

Doctor's Park Family Medicine Patient Registration Sheet

Account # _____

Patient's Name _____			Male <input type="checkbox"/>	Female <input type="checkbox"/>	Birthdate _____
<small>Last</small>	<small>First</small>	<small>Middle Initial</small>			
Street _____		City _____	State _____	Zip _____	
Home Phone () _____		Work Phone () _____	Cell Phone() _____		
SSN # _____ - _____ - _____					
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					
Employer _____					
<small>Employer Name</small>		<small>Employer Address</small>		<small>Employer Telephone Number</small>	
Spouse's Name _____					
Spouse's Employer _____					
<small>Employer Name</small>		<small>Employer Address</small>		<small>Employer Telephone Number</small>	
Responsible Party (if different from PATIENT)					
Relationship to Patient _____		Name _____		SSN# _____ - _____ - _____	
Street _____		City _____	State _____	Zip _____	
Home Phone () _____		Work Phone () _____	Birthdate _____		
Employer _____					
<small>Employer Name</small>		<small>Employer Address</small>		<small>Employer Telephone Number</small>	

Primary Insurance Company (provide card copy) _____	
Cardholder's Name _____	Relationship to Patient _____
Group/Account # _____	ID # _____
Cardholder's Birthdate _____	Cardholder's SSN# _____ - _____ - _____
Secondary Insurance Company (provide card copy) _____	
Cardholder's Name _____	Relationship to patient _____
Group/Account # _____	ID # _____
Cardholder's Birthdate _____	Cardholder's SSN# _____ - _____ - _____

Emergency Contact Person's Name _____	Relationship to Patient _____
Home Phone () _____	Cell/Work Phone () _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In order to bill your insurance carrier, we must have authorization to release necessary medical information.

The undersigned hereby authorizes release of information necessary to file a claim with my **group or commercial** insurance company and assign any benefits to Doctor's Park Family Medicine, which would otherwise be payable to the undersigned under the terms of the insurance policy. The undersigned understands that they are financially responsible for any balance not covered by the insurance company and hereby obligates to pay the account of the treating health care provider in accordance with the regular rates and terms of said providers. Should the account be referred for collection, the undersigned shall pay reasonable attorney's fees and costs of collection. The undersigned recognizes that all treating health care providers furnishing services to the patient may send a separate statement or account from/for each such health care provider.

Signature (patient/guardian) _____
Date

Medicare Patients

I request that payment of authorized Medicare benefits be made to Doctor's Park Family Medicine on my behalf, for any services furnished to me by or in Doctor's Park Family Medicine, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration (HCFA) and it's agents any information needed to determine these benefits for related services. I understand I am financially responsible for any balance not covered by my insurance company.

Signature (patient/POA) _____
Date

Physician's Practice Organization
D/b/a
Doctors Park Family Medicine
Patient Information Brochure

To Our Patients

Thank you for choosing Doctors Park Family Medicine as the health care provider for you and your loved ones. We appreciate the opportunity to assist you with your healthcare needs and pride ourselves on the excellent care and quality treatment you will receive from our fine staff. We accomplish this in several ways. This brochure has been created to help answer questions you may have regarding our office.

Office Hours:

Doctors Park Family Medicine is open Monday through Friday from 8:45AM-4:30PM. We are closed for the lunch hour from 12:00-12:45PM. For the convenience of our patients who may require fasting blood work our Lab opens at 8:00AM Monday through Friday. (Medicare patients requiring blood work can only be seen from 8:45AM-4:30PM due to Medicare rules). Our office phone number is 812-372-8281.

There is a physician on call at all times if you should have an urgent need after hours that you believe can not wait until the office reopens. Please call the hospital operator at 379-4441 outside of our normal business hours to reach the doctor on call. However, because the on call doctor will not have access to your medical chart, if he determines that your symptoms are not of an emergent nature you will be directed to contact the office the next business day. If you should experience symptoms such as chest pain, shortness of breath, profuse bleeding or a possible broken bone please go directly to the Emergency Room.

Appointments:

When scheduling an appointment with our physicians please explain the reason for your visit when you phone for your appointment. This will allow us to schedule the appropriate time needed by the doctor to address your healthcare needs. If this is your first visit with us, please arrive 15 minutes prior to your appointment time so that we may obtain the information we require in order to bill your insurance carrier for you. Please bring your insurance cards with you because we will need to make a copy of your card for billing purposes. In addition please be sure to bring any medication bottles that you are taking so your doctor can review your medications with you.

Advanced scheduling to see your doctor is required. However, if you have an urgent need please call as early as possible and we will make every effort to offer you an immediate appointment. We do our best to stay on schedule, but emergencies may sometimes cause unexpected delays. You play a major role in helping us stay on schedule. If you are running late, please phone before you come. We may need to reschedule your appointment so that you and our other patients are not inconvenienced.

A room and the physician's time has been reserved for your appointment. If you find that you are unable to keep your appointment we do request that you notify our office as soon as possible, but no later than 24 hours prior to your appointment. This will allow us to utilize the time reserved for you for another patient who may be ill and needing the doctor's services. We believe that maintaining good health requires timely medical care and follow-up. It is our policy that if a patient misses 3 appointments within a 6-month time period **without** providing prior notification to us they will be discharged from our practice.

Treatment and Follow-up:

When you are treated by the doctor you have chosen as your family physician, all subsequent appointments should be made with the same doctor when possible. However, should you develop a problem that requires immediate attention and your doctor is unavailable, you may be asked to see another physician in our office for that visit.

