Thank you for choosing Magnificat Family Medicine!

Helpful information before your first appointment:

• Please be sure this packet is filled out as completely as possible.

• This includes your pharmacy information!

• Please be sure to arrive 15 minutes prior to your appointment (We need time to get you into the computer before the doctor sees you.

• Please bring a valid photo ID and your insurance card. (if you have insurance)

• Co-Payments, Co-Insurances, and all other amounts are due at the time of service*

*Please speak to practice manager if you are unable to make payment at time of visit.
Patient Information Sheet

Date: ____________

Name: ________________________________ First       Middle       Last       Maiden

I prefer to be called: ______________________ Date of birth: ____________ Social Security #: ______________

Home Phone #: ______________________ Cell Phone #: ______________________ Work #: ______________________ (circle preferred #)

Home Address: ________________________________ Street       City       State       Zip Code

Employer: ________________________________ Occupation: ________________________________

Employer Address: ________________________________ Street       City       State       Zip Code

Marital status: _______ Male_____ Female____ Email: ________________________________

Pharmacy name: ________________________________ Pharmacy phone #: ________________________________

Pharmacy Address: ________________________________ Street       City       State       Zip Code: ______________

Person responsible for account: ________________ Consent to receive text/email appt. alerts? Yes____ No____

PARENT/GUARDIAN (IF PATIENT IS A MINOR)

Name: ________________________________ First       Middle       Last       Maiden

Relationship to patient: ________________________________ Social Security #: ________________________________

Home Phone #: ______________________ Cell Phone #: ______________________ Work #: ______________________ (circle preferred #)

Home Address: ________________________________ Street       City       State       Zip Code

Employer: ________________________________ Occupation: ________________________________

Employer Address: ________________________________ Street       City       State       Zip Code
EMERGENCY CONTACT INFO:

Name: ___________________________________________ Relationship: __________________________

Home Phone #: ___________ Cell Phone #: ___________ Work #: ___________

INSURANCE CARRIER

Name: ___________________________________________ Date of birth: __________________________

First Middle Last

Home Address: ___________________________________________ Social Security #: ______________

Street City State Zip Code

Home Phone #: ___________ Work #: ___________ Relationship to patient: __________________________

Employer Name/Address: __________________________________________________________

Street City State Zip Code

AUTHORIZATION FOR MEDICAL INFORMATION

I authorize that Magnificat Family Medicine, LLC, may communicate with me regarding appointments/scheduling, lab results, as well as but not limited to, brief treatment and follow-up instructions, and which may be communicated by the following: (please initial where applicable)

Home answering machine/voicemail ___________ Authorization for communication with family member(s) (Please include their name)

Cell phone voicemail ___________

Work voicemail ___________

Clinic secure email account ___________

Other ___________

The patient (parent/guardian) is responsible for all fees, regardless of insurance coverage. This includes, but is not limited to, co-insurance, co-payment, deductible, and non-covered services.

I authorize the release of any medical information necessary to process medical claims on my behalf. I also request payment of benefits to myself or Magnificat Family Medicine, LLC. I authorize the release of my medical records to consulting specialists or facilities for the continuation of care as deemed necessary by my physician. I authorize the release of my financial records to my spouse or authorized parent/guardian for the purpose of reconciliation of my account.

Patient’s or Authorized Person’s Name __________________________________________________________

Patient’s or Authorized Person’s Signature __________________________________________________________

Date Signed ________________________
NEW ADULT PATIENT MEDICAL HISTORY

Name: ___________________________ Date of Birth: __________________
Age: ___________________________ Today’s Date: ______________________
If minor, Accompanying Adult’s Name: ________________________________

Please tell us the REASON FOR TODAY’S VISIT or any special concerns you would like to discuss with your doctor today:

__________________________________________________________________________________________________
__________________________________________________________________________________________________

Please list your CURRENT MEDICATIONS/VITAMINS/SUPPLEMENTS:

