

Patient Name: _____ Date of Birth: _____/_____/_____
(Print Name)

Date: _____/_____/_____

Medication Name	Strength	Frequency Taken

HIPAA DESIGNATION OF PERSONAL REPRESENTATIVE

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you or your child. By completing this form, you are informing us that you wish to designate the named person(s) as you or your child's personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

Patient Name: _____ Date of Birth: _____/_____/_____
(Print Name)

Designation:

I, _____ (print name), hereby nominate the following person(s) to act as my or my child's personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me or my child.

Please check the applicable box indicating if we may discuss your or your child's health status or financial (bill) matters with your selection(s) below.			Health Status	Financial
Relationship:	Name:	Phone#:	☐ Yes ☐ No	☐ Yes ☐ No
Relationship:	Name:	Phone#:	☐ Yes ☐ No	☐ Yes ☐ No
Relationship:	Name:	Phone#:	☐ Yes ☐ No	☐ Yes ☐ No
Relationship:	Name:	Phone#:	☐ Yes ☐ No	☐ Yes ☐ No

By signing this document, I acknowledge that I have read and understand this General Information and Consent. I further acknowledge that I have received a copy of the Hospital's Notice of Privacy Practices.

_____ _____/_____/_____ _____/_____/_____
Printed Name of Patient **Patient DOB** **Date**

_____
Signature of Patient or Authorized Representative

Reason Patient Unable to Sign:
☐ Incapacitated ☐ Restraints
☐ Other _____

Relationship to patient: ☐ Spouse ☐ Child ☐ Parent ☐ Other _____

JMH Witness Signature: _____ **Date**: _____