Dear New Patient,

The physicians and staff of the Marion Independent Physicians Association (MIPA) would like to welcome you to our group and thank you for choosing MIPA to assist you with your medical needs. MIPA features specialties including Family Practice, Orthopedic Surgery, General Surgery, Physical Therapy, and Psychiatry. Our entire group is dedicated and focused on providing the best care possible to you and your family.

Included in this packet, you will find information that our office feels will be helpful to you, along with the forms that need to be completed and returned to our office. It is important that these forms are completed and returned to our office **AT LEAST 2 DAYS PRIOR** to your appointment. The “Release of Medical Records” form should be filled out and sent to any physicians and/or facilities that have provided treatment to you that may be pertinent to your care and treatment by our MIPA physicians. Please bring all your medications to your first appointment.

At the time of your appointment, please be sure to bring your current insurance cards and picture ID. Please note that it is your responsibility to ensure that the physician you are seeing is a participating provider with your insurance company. Also, it is your responsibility to find out if your insurance company requires prior authorization for treatment, such as mental health services. Most insurance cards have this information on the back with an 800 number to call **PRIOR** to your initial visit. Failure to get prior authorization could result in a denial of claim and in turn you will be responsible for this payment. All co-pays must be paid at the time of service. For your convenience, MIPA accepts cash, check, and all major credit cards.

To Summarize, please review the following items:

- Complete the enclosed forms and return our office.
- Bring your insurance card, picture ID, and be prepared to pay any co-pays.
- Verify insurance coverage prior to appointment.
- Bring current medications.
- Please arrive 15 minutes early for your first appointment.

If for any reason you need to cancel or reschedule your appointment, please give us a 24 hour notice.

We appreciate that you are choosing MIPA for your health care needs and hope that you will find your visit with us rewarding and beneficial.

Sincerely,

Raymond Gardner, MD
Family Practice

Srinivas Ravi, MD
General Surgery

J. Timothy Spare, MD
Psychiatry

Shelia Reddy, MD
Internal Medicine

MIPA Physical Therapy

PATIENT RESPONSIBILITES & PATIENT BILL OF RIGHTS

PATIENT RESPONSIBILITIES:

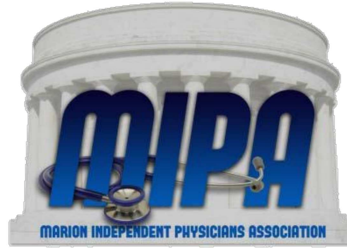
To ensure the finest care possible, you must understand your role in your health care. As a patient of MIPA you are responsible for the following:

1. To provide to the best of your knowledge, complete information about your symptoms, past illnesses, medications, and other matters relating to your plan of care.
2. To schedule and keep doctor appointments, or call to cancel appointment if you cannot be there.
3. To notify MIPA of any changes in address, family members, or insurance coverage (provide current copy of insurance card).
4. To ask questions when you do not understand explanations about your care or services.
5. To be responsible for your actions if you refuse treatment or do not follow you providers instructions.
6. To follow the organizations policies.
7. To be courteous and considerate of MIPA personnel and other patients.
8. To know and understand your CURRENT insurance policy and coverage.

PATIENT BILL OF RIGHTS:

As an individual receiving medical services from MIPA you have the following rights:

1. To receive quality medical care regardless of your age, sex, religion, national origin, sexual preference, disability, or health status.
2. To be treated with respect by all MIPA personnel.
3. To information contained in your medical record. You also have the right to participate in decisions involving your health care.
4. To personal privacy. Any discussion, consultation, examination and/or treatment regarding your care will be done discreetly.
5. To confidentiality of your medical record and other information related to you medical condition.
6. To be seen in a safe and clean environment.
7. To have special needs met, such as handicap requirements.
8. To appoint a person to make health care decisions on your behalf in the event you lose the ability to do so.
9. To make advance directives regarding your medical care and have them honored.
10. To file a complaint about your care without fear of penalty, to have your complaint reviewed, and when possible resolved.



Privacy Consent- For the Use and Disclosure of Protected Health Information

This consent is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to Marion Independent Physicians Association and its Affiliates to use and disclose my protected health information for the purposes of treatment, payment and operations of my healthcare and this practice.

Consent for treatment: With my signature, I authorize Marion Independent Physicians Association, its Affiliates and any employee working under the direction of the physician to provide treatment, for the purpose of evaluating my health and diagnosing medical condition.