*Please inform our front desk staff of any change in address, telephone numbers, insurance coverage or employment.

*Please inform your doctor or nurse of any change in medications or medical history.

Medical Test Results:

You will receive prompt notification of any test result that requires immediate attention. Otherwise, please allow 7-10 working days for test completion, doctor review of the results and oral or written communication from your nurse.

Prescription Refills:

Prescription refills will only be authorized during normal office hours. It is our policy that no narcotics or cough medications will be called in after hours or on weekends. Please evaluate your medication supply prior to your office visits and request your doctor to write your refill prescriptions at the time of your visit. If you have not seen your doctor within a 6-month period of time you will need an appointment to see your doctor before any refills can be authorized.

If you should become ill or begin experiencing symptoms of illness an appointment with a doctor for an evaluation is required before any medication can be prescribed. This is necessary to insure you receive the appropriate treatment course for your current illness.

Medical Records:

Your medical records are strictly confidential. The Health Information Portability and Accountability Act (HIPAA) restricts us from releasing any information without your written permission, for reasons other than payment, treatment and healthcare operations.

There may be times when you may request that we provide copies of our records on you to other entities. We do incur an expense to provide you with this service and that cost will be passed on to you. Our fee for copies is \$20 that includes copying up to 10 pages. There is a \$0.50 charge for each additional page plus postage cost. If the cost for the copies is not reimbursed by the receiving entity that you have authorized to obtain these records you will be responsible for payment before the records can be released.

Form Completion:

There is a standard fee for any form completion including FMLA forms. This amount is per form and based on the number of pages per form. This amount is due at the time the forms are submitted to our office. Please allow 3 working days for processing.

Questions:

We have an excellent nursing staff that is well trained in assisting patients. Should you have a specific question regarding treatment and the nurse is unavailable to take your call, you may leave a detailed message and she will return your call as soon as she has had an opportunity to talk with your physician. Please be sure to leave all phone numbers where you may be reached and you will be contacted no later than 5:00PM the following day.

Insurance and Payment for Services:

Payment is expected at the time of service. It is our policy and a requirement of our provider contract with your insurance company to collect all co-pays and deductibles at the time of your visit from you. For your convenience we accept cash, checks, MasterCard, Visa, and Discover credit cards. As a courtesy we are contracted with several insurance providers and we will file your insurance claim for you. Please provide any new information regarding your insurance to the front desk. Accurate insurance information is vital for processing your claims. Please remember that insurance is considered a method of reimbursing the member for fees paid to the doctor and is not a substitute for payment. Payment for the account remains your responsibility.

We strive to have a mutually respectable relationship with all of our patients. As part of that relationship we believe it is important that you maintain your account with our office in good standing. Should your account become delinquent and you default on payment of your debt your account will be turned over to an outside collection agency. Should this become necessary you will be responsible for all additional expenses incurred to collect this outstanding debt and you will be discharged from the practice.

From the Physicians and Staff at Doctors Park Family Medicine

Thank you for allowing us to care you.

Notice of Privacy Practices



PHYSICIAN'S PRACTICE
ORGANIZATION, INC.

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

The Privacy Officer or Office Manager for assistance.

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

- 1. Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

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2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you with your authorization

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

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4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

7. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

8. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

9. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

10. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the **Privacy Officer** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to the **Privacy Officer**. Your request must describe in a clear and concise fashion:

- (a) the information you wish restricted;
- (b) whether you are requesting to limit our practice's use, disclosure or both; and
- (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the **Privacy Officer** in order to inspect and/or obtain a copy of your IIHI. Our

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practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the **Privacy Officer**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the **Privacy Officer**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the **Privacy Officer**.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the **Privacy Officer**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the **Privacy Officer**.

Physician Practice Organization, INC

Doctors Park Family Medicine

Acknowledgement of Receipt
Notice of Privacy Practices

Date: _____

Patient's Name: _____

I acknowledge that I have received a NOTICE OF PRIVACY PRACTICES information sheet from Doctors Parks Family Medicine. I understand that staff is available to answer any questions I may have concerning this notice.

Patient or patient guardian signature: _____



DOCTORS PARK FAMILY MEDICINE

PHYSICIAN'S PRACTICE ORGANIZATION, INC.

1950 Doctors Park Drive
Columbus, IN 47203
812-372-8281

Medical Test Results

As part of your medical evaluation your physician has requested further testing for you. Our office policy is any test result received that requires immediate attention you will receive prompt notification. Otherwise, please allow 7-10 working days for test completion, doctor review of the results and oral or written communication from your nurse. To assist us in communicating results with you efficiently, please indicate your preferences for communicating this information to you below.

A. Information about my care and services can be mailed to my address on record. [] YES [] NO

B. Information about my care and services can be left by voice mail at my phone number on record. [] YES [] NO

C. Information about my care and services can be left with my spouse or alternate family member. [] YES [] NO

If yes, please list name of spouse or alternate family member

List Alternate phone number or address if No to question A, B or C.

Exceptions:

My signature below certifies that I have read the above information and I give my permission for Doctors Park Family Medicine to utilize the indicated means above to convey my test results to me should they be unable to reach me personally. Doctors Park is entitled to rely upon this document unless I contact the office manager in writing and revoke or change the document.

Witness: Patient's Signature:

(If patient is a minor or unable to sign, the person who is taking the responsibility must sign below.)

Relationship:

Date: Time: Date: Time: