Thank you for choosing
SPRING HILL INTERNAL MEDICINE
CLARK PHYSICIAN GROUP
Dr. Mark E. Head
Dr. Tina N. Bradley
Dr. Laura C. Larch
Nicole Flippen, NP
Kim Sickels, NP

Information about our practice

OFFICE HOURS:
Monday through Friday, 8 a.m. to 6:00 p.m., depending on which provider you see.
The phones are answered from 9:00-4:30

Note: PROVIDERS
Once a patient has established care with a specific provider, whether it's a Nurse Practitioner or a Physician, it is an office policy that the patients' care REMAIN with that provider. Meaning, our providers do not see each other's patients. The only exception is that our Nurse Practitioners are available to see call-in sick visits of all of our patients, not just the ones that have established with them as their Primary Care Provider.

TELEPHONE CALLS:
Our trained team members are available throughout the day to answer any questions you may have. Please call during regular office hours. During the evenings and on weekends our answering service will be available to take your calls when you call the regular office number.

PRESCRIPTIONS:
We recommend having your prescriptions written or electronically faxed during routine office visits. This applies to local pharmacies as well as mail order. Please do not wait until you are out of a medication to request a refill. We ask that you give 48-72 hours' notice for a prescription refill. When you need a refill, simply **call your pharmacy first** and they will forward a refill request to our office. Only in emergency situations will a refill be called in after office hours. Our providers do not typically prescribe controlled substances.

LAB RESULTS:
Our providers may order laboratory tests as part of the evaluation of your general health due to specific concerns. These tests are always reviewed carefully by your provider. Most tests are resulted in 2-3 business days. Please contact us for your test results. Do not assume they are normal if you have not heard from us. Most lab tests are performed by LabCorp and you may receive a separate bill from them for the tests.

APPOINTMENTS:
In order to better serve you, office visits are by appointment. If you are unable to keep an appointment please contact our office as soon as possible to cancel. Two days prior to your appointment you should receive a courtesy call from an automated system. Please listen carefully to your options when receiving this call as some appointments have been cancelled due to pressing the wrong number. We also offer reminder text messaging. For emergent or urgent situations we will make every effort to see you as soon as possible. Please bring your insurance card(s), picture ID, current list of medications, and any copay, co-insurance, or deductible you might have to each appointment. These are to be paid at the time of service. It is our policy that insurance cards are to be scanned into our system once a month, so please be sure to bring your card with you. Most same day sick visits will be scheduled with one of our Nurse Practitioners. **Please note: Dr. Larch requests her patients arrive 15 minutes prior to an appointment to check in, to be triaged and in an exam room by your appointment time. Dr. Larch runs on time. If you are late for an appointment, you may be asked to reschedule**

NO CALL/NO SHOWS:
We require patients to call the office to cancel a scheduled appointment. If three (3) appointments are missed in a six (6) month time period the patient may be released from the practice at the provider's discretion. If you are scheduled for a NEW PATIENT appointment, our office policy dictates that if you do not call and do not show up for that new patient appointment then you will not be allowed to reschedule your appointment.

FINANCIAL POLICIES:
Our office participates in most traditional and managed care insurance plans, including Medicare. Please call your member services number on the back of your card to verify our participation in your plan. Your co-pay, co-insurance or deductible may be due each time you see the provider, as dictated by your insurance plan. We accept MasterCard, Visa, Discover, American Express, and debit cards. For our uninsured patients, we offer a 25% discount for your office visit when making full payment on the date of service. Please contact our office for details.

WELL VISITS:
Most insurance plans cover well physicals. Please check with your insurance for benefits information prior to your appointment. It is your responsibility to notify the appointment scheduler of your desire to have a well physical. During the well physical, no treatment will be given in order for it to qualify as a well physical. This appointment may be rescheduled at the discretion of the provider if he/she feels the visit does not qualify for a well visit. *We cannot and will not change medical records in order for a claim to be paid.*

IDENTITY:
Due to the increased rate of identity and insurance theft, our office will ask for a photo ID at your initial visit and as needed thereafter. This is for your protection. Your private information is kept confidential.