Consent for payment and operations: I also authorize this practice to furnish my health information as needed to obtain payment for my health care services. This may include certain activities that my insurance plan may undertake before it approves or pays for health care services MIPA recommends, such as: making determination of eligibility or coverage for insurance benefits, reviewing services provided to me for medical necessity, and undertaking utilization review activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice. This release may include information about drug use/abuse, alcohol use/abuse, mental health issues or concerns, AIDS or HIV status as pertinent to my medical care. I Understand that these records are protected by the Code of Federal Regulations Title 43 Part 2 (42 CFR Part2) which prohibits the recipient of these records from making any further disclosers to the third parties without the express written consent of the patient.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice Privacy Officer by phone or writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Patient Name Printed ____ DOB: ___________

Guardian Name Printed (if Applicable): ____

Patient/Guardian Signature: ____________________________________Date:____________

If not Patient, relationship: ____

Patient unable to sign due to: _______________________ Refusal to sign Date: __________

CANCELLATION/NO SHOW POLICY:

MIPA Primary Care requires a 24 hour notice for the cancellation of a scheduled appointment. There is a $25 charge for a no-show or cancellation without prior notice. This charge ***will not*** be covered by your insurance. For every cancellation or no-show, a $25 fee will be assessed. Maintaining regular office visits is essential for positive outcomes. Repeated cancellations and/or no-shows will hinder your care and may result in discharge from our practice. We understand that extenuating circumstances may occur.

LATENESS POLICY:

It is equally important that you be on time for your scheduled appointment. You are welcome to call in advance to request an earlier or late time. We will be happy to honor your request if other appointment times are available; however, simply arriving late or early changes the course of treatment for yourself and others. If you are more than 15 minutes late for your appointment, we will be happy to reschedule you for another available opening. Similarly, you may be asked to wait until your scheduled appointment time if you have arrived too early. In order to provide you with the best possible care, we ask that you arrive on time for your appointment. Please DO NOT abuse this 15 minute leeway, excessive lateness will not be tolerated.

We take these policies seriously. When a patient misses an appointment, several people are adversely affected:

1) You, the patient – for not receiving the treatment that you need.
2) Your provider – as he/she now has a gap in their schedule.
3) Other patients – who could have had your appointment time.

I consent to the above, as indicated by my signature below:

____
(Print Name)

____
(Signature) (Date)

Effective January 1, 2017

MIPA Primary Care
1069 Delaware Ave, Suite 205
Marion, Ohio 43302
Ph: 740-387-4578 Fax: 740-387-8638

Mark Davis, MD
Raymond Gardner, MD

PATIENT CONFIDENTIALITY - Adult

Patient: ___________________________ **DOB: ______________**

To ensure the confidentiality of all our patients, it is the policy of our office to release information regarding each patient only to the patient/parent. If you wish for others to receive information regarding your care, you must sign this release. By signing this, you are giving our office staff permission to release information to your insurance companies, any necessary treating physician, therapist, hospitals, or outpatient services.
If you would like us to release patient information to someone other than those mentioned above, please list their names, phone numbers and relationship to you. This may include spouse, children (not minors), parents, etc. Also, if grandparents or step-parents are allowed to bring in for treatment/pick up rx, please list names below:

NAME	PHONE NUMBER	RELATIONSHIP
____	__________________________	__________________
____	__________________________	__________________
____	__________________________	__________________
____	__________________________	__________________

Home Phone number________________________
When trying to reach you by telephone, do we have permission to leave a message regarding your medical care or test results on your home voice mail?   Yes   No

Cell Number _____________________ May we call your cell?   Yes No

May we leave a message on your cell?   Yes No May we send you a text?   Yes No

May we reach you at work? Yes No   Work Number ___________________

What number do you prefer to be reached at ? ___________________________

I understand by signing this form, I have authorized this practice to release my medical information.

