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.

<u>To Summarize, please review the following items:</u>

- 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

1167 Independence Avenue Suite 100 - Marion, Ohio 43302 - (740)387-7200 - Fax (740)387-5728

PATIENT RESPONSIBILITES & PATIENT BILL OF RIGHTS

PATIENT RESPONSIBILITIES:

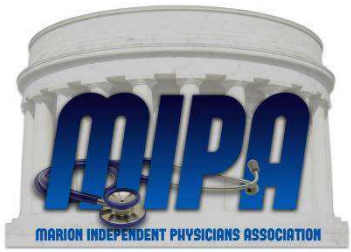
To ensure the finest care possible, you must understand your role in your health care. As a patient of MIPA you are responsible for the following:

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.

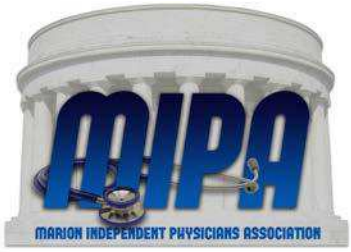
Patient Name Printed _____ DOB: _____

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

General Education about Psychiatric Medications

I. Storage of Medications

Keep medications in their original bottles. Do not mix different medications in the same bottle. Please store medications as directed by the pharmacist. Keep medication out of the sight and reach of children because an overdose can be dangerous. Make sure the labels are clearly readable.

II. Side Effects & Risk/Benefit Analysis

No psychiatric medication is completely risk-free. In weighing risks and benefits of a given treatment decision you may realize that a risk you assume by choosing a treatment seems more risky than a risk you take by not treating your illness even though the risk of doing nothing may be greater.

Most medications have a long list of medication side effects listed in the package insert. We are happy to discuss any questions about these side effects. It may be difficult for you to remember every single side effect of each medication that you take. It is therefore important for you to report any physical or mental discomfort or worsening of your condition to the prescribing doctor. There may be yet unknown or long-term side effects especially of medications taken over a long period of time. It is therefore important that you partner with the prescribing doctor in ongoing risk/benefit analysis during your regular medication management appointments.

It is possible to have an allergic reaction to any medication. This may show itself in the form of skin reactions, breathing difficulties, or other allergic responses. These must be immediately reported to the prescribing doctor. If they are causing serious discomfort, please seek emergency help at your nearest Emergency Room/Urgent Care facility.

Dangerously low white blood cell count can be a rare side effect of some medications. Common symptoms of this are fever and sore throat. These need immediate *medical* attention.

Some medications can cause liver problems sufficiently rarely that regular blood tests are not recommended by the FDA. Immediate attention is needed however, if signs and symptoms of liver problems are noted. These include itchy skin, Jaundice (yellow coloring of skin and eyes), dark urine, upper right-sided abdominal tenderness or unexplained “flu-like” symptoms.

Regular medication blood level tests are essential to monitor dosing of certain medications like lithium carbonate where the difference between therapeutic blood levels and toxic blood levels is rather small.

III. Pregnancy

It is very important to avoid pregnancy and breastfeeding during the time when you are taking psychiatric medications. When you do plan a pregnancy, inform your doctor well in advance so that he can discuss the possibilities of risk to your baby during pregnancy and breastfeeding. We suggest you visit www.womensmentalhealth.org for additional education in this matter.

IV. Machinery & Driving

Most psychiatric medications can, for some people, cause tiredness, sleepiness, or a decrease in concentration. You must not drive or operate machinery if your medications affect you in this way. Since there are wide variations among different people in this regard it is important that you avoid driving and or operating machinery until you are quite familiar with how your medication affects you. In any case, exercise extra caution in driving and in operating machinery.

V. Sun Exposure/Tanning

Some psychiatric medications make you more sensitive to sunburn. They may also cause skin damage in a tanning bed situation. Please be extra cautious and use sun screen in these situations. Also, in the summer months it is particularly important to stay cool and drink plenty of water and liquids unless otherwise directed by your doctor.

VI. Medication Interactions

To avoid and mange medication interaction it is important to inform ALL your current and new doctors and dentists of ALL your medications.

VII. Alcohol & Drugs

It is important to avoid any street drugs or alcohol when you are being treated with psychiatric medications. If you use drugs or alcohol, unpredictable and unusual side-effects and reactions may occur.