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage (ie, MG)</th>
<th>How Taken (ie, 1 tablet daily)</th>
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Please list any ALLERGIES to medications/foods:

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Type of Reaction (ie, rash, nausea)</th>
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Please provide your IMMUNIZATION HISTORY:

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<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
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<tbody>
<tr>
<td>Tetanus-Diphtheria Booster</td>
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<tr>
<td>Influenza Vaccine (Flu Shot)</td>
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<tr>
<td>Pneumococcal Vaccine</td>
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<tr>
<td>Tuberculosis (TB) Skin Test</td>
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Hepatitis A Vaccine
Hepatitis B Vaccine
Human Papilloma Virus (HPV)
Varicella Vaccine

For Nurse Use Only:   Ht_________ Wt______ BMI_________ BP__________ Pulse________ Resp______ SpO2________
Please provide your **PAST MEDICAL HISTORY**:

| ____ Allergies          | ____ Blood clots                 | ____ Gallbladder disease     | ____ MI (heart attack) |
| ____ Anemia             | ____ Cancer, type___________ | ____ GERD (reflux)          | ____ Osteoarthritis    |
| ____ Angina (chest pain)| ____ CVA (stroke)                | ____ Hepatitis C             | ____ Osteoporosis      |
| ____ Anxiety            | ____ COPD (emphysema)           | ____ High cholesterol        | ____ Peptic ulcer disease |
| ____ Arthritis          | ____ CAD (heart disease)        | ____ High blood pressure     | ____ Renal disease (kidneys) |
| ____ Asthma             | ____ Crohn’s disease            | ____ Irritable bowel disease| ____ Seizure disorder |
| ____ Atrial fibrillation| ____ Depression                 | ____ Liver disease           | ____ Thyroid disease   |
| ____ BPH (enlarged prostate)| ____ Diabetes | ____ Migraine headaches     | ____ Other____________ |

**PAST OPERATIONS:** What operations have you had?

<table>
<thead>
<tr>
<th>Type of Operation</th>
<th>When it happened</th>
<th>Doctor or Hospital</th>
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Please provide your **SOCIAL HISTORY**:

Do you Smoke?  Yes  No  Former  Type of Operation

- Yes
- No
- Former

- Total # of Lifetime Partners: __________

- Do you currently sexually active?  Yes  No  Former

- When was your last drink? __________

- Do you drink Alcohol?  Yes  No  Former

- Type of alcohol: __________

- Frequency and Amount: __________

Are you currently sexually active?  Yes  No  Former

- Do you use Illegal drugs?  Yes  No  Former

- Type of drug: __________

- Frequency and Amount: __________

- When was your last drink? __________

- Do you have an eating disorder?  Yes  No  Former

- Do you view pornography?  Yes  No  Former

- Other Addictions? __________

FOR FEMALES ONLY:

Age at First Period: __________

Are periods  [ ] Regular  [ ] Irregular

- Menopause  [ ] Hysterectomy

- Cycle Length (i.e. 28-30 days): __________

- # of days Bleeding: __________

- Date of Last Menstrual Period: __________

- Date of Last Mammogram: __________

- Date of Last Pap Smear: __________

- Any history of abnormal pap smears?  Yes  No

- Number of Pregnancies: __________

- Number of Live Children: __________

- Number of Miscarriages: __________

- Number of Abortions: __________

- Do you have pain with period?  Yes  No

- Or any of the following:  Pelvic Pain

- Back Pain

- Breast Tenderness

- Mood Swings

- Headaches

- Is Flow:  Normal  Heavy  Light  Spotting

- If Yes, When: __________
Please provide your FAMILY HISTORY:

FATHER: □ Alive □ Deceased  Age _____  Reason Deceased? ____________  
Health Problems________________________________________________________________________

MOTHER: □ Alive □ Deceased  Age _____  Reason Deceased? ____________  
Health Problems________________________________________________________________________

BROTHERS AND SISTERS: (each one, are they living?, what die from?, ages, other health problems)  
_______________________________________________________________________________________  
_______________________________________________________________________________________  
_______________________________________________________________________________________