________________________________ _______________
Patient Signature Date

PAST, FAMILY AND SOCIAL HISTORY

NAME__________________________________AGE_______DOB__________ DATE____________________
MARITAL STATUS______________OCCUPATION_________________
ALLERGIES/REACTION____

PRESENT MEDICATIONS:

1.________________________ 2.________________________ 3.________________________ 4.______________________
5.________________________ 6.________________________ 7.________________________ 8.______________________

SOCIAL HISTORY:

TOBACCO	Y	N	PACKS PER DAY_____FOR_____YEARS, QUIT DATE_______(YEAR)
ALCHOL	Y	N	FREQUENCY & AMOUNT____
CAFFINE	Y	N	CUPS/CANS PER DAY____
ILLEGAL DRUGS	Y	N	TYPE____
EXERCISE	Y	N	TYPE______________________HOW OFTEN_______________________

SURGERIES AND MAJOR HOSPITAL STAYS W/DATES

1.____ 2.____
3.____ 4.____
5.____ 6.____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING MEDICAL CONDITIONS?

			DATE				DATE
CHILDHOOD DISEASES	Y	N	________	YELLOW JAUNDICE OR LIVER	Y	N	________
STROKE	Y	N	________	RHEUMATIC FEVER	Y	N	________
GLAUCOMA	Y	N	________	EPILEPSY/SEIZURES	Y	N	________
EMPHYSEMA	Y	N	________	BRONCHITIS	Y	N	________
PNEUMONIA	Y	N	________	ASTHMA	Y	N	________
HIGH BLOOD PRESSURE	Y	N	________	HEART PROBLEMS	Y	N	________
HEPATITIS	Y	N	________	STOMAC ULCERS	Y	N	________
KIDNEY PROBLEMS	Y	N	________	ARTHRITIS	Y	N	________
DIABETES	Y	N	________	SEXUALLY TRANSMITTED DISEASE	Y	N	________
CANCER	Y	N	________	GONNORRHEA/SYPHILIS/CHLAMYDIA	Y	N	________
AIDS	Y	N	________	PROSTATE PROBLEMS	Y	N	________
THYROID PROBLEMS	Y	N	________	BLEEDING DISORDER	Y	N	________
MIGRAINES	Y	N	________	ANEMIA, BLOOD DISORDER	Y	N	________
MENTAL ILLNESS	Y	N	________	DEPRESSION	Y	N	________
BLOOD TRANSFUSION	Y	N	________				

FAMILY HISTORY:

HAS A BLOOD RELATIVE EVER HAD?

			RELATION
DIABETES	Y	N	__________________
CANCER	Y	N	__________________
HEART DISEASE	Y	N	__________________
HIGH BLOOD PRESSURE	Y	N	__________________
STROKE	Y	N	__________________
KIDNEY DISEASE	Y	N	__________________
MENTAL ILLNESS	Y	N	__________________
OTHER	______________		

THE LAST TIME YOU HAD A (YEAR)

FLU VACCINE______ TETANUS SHOT______ T.B. TEST_______ DENTAL EXAM_______
PNEUMONIA SHOT______ RECTAL EXAM_______ SIGMOID EXAM_______
STOOL BLOOD TEST______ EYE EXAM_______ CHOLESTEROL TEST/RESULT__________

WOMEN ONLY:

DO YOU PERFORM MONTHLY SELF-BREAST EXAMS? Y N LAST BREAST EXAM(DATE)__________
DO YOU TAKE CALCIUM SUPPLEMENTS? Y N LAST MAMOGRAM(DATE)__________
PAIN OR BLEEDING DURING OR AFTER SEX? Y N LAST PAP(DATE)__________
ON HORMONE REPLACEMENT THERAPY? Y N BIRTH CONTROL METHOD______________
POST-MENOPAUSEL BLEEDING? Y N EXCESSIVE CRAMPING Y N
AGE YOU STARTED PERIODS_______ AGE YOU STOPPED PERIODS_______
NUMBER OF PREGNANCIES_____LIVE BIRTHS_____MISCARRIAGES_____ABORTIONS_____
OTHER PROBLEMS?______________________

Family History

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brother				
Sister				

Check if your blood relatives had any of the following

	Disease	Relationship to child
	Asthma	
	Allergies	
	Tuberculosis	
	Attention deficit disorder	
	Hyperactivity	
	Seizures	
	Anemia	
	Bleeding Disorder	
	Sickle cell disease	
	High blood pressure	
	Heart Attack	
	Stroke	
	Cancer	
	Diabetes	
	Depression	
	Anxiety	
	Drug or alcohol problems	
	Other	