TESTING AND ADMISSION:
Our providers prefer to admit patients to Clark Memorial Hospital. We use other Clark Physician Group providers unless requested differently by the patient. If you need medical attention after office hours or on weekends, we recommend that you use the Urgent Care Center in Sellersburg (Hunter Station) or Clark Memorial Hospital Emergency Room.

EMR:
The Clark Physician Group uses an electronic medical record system called Allscripts. This provides improved speed on prescription refills, decreased risk for medication errors, drug interactions, and reduction in repeat diagnostic testing, just to name a few. The Urgent Care Center in Sellersburg has access to this system and may use it as a tool in your treatment to retrieve information that may be vital to your treatment. Information such as allergies, medications, testing, office notes, consultations, and past medical history are available to them

PROPER COMMUNICATION:
Some of our providers are on social media sites like Facebook, etc. It is NOT proper, nor acceptable, to contact a provider through any form of social media for medical questions or requests. We require you to contact our office directly, either by calling our office or through the Patient Portal.

CONTROLLED SUBSTANCES:
Our providers do not prescribe long term controlled substances such as pain medications. Patients needing pain maintenance medications are referred to a Pain Management facility. In addition, our Nurse Practitioners do not prescribe any ADHD or ADD medications.

In order to improve our practice, you may receive a random survey in the mail. If you feel you received "VERY GOOD" care from us, please let us know, WE REALLY APPRECIATE IT!

It is our goal to improve our practice and the care that we provide!

THANK YOU FOR CHOOSING SPRING HILL INTERNAL MEDICINE!

Clark Physician Group

A Norton and LifePoint Partnership

Today's Date ____/____/_____ # PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name Last	First	Middle	□ Mr □ Mrs □ Miss □ Ms	Marital Status (circle) Single/ Married / Divorced /Sep/ Widow
Is this your legal name? □ YES □ NO	If not, what is your legal name?		Birthdate / /	Age Sex □ M □ F □ T
Street or Mailing Address (circle one)	City	State Zip Code		Home Phone Number ( )
Cell Phone Number ( )	E-Mail Address (To be used for appointment reminders)			Social Security - -
Occupation	Employer		Employer Phone Number	

Employment Status: □1 – Full-Time □2 – Part-Time □3 – Not Employed □4 – Self-Employed □5 – Retired □6 – Active Military
Student Status: □F – Full-Time Student □P – Part-Time Student □N – Not a Student

Race: □American Indian/Alaska Native □Asian □Native Hawaiian/Pacific Islander □Black/African American □White □Hispanic □Other □Declined

Ethnicity: □Hispanic or Latino □Not Hispanic or Latino □Declined

Language: □English □Spanish □Indian □Japanese □Chinese □Korean □French □German □Russian □Other _____

Pharmacy: Do you have a living will? □ YES □ NO

Referred By (Please check one box)
□ Dr. _____ □ Insurance □ Hospital □ Family □ Friend □Yellow Pages □ Other _____

Other Family Members Seen Here

PCP Name Phone #

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party: □Another Patient □Guarantor □Self □Check here if information is same as patient

Name	Address	Home Phone Number
Birth Date / /	E-Mail Address	( )

Occupation	Employer	Employer Address	Employer Phone Number
			( )

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? □ WORKERS COMPENSATION (WC)
□ OCCUPATIONAL MEDICINE (OM) □ MOTOR VEHICLE ACCIDENT (MVA) □ ACCIDENT DATE _____

Does the patient have healthcare coverage? □ YES □ NO **Insurance Name**

Name of Insured	Social Security Number - -	Birth Date / /	Effective Date / /	Group ID	Subscriber ID (Policy Number)

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other _____

Name of Secondary Insurance	Name of Insured	Date of Birth / /	Group ID	Subscriber ID (Policy Number)

Patient Relationship to Insured □ Self □ Spouse □ Child □ Other _____

EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Home Phone Number ( )	Other Phone Number ( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I consent to receive text messages and/or email messages from the practice to any cell number and/or email provided which may include appointment reminders, bills, payment receipts, or marketing materials. I understand that a patient's care is directed by his/her physician(s) and I consent to any services that are appropriate for my care and as ordered by my physician(s).

