JMH Surgical Specialists
1155 W. Jefferson St Suite 102
Franklin, IN 46131
P 317-736-7603
F 317-736-7932

Date: _____ /_____ /_____

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

Re: Screening Colonoscopy

Dear _____,

JMH Surgical Specialists has received a referral from your primary care physician for you to have a screening colonoscopy. Please complete the enclosed forms and return them to our office along with the following items:

- Insurance Card (front and back).
- Photo ID.

Once we have received the required information, we will contact you to schedule the procedure and provide you with bowel preparation instructions. If any symptoms or problems are noted on your completed paperwork, an office consultation may be required prior to scheduling your procedure as active symptoms warrant a diagnostic colonoscopy rather than a screening colonoscopy.

It is your responsibility to contact your insurance company to verify that screening colonoscopies are a covered benefit. We will contact your insurance company for prior authorization only. Prior authorization does not verify coverage or benefits and does not guarantee payment.

If you have any questions, please do not hesitate to contact our office.

Sincerely,
JMH Surgical Specialists

Please list any dates and/or times you will **NOT** be available for the next few months: (Please note that you will need a driver on the day of your procedure. This procedure requires sedation and you will not be allowed to drive the remainder of the day.)

_____ _____

_____ _____

_____ _____

JOHNSON MEMORIAL HEALTH

COLONOSCOPY QUESTIONNAIRE

I have been informed by JMH Surgical Specialists 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. 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. **Colonoscopy must be performed within six months of completion of this form. You are responsible for notifying us if you have had any changes in your medications or histories.**

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 stool-based test such as a Cologuard, FIT, hemoccult?
No _____ Yes_____ **If yes, when** _____

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 **1st degree relative** who has had a history of colon polyps or colon cancer?
No _____ Yes_____ **If yes, did they have colon polyps or colon cancer (please circle one)**
A First Degree Relative is a parent, sibling or child.

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

Chronic Kidney Disease (other than stones)____ Nephrologist's Name: _____

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**

JOHNSON MEMORIAL HEALTH

Welcome to **JMH Surgical Specialists**. 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 between 24-48 hours for approval. Refills will not be authorized after normal 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: _____/_____/_____

Patient Name Printed: _____

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
1125 West Jefferson St., PO Box 549
Franklin, IN 46131

The terms "Johnson Memorial Health" and "JMH" and "Hospital" include: Johnson Memorial Hospital; and Johnson Memorial Health (and the Departments and Centers of the Hospital including Employed Physician Practices) and Johnson Memorial Immediate Care & Occupational Health Center.

HIPAA Privacy Authorization

Authorization for Use and Disclosure of Protected Health Information
Required by the Health Insurance Portability and Accountability Act (HIPAA) – 45 CFR Part 160 and 164

Johnson Memorial Health (hospital and/or hospital outpatient clinics):

- ☐ Hospital
- ☐ Immediate Care & Occupational Health
- ☐ Comprehensive Pain Services
- ☐ Oncology
- ☐ Podiatry
- ☐ Pulmonary Clinic
- ☐ Therapy
- ☐ Wound Healing & Vascular

Johnson Memorial Health Physician Network (JMH physician offices):

- ☐ Family Medicine
- ☐ Internal Medicine
- ☐ Gastroenterology
- ☐ Orthopedic Surgery/Sports Medicine
- ☐ Pediatrics
- ☐ Surgical Specialists
- ☐ Women's Health (OB/GYN)

I understand that I am entitled to a copy of the Johnson Memorial Health's Notice of Privacy Practices.
I can access a copy of the Notice of Privacy Practices from the JMH website or from a hospital representative.

I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

By signing this document, I acknowledge that I have read, understand and may request a copy of this HIPAA Privacy Authorization form, and I further acknowledge that a copy of the Hospital's Notice of Privacy Practices has been made available to me.

I understand that I may change or update the list below as needed, as it describes who may receive confidential information regarding my financial bills and who may speak with my Medical Providers regarding my clinical care.