Child Development and Emotional Concerns

Check if now having problem, or has had in the past

	Now	Past
Growth or Weight		
Development		
Speech or hearing		
Toilet training		
Eating habits or diet		
Bedwetting or soiling		
Sleeping patterns		
Nightmares or night terrors		
Thumb sucking or nail biting		
Getting alone with adults		
Getting along with other children		
School work		
Discipline or behavior problems		
Inappropriate sexual behavior		
Use of alcohol or drugs		
Drinking or drugs in family		
Emotional, physical, or sexual abuse		
Violence in family		

In the child's home

Does anyone smoke?	No	Yes
Is there a gun?	No	Yes
Is there working smoke detectors	No	Yes
Is the home child proofed?	No	Yes

When riding in an automobile, does the child always ride in an approved safety seat (if less than 40 lbs) or in a booster seat or lap belt appropriate for their age and weight? No Yes

When riding a bicycle, does the child always wear an approved helmet? No Yes

What does the child do for fun?

How many hours of TV/video/computer time does the child get each day? ____

How much and what kind of exercise does the child get? (please check any that apply and indicate hours):

Regular active play ____ hours
Regular sports ____ hours
School PE ____ hours
Occasional active play ____ hours
Very little or none ____ hours

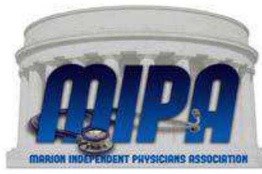
Any other concerns?

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my child's doctor if my child ever has a change in health.

____
Signature of Parent or Legal Guardian Date

____
Please Print Name

____
Reviewed by Date



Release Of Records

Printed Name of Patient:_________________________________ ______________Date of Birth: ______________________
Patients Social Security Number: ______________________________ Phone Number: _____________________________
Address: ____

Street City State Zip Code

____________________________________ ____ __________________

Signature of Patient or Patient's Representative Relationship of Representative to Patient Today's Date

MUST HAVE COMPLETE INFORMATION BEFORE THIS REQUEST CAN BE PROCESSED

I hereby authorize the use and disclosure (release) of my Medical Record information:

From: To:

____ ____
____ ____
____ ____

The information to be released includes: Entire Medical Record _________ Other____________

____

The Medical Record Information will be used and/or disclosed for the following purposes:

__ At the request of the individual __ Changing Primary Care Physician __ Changing/Seeing Specialist
__ Other (write purpose here) ____

I acknowledge and agree that the term Medical Record information may include: notes by the provider and other personnel, results, reports, correspondence, x-rays and other diagnostic imaging films, as well as claims, billing and payment information. I expressly authorize the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions unless specifically excluded.

Please <u>exclude</u> the following information, if it is part of my Medical Record Information (Check any or all you want excluded from this authorization for use or disclose):

__ Chemical Dependency/Substance Abuse __ Psychiatric/Psychological conditions
__ Sexually Transmitted Diseases __ Alcohol __ Drugs __ N/A

I understand that this authorization shall remain in effect for a period of 90 days. I further understand that I may revoke this authorization at any time by notifying MIPA in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by MIPA before receiving my revocation.

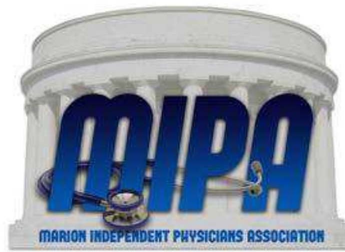
I understand that I have the right to restrict disclosure of my PHI to a health plan, if the disclosure is for payment or healthcare operations and pertains to a healthcare item or service for which I have paid out-of-pocket in full. I have the right to an accounting of disclosures of any and all breach notifications of my unsecured PHI upon my written request to MIPA. I also understand that I have the option to "opt-out" of receiving communications from my provider should I choose to do so as long as I provide MIPA with the request in writing.

I am designating ____ to pick up my medical records. I understand my designee or I will need to produce a picture ID in order to obtain the records.

Refusal to sign this authorization in no way affects my treatment, payments, or eligibility for benefits. Any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Patient received free copy: ______ Yes ______ No, dates included __________ to __________

*For records covered by 42 CFR Part 2, or that concern HIV/AIDS related information: This information has been disclosed to you from records protected by State and/or Federal Confidentiality Rules (ORC 3701.243 and 42 CFR Part 2). These rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.