SPouse: □ Alive □ Deceased  Age _____  Reason Deceased? ____________  
Health Problems________________________________________________________________________

CHILDREN: (NAMES AND AGES, living or deceased, what die from?, ages, other health problems)  
_______________________________________________________________________________________  
_______________________________________________________________________________________  
_______________________________________________________________________________________

Does anyone in your family have these health conditions? (Please check & list relation even if listed above)  
_______ Heart Problems (heart attacks, _______ Prostate Cancer  _______ Mood disorders  
heart failure)  _______ Skin Cancer (anxiety, depression, bipolar, etc.)  
_______ Breast Cancer  _______ Diabetes  
_______ Colon Cancer  _______ Strokes

HEALTH MAINTENANCE: (Please list Date)  
Last Dental Appointment: __________________________  
Last Eye Doctor Appointment: _____________________  
Method of Family Planning: ________________________  
Last Cholesterol: _________________________________  
Last Blood Sugar: _________________________________  
Last Heart Scan/Stress Test/Echo:____________________  
Last Colonoscopy: ________________________________

PATIENT SIGNATURE: ______________________________________________________ DATE: ________________

PHYSICIAN REVIEWED: ______________________________________________________ DATE: ________________
Magnificat Family Medicine, LLC
Meaningful Use Patient Registration Form

In compliance with the HITECH Act (HER) to attain meaningful use, we are required to capture demographic data including your preferred language, race, and ethnicity. This is an important part of your medical history and will assist us during our clinical quality improvement process. Please complete the information below.

Patient Name:____________________________________________________

Date of birth:___________     Age:___________

Race:

___ African-American
___ Arabic
___ Asian
___ Caucasian
___ Filipino
___ Hispanic
___ Other __________________________

Ethnicity:

___ Hispanic
___ Non-Hispanic

Primary language:

___ Arabic
___ Chinese
___ English
___ French
___ Korean
___ Spanish
___ Other __________________________

Please provide information about previous tests, immunization (including date or year of the last).

Flu shot ________________    Pneumococcal Vaccine ________________

Male:

Colonoscopy ______________

Female:

Colonoscopy ______________

Mammogram ______________

Tobacco use:

___ Never
___ Current every day smoker
___ Current smoker – does not smoke every day
___ Former smoker

Patient Signature:________________________________________________ Date:_________________
Magnificat Family Medicine, LLC

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I understand Magnificat Family Medicine, LLC, Notice of Privacy Practices, containing a description of the uses and disclosures of my health information. I further understand that Magnificat Family Medicine, LLC may update its Notice of Privacy Practices at any time and that I may receive an updated copy by submitting a request in writing to the office or by going online to www.magnificatfamilymedicine.com.

Printed Patient Name _____________________________________________________

Patient Signature ___________________________________________________________________

Date Signed _____________________________________________________

Date of Birth _____________________________________________________

If completed by Patient’s Authorized Person (parent/guardian), please print name and sign below.

Printed Authorized Person’s Name _____________________________________________________

Signature of Authorized Person ___________________________________________________________________

Relationship to patient _____________________________________________________

Date Signed _____________________________________________________
While Magnificat Family Medicine will not charge you to release or obtain records, the physicians we are requesting your records from may have a fee for this service. Please contact them about their policy.

Magnificat Family Medicine, LLC
Authorization to Release/Obtain Medical Information

Date:__________________
Patient Name:_________________________________________  Date of birth:_____________
Home Address:__________________________________________
__________________________________________
Street  City  State  Zip Code

Please release the following:

____  Progress notes  ____  Mental health/counseling records
____  Labs/imaging reports  ____  Substance abuse treatment records
____  All records  ____  Other  _____________________________

Release records to: Magnificat Family Medicine, LLC
5455 W. 86th St., Suite #210
Indianapolis, IN 46268
Office: 317-306-5588
Fax: 317-550-1544

Dear Patient, Please list the NAME AND FAX NUMBER of any doctor, specialist or hospital that you have previously seen. Then sign at the bottom.

Dr./Practice Name:  FAX:
__________________________

Dr./Practice Name:  FAX:
__________________________

Dr./Practice Name:  FAX:
__________________________

Dr./Practice Name:  FAX:
__________________________

By signing I authorize and request disclosure of all protected information. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. This release is effective for one year from the date of execution; however, I may revoke it at anytime by providing notice in writing to the above named party. I accept and understand this will not be sent without a correct FAX number.

Patient Signature:________________________________________    Date:__________________

*While Magnificat Family Medicine will not charge you to release or obtain records, the physicians we are requesting your records from may have a fee for this service. Please contact them about their policy.
Magnificat Family Medicine
Financial Policies

We would like to thank you for choosing Magnificat Family Medicine as your medical provider. We have written this policy to keep you informed of our current financial policies.

**Insurance:** Although we are contracted with several insurance companies, it is your responsibility to make sure that our physician is in your plan. It is also your responsibility to know your insurance benefits.

As a courtesy to our patients we will file primary insurance forms from our office. We will need all your demographic information prior to your appointment. We ask that at the time of your appointment you bring your insurance card and photo ID as well as any other forms that will assist in making sure that your claim is filed correctly. At the time of service, you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles, and non-covered services or items received. You may receive a statement from our office for any balance due. For your convenience we accept cash, checks, credit cards, and money orders. Payments are also accepted by phone.

**Liability Injury:** If your injury is a result from another party’s negligence, you are required to pay for services and then collect from the responsible party. We will not file your insurance but will provide you with a receipt to do so.

**Worker’s Compensation:** If your injury is due to an accident in your workplace, please inform the front desk staff immediately. We are not authorized to treat you for this type of claim. You will need to contact your supervisor for instructions on how to file a worker’s compensation claim. We regret any inconvenience this may cause.

**Return Checks:** There will be a charge assessed for any check returned by your bank for any reason.

**Disability, Insurance Forms, Attending Physician Statements, FMLA:** There will be a charge of $25.00 for the completion of medical forms or you may be required to schedule an appointment. Payment is due at the time when you pick-up these forms. Please allow 7-10 days for the completion of these forms. If you would like the forms mailed to you or the insurance, payment will be due prior to mailing. FMLA forms require that you come in for an appointment.

**Medical Records:** We will provide you a copy of your medical records upon request and for a fee. You will need to sign a letter of release prior to having them copied. Please allow up to 30 days for this request to be processed.

**X-rays:** We will provide you a copy of your x-rays upon request and for a $25 fee. You will need to sign a letter of release at the time of pick-up. Please allow 48 hours from the time of your request.

**Lab Work:** All lab services are billed by the contracted lab. You may receive a bill from MACL, Genpath, or LabCorp. Please contact their billing department prior to calling our office. We do not have access to their billing information. If necessary, call our office at 317-306-5588.

**Billing:** If you receive a bill from us, it is because we believe the balance is your responsibility. Please contact your insurance company first, if you think there is a problem. If you have any questions about your bill, please call our billing department immediately at 317.272.1838. If you cannot pay your entire balance, please call to make payment arrangements.

**Collections:** Accounts that are not paid within 30 days begin out in house collection process. If your balance becomes 65 days old, your doctor will be notified and you may be subject to dismissal from the practice.

I acknowledge that I have received and read a copy of the Magnificat Family Medicine Financial Policies.

____________________________________
Signature/ Patient or Guardian          Date
We would like to thank you for choosing Magnificat Family Medicine as your medical provider. We have written this policy to keep you informed of our current office policies.

**Office Hours:** Mon, Tues, Wed & Friday we are open 8am-4pm. Thursday we have nurse visits only and are open from 8AM-12PM. The office is closed daily 12pm-1pm for lunch.

**Appointments:** We see patients by appointment only. Same day appointments are usually available for urgent or sudden illness/injury.