Telephone Consumer Protection Act:

I expressly consent to allow JMH, it's agents, and those Providers of professional goods or services that provided or assisted in treatment, to contact me by use of an automated telephone dialing device and to leave automated or pre-recorded voice messages, send text messages, send short message service alerts (SMS), or send me email messages. When designated, JMH may contact me regarding my appointment, exam confirmations, reminders, wellness checkups, hospital pre-registration instructions, pre-operative instructions, LAB results, post-discharge follow-up intended to prevent readmission, prescription notifications, home healthcare instructions, treatment, notification that certain medications or other products or services being provided to me are ready for pick up, communicate to me about my account, or communicate with me regarding the collection of any money that I may owe JMH or those Providers of professional goods or services that provided or assisted in treatment, or related to treatment provided to me, my child or a person to whom I am a guardian.

I agree that this prior express written consent shall also extend to any third party that is servicing my account on behalf of JMH or those Providers of professional goods or services that provided or assisted in treatment, or who are attempting to collect any money due regarding my account on behalf of JMH or associated Providers. This consent also includes telemarketing of future goods and services to me by those parties described herein. My express consent includes contact to my listed telephone numbers and/or email address, plus any other telephone numbers to which I may become a subscriber or regular user in the future.

Messages and Electronic Communication Consent:
I agree that Johnson Memorial Health (JMH) may communicate with me via voice mail and/or personally on phone number(s) below. By providing my contact phone number(s) in this section, I authorize JMH to contact me via the following means of communication.

Home Phone # _____ Mobile Phone # _____

If unable to reach me (please check one):

____ **Yes, y**ou may leave a ***DETAILED*** **voicemail message** regarding normal test results, appointments, medication, billing, etc.

___ Home ___ Mobile Phone

____ **Yes,** you may leave a ***GENERIC*** **voicemail message** and ask me to return your call.

___ Home ___ Mobile Phone

____ **Yes,** you may speak with someone that may answer my phone and leave a ***GENERIC*** **message** and ask me to return your call.

____ **DO NOT leave any message** on my answering machine or voicemail and **DO NOT** speak to anyone that may answer my phone. I prefer that my doctor or staff speak to me personally regarding any medical information, appointments or billing needs.

Designee(s) List

Notes:

- This list must be updated annually for physician offices and other clinics.
- This list must be completed for each hospital visit and/or service. (Inpatient, Outpatient, Laboratory, Radiology, etc.)

I acknowledge that I have the right to authorize access and/or verbal disclosure of my Protected Health Information (PHI) to anyone I choose. This data may include: billing; condition; treatment; and prognosis of my condition.

This information may be released to the following individual(s). I may update this list by giving written consent to JMH.

Please check the applicable box indicating if we may discuss your health status and/or financial (bill) matters with your Designee(s) below. ***Note, the information shared will only be for the dates designated by you.***			Discuss **Health Status** with my Provider	Discuss **Financial Billing** Information
Relationship	**Name:**	**Phone #**	☐ YES ☐ NO	☐ YES ☐ NO
Relationship	**Name:**	**Phone #**	☐ YES ☐ NO	☐ YES ☐ NO
Relationship	**Name:**	**Phone #**	☐ YES ☐ NO	☐ YES ☐ NO

Unless otherwise revoked, this authorization shall be in full force & effect for the next 12 months following the date & signature indicated below, for each designated JMH physician office. (each visit for hospital accounts)

If I wish to limit or restrict the release of any confidential information, I must submit a written request to the JMH Medical Records Department or a designated JMH Physician Office.

_____ _____ _____ _____

Signature (Patient or Authorized Representative) Date Time Signee Relationship

Reason patient unable to sign:
☐ Incapacitated ☐ Restraints ☐ Other:_____

_____ _____ _____

JMH Witness Date Time

JOHNSON MEMORIAL HEALTH

JMH Surgical Specialists Medication List

Date: ____/____/____

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

Name of Medication	Strength	Frequency Taken