Patient Portal

The patient portal is a web-based application that allows patients to securely view and share information related to your healthcare with our practice. The patient portal has a variety of different functionalities depending on which vendor you select. Accounts will be created for all patients age 18 and over. Any dependents under 18 will have their information included with the adult(s) responsible for their account. Dependents will be listed under both parents. Some common features are as follows:

- Online statements and bill payment
- Online Verification of Demographics
- Online Completion of New Patient Paperwork
- Online Viewing and Printing of Limited Health Records
- Please be aware that not all of your protected health information residing at MIPA is available via the MIPA Patient Portal.

How do I access the patient portal?

1. You must provide a current personal email address to your doctor's office.
2. Once your portal is activated, you will receive an email providing you with your login and temporary password for the portal.
3. Please click on the link in the email and use your temporary password to register for the portal. During registration, you will be required to change your password and set up a security question.
4. Once you are registered, you can also access the portal by going to www.mipallc.com and clicking on Patient Portal.

A copy of this authorization form has been included with the copy of the medical record.

** For records covered by 42 CFR Part 2, or that concern HIV/AIDS related information: This information has been disclosed to you from records protected by State and/or Federal Confidentiality Rules (ORC 3701.243 and 42 CFR part 2). These rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

Patient Portal

Patient Name: ____ DOB: ____________________

Minors: ____ DOB: ____________________

Minors: ____ DOB: ____________________

Minors: ____ DOB: ____________________

Minors: ____ DOB: ____________________

Email: ____

Signature: ____ Date: ____________________

MIPA Primary Care

Controlled Substance Agreement

This controlled substance management agreement is entered on this_____day__________,20___between____________________DOB:______ and the physicians of MIPA Primary Care. The purpose of this agreement is to establish rules for the use of controlled substance medications, their safe use and their appropriate prescribing.

Violation of this controlled substance agreement will result in termination from this practice

1. I will receive my prescriptions for controlled substance medication only from MIPA Primary Care.
2. I will take my medications as prescribed and will not alter how I take these medications unless instructed by my physician.
3. I will attend all scheduled appointments with the physician or practitioners to which I am scheduled to see every 3 months.
4. I will avoid alcohol and illegal drugs while I am taking a controlled substance.
5. I will allow my physician to contact my family, friends and other treating practitioners for their assistance in managing my conditions and the use of my medications.
6. I will not give or sell my medications to other individuals.
7. I am willing to take random drug screens at the request of my treating physician or practitioner. If my drug screen is not covered by my insurance

company, Workers Compensation or other payor source, I AGREE TO PAY FOR THE TESTING MYSELF.

8. I will not take my controlled substance and operate equipment if they impair my ability to concentrate and think clearly or produce dizziness/drowsiness. I will notify my physician of this information.

9. I understand that if I take a controlled substance for a long period of time, this can result in physical dependence. This means that if I stop taking my medication suddenly/abruptly, I may experience withdrawal symptoms, such as watering eyes, runny nose, sweating, tremors, joint pain, difficulty sleeping, agitation, diarrhea and abdominal pain. This could be a life threating medical issue. I will notify my physician if this occurs.

10. I understand that taking controlled substance medications for a long period of time may put me at risk for developing an addiction. This means that I could become preoccupied with taking my medications and other prescribed or illegal drugs to the point that the other aspects of my life could suffer. I will notify my physician if this occurs.

11. I understand it is my responsibility to protect my medications. If my medications are lost, destroyed or stolen, I understand they will not be replaced before they are due. This could cause withdrawal symptoms as listed in numbers 9 and 10.

12. I will avoid any situations that may put myself or my medications at risk.

13. I understand that I may be required to provide my controlled substance medication in their original bottles within 24 hours to my physicians office for random pill counts.

14. I understand that my physician/practitioner will not refill my controlled substance medications any earlier than the date to which a refill is due. This may mean I need to plan ahead for vacations and holidays. **NO EXCEPTIONS**

15. I have read the above Agreement and understand it. I have asked and had my questions answered concerning the agreement. I consent to the use of the Controlled Substance Management Agreement as detailed above and understand the random drug screening process. I acknowledge that the purpose of this Controlled Substance Management Agreement is to protect myself from addiction or other misuse of drugs, and to provide MIPA Primary Care and it's providers with information and controls necessary to monitor my treatment and avoid my taking more medication than appropriate or from taking medications that may counteract or interact in ways that are harmful to me/my child.

____________________________	____________________________
Patient/Legal Guardian Name	Patient/Legal Guardian Signature

____________________________	____________________________
Physician Printed Name	Physician Signature