JOHNSON COUNTY
WOMEN'S CARE GROUP, LLC

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Welcome to our practice! We have enclosed for your convenience our Patient Information Sheet. Please complete this form prior to your visit.

We would like to remind you to bring the enclosed form, your insurance card and a picture ID to your appointment. To prevent having to reschedule your visit, we encourage you to contact your benefits department at your insurance company to ensure your doctor is an approved provider under your selected plan. In addition, if your individual insurance plan requires authorization from your primary care physician, please be sure to bring your referral to your appointment.

We encourage you to have the following information available to optimize the success of your visit.

medication list
family medical history
medical and surgical history

As a courtesy, our central billing office will submit your claim to your insurance company. If your insurance plan requires you to pay an office co-pay, this will be collected at your visit. In addition, if you do not have any insurance coverage, you will be required to pay for your visit at the time your service is provided.

If you are not able to keep your appointment, please call us at (317) 738-0630 to reschedule or cancel. If we do not hear from you, a $25.00 no show fee will be charged to your account and will be required to be paid prior to scheduling any subsequent visits.

We look forward to meeting your healthcare needs and having the opportunity to provide you with the best medical care.

Sincerely,

The Johnson County Women's Care Group

Welcome To Our Practice

Today's Date:	**JOHNSON MEMORIAL HOSPITAL PHYSICIAN PRACTICES**

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:**

Personal Email Address: _____ **(required for patient portal)**

RESPONSIBLE PARTY INFORMATION

Person Responsible for Bill:	Relationship:
Address if different from Patient:	
Employer Name:	Employer Address/Phone:

INSURANCE INFORMATION

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

____ Check here 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: **Self - patient is the insured**
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: 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:

Scan to: **REG/HIPAA**

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

Name Plate

I, _____ 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 is 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: _____ Phone Number: _____ Health Financial

Party's Name: _____ Phone Number: _____ Health Financial

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-judgment and/or post-judgement. By providing my telephone number (landline and/or cell) I am allowing Johnson Memorial Hospital Employed Physicians and our collection agency to contact me regarding collections of my account. Methods of contact may include using pre-recorded/artificial voice messages and/or use of any automatic dialing device, as applicable.

_____ _____

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**