_____ _____

Patient/ Guardian Signature Date

Clark Physician Group

A Norton and LifePoint Partnership

Date: _____

FAMILY AND PERSONAL HEALTH HISTORY

Patient's Full Name: _____ DOB: _____

Pharmacy Name/Address: _____

Previous Primary Care Physician: _____ Referred by: _____

Have you been seen in our office before: Yes No

OTHER PHYSICIANS THAT PARTICIPATE IN YOUR HEALTHCARE:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

MEDICATION/SUBSTANCE ALLERGIES: (Please list reactions)

1. _____
2. _____
3. _____

MEDICATIONS: (Please list name, dose, and frequency)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

ADVANCED DIRECTIVES:

Do you have a Living Will? (Please provide copy) [ ] Yes [ ] No

Do you have a Power of Attorney? (Please provide copy) [ ] Yes [ ] No

What is your Code Status? (Example: DNR- Do Not Resuscitate) _____

SOCIAL HISTORY:

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Alcohol Use: [ ] Never [ ] Former [ ] Occasional [ ] Everyday # per day _____

Tobacco Use: [ ] Never [ ] Former [ ] Occasional [ ] Everyday # per day _____

Illicit Drug Use: [ ] None [ ] Marijuana [ ] Cocaine [ ] Crack [ ] Meth [ ] Other _____

Caffeine Use: [ ] Soda [ ] Coffee [ ] Tea # per day_____

Do you exercise regularly: [ ] Yes [ ] No How many times per week? _____ How long? _____

Activities:_____

Religion: _____

Occupation:_____

With whom do you live?_____

Patient's Name: _____

DOB: _____

PERSONAL HISTORY:

[ ] Yes [ ] No Diabetes
[ ] Yes [ ] No Heart Attack
[ ] Yes [ ] No Heart Disease
[ ] Yes [ ] No High Blood Pressure
[ ] Yes [ ] No High Cholesterol
[ ] Yes [ ] No Kidney Disease
[ ] Yes [ ] No Liver Disease
[ ] Yes [ ] No Depression, Anxiety, Bi-Polar
[ ] Yes [ ] No Stroke
[ ] Yes [ ] No Osteoporosis
[ ] Yes [ ] No Cancer (Type) _____
[ ] Yes [ ] No Other _____

# of Pregancies ____ # of Live Births ____ Miscarriages ____ Abortions ____

C-Sections (# and Year) _____

PREVENTIVE HEALTH: (Please list dates and results)

Cholesterol _____ Dexa Scan _____

Mammogram _____ Pap Smear _____

Colonoscopy _____ PSA _____

IMMUNIZATIONS: (Please list dates)

Pneumonia _____ Hepatitis A _____

Tetanus _____ Hepatitis B _____

Measles _____ Tuberculosis _____

Influenza _____ Shingles _____

Other _____ Other _____

FAMILY HISTORY: (Please check all that apply)

Illness/Condition	Father	Mother	Sibling	Grandparents (Maternal/Paternal)
Diabetes				
Heart Attack				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Kidney Disease				
Liver Disease				
Depression/Anxiety/Bi-Polar				
Stroke				
Osteoporosis				
Cancer				
Other				

RECENT HOSPITALIZATIONS: (Year, Illness, Surgeries)

1. _____
2. _____
3. _____
4. _____
5. _____

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HIPAA ACKNOWLEDGEMENT, PATIENT CONSENT AND FINANCIAL POLICY

I. CONSENT FOR TREATMENT: I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. NOTICE OF PRIVACY PRACTICES: Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

_____
Patient Initials

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

NAME	RELATIONSHIP	CONTACT NUMBER

III. ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION: I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence,, mental or

behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

IV. **PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S):** Federal and state laws may permit this Clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates may be found in the Notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

V. **EMAIL AND TEXT COMMUNICATIONS:** If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

VI. **FINANCIAL POLICY:** The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

- The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient-responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

VII. PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS: If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

_____ _____

Printed Name of Patient or Representative Signature of Patient or Representative

_____

Date

Relationship to Patient (if other than patient) _____

CLINIC STAFF USE ONLY

☐ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

_____ _____

Witness (Staff) Signature Witness (Staff) Printed Name

Date: _____