JOHNSON MEMORIAL HEALTH

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 Health 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 JMH Physician Network reserves the right to reschedule your appointment.

Patient Information: A complete patient registration will be kept on file and will be updated by the patient at each visit. It is the responsibility of the patient to inform our office of any demographic and/or insurance changes.

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. Some 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 to complete their new patient packet. 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 late cancel the appointment, a fee will be charged to your account. Future appointments will be suspended until the fee associated with the missed appointment has been settled. The related fee for a no-show or late cancellation is **$70** for a new patient and **$25** for a follow-up appointment. The applied fee cannot be billed to your insurance carrier and will be a direct expense to you.

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 up to 24-48 hours to authorize. To avoid complications of your medical treatment and to prevent a lapse in medication, it is imperative to keep your scheduled appointments. The on-call physician will handle acute care prescriptions and post surgery medications.

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/Guardian Signature: _____ Date: _____/_____/_____

Date of Birth: _____/_____/_____

Welcome To Our Practice

Today's Date:	JMH Physician Network Surgical Specialists

PATIENT INFORMATION

Patient Last Name:	First:	Middle:	Prefix:
Street Address/City/State/Zip:	HomePhone:	CellPhone:	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:

Personal Email Address: _____

[ ] I want access to my medical records (email address required) **[ ] I do not want access to my medical records**

RESPONSIBLE PARTY INFORMATION

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

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: _____

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

Johnson Memorial Health Physician Network Surgical Specialists

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 your 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 Date

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

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

_____ _____/_____/_____
JMH Witness Date

JMH Surgical Specialists Medication List

Date: ____/____/____

Patient Name:_____ D.O.B. ____/____/____

Name of Medication	Strength	Frequency Taken