**After hours and Emergencies:** For a serious emergency call 911 right away. If you are not sure and you call our office if will send you to our after-hours answering service. Choose option #3 to speak to physician on call.

**Urgent or Sudden Illness/Injury:** We have a limited number of same day or “work-in” appointments available every day. Please call early in the day, as these spots fill up quickly. If there are no available appointments, the front office coordinator will offer an appointment at the next soonest availability or transfer you to the nurse who will discuss your needs with the physician and determine what you should do.

**Cancellations:** Please call within 24 hours if you are unable to keep your scheduled appointment. This allows us to provide that time slot to another patient. You will be assessed a $25 fee if we are not notified within 24 hours.

**Running on time:** We know your schedule is busy and that your time is valuable. Please let us know if you have waited more than 15 minutes so we can double check to see if you have been properly checked in.

**Treatment of Minors:** Patients under the age of 18 must be accompanied by a responsible adult or have written permission for treatment from a parent or guardian.

**Complete Physical Exams:** We believe that routine, annual complete physical exams with screening lab tests are very important to the maintenance of good health. However, insurance benefits vary. Some policies cover “wellness” and others cover visits when you have a complaint. Please learn about your benefits prior to your appointment so you will know what is covered by your insurance plan.

**Speaking with a “Nurse”:** When you call the office, you may make a request to the front office coordinator to speak with a nurse. Often at the time you call the nurse may be helping the doctor, so your call is answered by the voicemail. Please leave a detailed message, including your full name and date of birth, and the nurse will call you back usually the same day.

**Test Results:** If you have diagnostic testing, i.e., lab, x-ray, echo, ultrasound, sleep study, please schedule a follow-up appointment, within 7-10 days, to go over the results in a nurse visit. You will be subject to your copay/coinsurance. **Results will not be given over the phone.**

(Over)
Prescriptions and Refills:

- The best time to get a prescription refill is at your appointment.
- If you need to call for refills, don’t wait until you have run out.
- Don’t go to the pharmacy to wait for our prescription to be called in. Call them first to see if it is ready.
- Refill requests called to us before 12:00 p.m. will be handled by the end of the day. After 12:00 p.m., it may be the next morning before your request can be addressed and they are handled in the order we receive them.
- Some medications have potential side effects that must be monitored. We require check-ups every 3 months for these medications. Be sure to keep those follow-up appointments.
- Some prescriptions cannot be called in. The prescription must be printed for you to pick up.
- Don’t call after hours for prescription refills. There is no access to your chart and we may not be able to help you.

Narcotics: These medications can be misused, abused or lead to addition. Please see controlled substance agreement for additional information. We do not call in narcotics after hours.

Mail Order Prescriptions: Many insurance plans offer financial incentives for using mail order pharmacies. We are glad to print out prescriptions for your mail order pharmacy needs. You can pick these up at our office. We do not fax or call in mail orders.

Referrals: Referrals are handled by our Referral Department. Sometimes this can be done on the same day as your appointment and sometimes it can take 2-3 days, depending on your insurance and/or the urgency of your situation. Someone will contact you as soon as the referral authorization is obtained.

As a patient, it is your responsibility to ensure that your specialist is on your plan. It is also your responsibility to ensure your specialist receives your test results. You should pick-up a copy of your test results from our office and hand deliver them to your specialist. We will not fax test results and it is possible that the specialist will not see you without these. Please understand that it can sometimes take a few weeks to get and appointment with a specialist. This is not something we have control over.

Patient Rights and Responsibilities and Notice of Privacy Practices: A copy of these forms is available to you at your request. They are also posted on our website.

Dismissal: If you are “dismissed” from the practice it means you can no longer schedule appointments, get medication refills or consider us to be your doctor. You have to find a doctor in another practice.

Common Reasons for Dismissal

- Failure to keep appointments, frequent no-shows
- Noncompliance, which means you won’t follow physician instructions about an important health issue
- Abusive to staff
- Failure to pay your bill

Dismissal Process

We will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical record to your new doctor after you let us know who it is and sign a release form.