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:

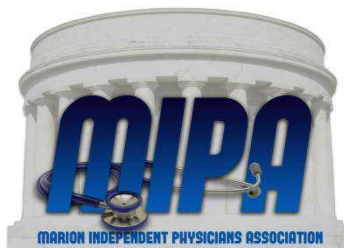
To ensure the finest care possible, you must understand your role in your health care. As a patient of MIPA you are responsible for the following:

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.

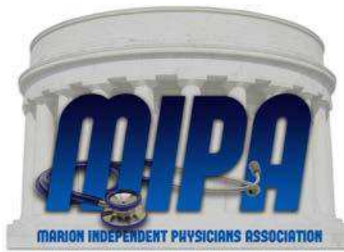
Patient Name Printed ____ DOB: ___________

Guardian Name Printed (if Applicable): ____

Patient/Guardian Signature: ____________________________________Date:____________

If not Patient, relationship: ____

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



PATIENT CONFIDENTIALITY

PATIENT NAME: _______________________________ Date of Birth: ______________________

To ensure the confidentiality of all our patients, it is the policy of our offices to release information regarding each patient only to the patient. 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.

NAME	PHONE NUMBER	RELATIONSHIP
___________________________	_____________________	______________________
___________________________	_____________________	______________________
___________________________	_____________________	______________________
___________________________	_____________________	______________________

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 answering machine/voice mail? ◯ Yes ◯ No
Phone Number________________

May we reach you at work? ◯ Yes ◯ No Work Number ____________________

May we call your cell? ◯ Yes ◯ No Cell Number ____________________

May we send you a text message? ◯ Yes ◯ No

May we leave a message on your cell? ◯ Yes ◯ No

Where do you prefer to be called? ______________________________________

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

_______________________________________ ______________
Patient Signature Date

Venous Health History Form

Name:_________________________________ Date:____________________

Age:___________ Sex: M ◯ F ◯

1. Have you ever had vein stripping surgery? Yes ◯ No ◯

2. Do you experience any of the following? Yes ◯ No ◯
   a. Aching/pain in your legs?.................... Yes ◯ No ◯
   b. Heaviness?.. Yes ◯ No ◯
   c. Tiredness/fatigue?................................ Yes ◯ No ◯
   d. Itching/burning?.................................. Yes ◯ No ◯
   e. Swollen ankles?.................................... Yes ◯ No ◯
   f. Leg cramps?.. Yes ◯ No ◯
   g.Restless legs?... Yes ◯ No ◯
   h. Throbbing?... Yes ◯ No ◯
   Other?__________________________ Yes ◯ No ◯
   Do you experience these problems in just one, or both legs? One ◯ Both ◯

3. Do you take any medication for pain(eg, advil, etc.)? Yes ◯ No ◯
   If yes, what medication and how often?_________________________________

4. Do you elevate your legs to relieve discomfort? Yes ◯ No ◯

5. Do you wear support hose prescribed by a doctor? Yes ◯ No ◯
   If yes, how long have you worn them?_____________

6. Do you have any problem walking? Yes ◯ No ◯

7. Do you stand much at work? Yes ◯ No ◯
   at home? Yes ◯ No ◯

8. Have you ever had any test(s) done on your veins? Yes ◯ No ◯
   If yes, when, what type of test and where on the leg?
   ____

9. Were you diagnosed with saphenous vein reflux? Yes ◯ No ◯

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:____________________