VIII. Over-the-Counter & Herbal Medications

It is important to keep your doctor informed about any herbal or over-the-counter medications that you are taking or planning to take.

IX. Overdose

Call 911 *and* Poison Control immediately in case of overdose.

X. Dosage Instructions

Make sure you understand exactly how the medication is to be taken. If in doubt, ask your doctor or pharmacist. Please call if there is a difference between what the doctor has told you and what the bottle says. Do call our office if you notice a change in the size or color of your pills on a refill. Parents need to supervise medication taken by their children.

XI. Refills

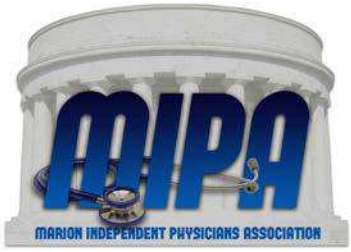
It is important to keep taking your mediation unless directed by your doctor to stop. Please make sure to make and keep regular follow-up appointments. In case you run out of medication because of unforeseen problems, please call us for refills until you r next appointment. Please note that schedule 2 controlled substances commonly used for ADHD need a new prescription each time they are filled. Refills are not allowed on these drugs. For each medical appointment, please bring a very accurate list of all medications that you are taking from any doctor. In place of a list, you may bring all the original medicine bottles.

XII. FDA Labeling

It is common in the present day psychiatric practice to use medications for different purposes and in different age groups that what the U.S. food and drug administration approved them for. We apply principles of risk/benefit analysis to these situations. This is particularly important for children because few commonly used medications have FDA labeling for children with psychiatric problems. Risk of not treating must also be taken in ton account in risk/benefits analysis.

XIII. Falls

Some psychiatric medications cause dizziness, lightheadedness, and a blackout like feeling. These problems can be minimized by getting up slowly from lying down or reclining positions. It helps to move your legs before you get up. These precautions for slow change of position can help minimize falls. These precautions are critical for elderly people because falls in this age group can have very serious consequences.



FINANCIAL POLICY

In an effort to promote understanding of the procedure for processing payments of accounts for services rendered in this office, the following guidelines are set:

If you have insurance, we will gladly bill your insurance company for you after we receive a copy of your current insruanc3e card and your signature allowing us to do the billing and receive payments. Co-pays must be paid at the time of service. When we receive response from your insurance company, we will mail you a statement for any balance not covered by insurance. That balance needs to be paid in full within 15 days. If that is a hardship for you, please call our billing office (740.387.7782) to arrange for a budget payment plan.

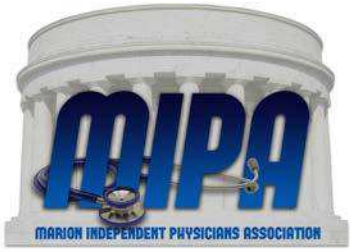
Most insurance will send payment to our office, however, if you receive the payment directly from your insurance, please notify our office immediately.

If you have an insurance that requires a prior authorization to see a specialist, please call the number on the back of your insurance card and get the prior authorization for your first visit and bring that information with you to your first visit. Otherwise, you will be responsible for payment in full if a prior authorization is not obtained.

Each patient is ultimately responsible for all fees for services. In the case of minor children, we can bill the insurance holder's insurance company, but the custodial parent is responsible for the account.

Any cancellation of an appointment must be made 24 hours before the scheduled appointment. Any late cancellations or no shows are subject to a late fee of $25.00 or more if cancels/no shows are done on a consistent basis. The late fee must be paid in full before another appointment may be scheduled.

Signature: _____ Date: _____



Patient Name: _____ Date of Birth: _____

PCP MEDICATION LIST

MEDICATION	STRENGTH	DOSAGE	PRESCRIBING DOCTOR

KNOW DRUG ALLERGIES

CHRONIC MEDICAL AND BEHAVIORAL HEALTH PROBLEMS

DATE	CHRONIC MEDICAL PROBLEMS	TREATING PHYSICIAN
DATE	**BEHAVORIAL HEALTH PROBLEMS**	**TREATING PHYSICIAN**

Patient Signature:_____ Date: _____