MONROE
PRIMARY CARE

Patient Information **(Please Print)** Date_____

Name:	Sex: Birthdate: Age:
Street Address:	Marital Status: ☐Married ☐Single ☐ Separated
City: State: Zip:	Occupation:
Social Security #:	Employer: Phone:
Home Phone: ( ) Cell: ( )	Address:
Mailing Address (if different):	City: State: Zip:

Person Responsible for Payment (if different from patient):

Name:	Relationship to patient:
Address:	Social Security #:
City: State: Zip:	Employer:
Home Phone: ( )	Address:
Work Phone: ( )	City: State: Zip:

Emergency Contact:

Name:	Relationship to Patient:
Address:	Home Phone: ( )
City: State: Zip:	Work #: ( ) Cell#: ( )

Referring Information: How did you learn about us?

Other: ☐ Insurance Co. ☐Yellow Pages ☑ Physician Referral Service ☐Friend/ Family ☐Radio ☐ Television
☐ Other (Please Explain) _____

Primary Insurance Company:	***Secondary Insurance Company:***
Company Name:	Co. Name:
Claims Address:	Claims Address:
City: State: Zip:	City: State: Zip:
Policy Holder's Name:	Policy Holder's Name:
Sex: Policy Holder's Birthdate:	Sex: Policy Holder's Birthdate:
Policy Holder ID or Soc Sec #:	Policy Holder ID or Soc Sec #:
Group or Policy #:	Group or Policy #:
Patient's Relationship: ☐ Self ☑ Spouse ☐ Child ☐ Other	Patient's Relationship: ☐ Self ☐Spouse ☐ Child ☐Other

Authorization & Assignment:

I authorize any holder of medical information to release to the Health Care Financing Administration (Medicare) or any other insurance company and its agents, any information needed to determine these benefits or benefits for related services. I further request that payment of authorized Medicare, Medigap, or any other insurance company benefits be made on my behalf directly to Monroe Hospital, LLC, for any services furnished to me by physician. I acknowledge responsibility for payment of any deductibles, co-insurance, and non-covered services. I understand that failure to pay my balance or arrange payments and follow that payment agreement, may result in further collection actions and I agree to pay any and all collection and legal fees related to collection of my unpaid balance. A photocopy of this authorization shall be considered as legal as the original.

I authorize Monroe Hospital LLC to provide medical care reasonable by today's standards.

Patient or Legal Representative's Signature: _____Date: _____

Revised 10/2008

MONROE PRIMARY CARE

Check if you have had any of the following:

ILLNESSES

- ☐ Measles
- ☐ Mumps
- ☐ Whooping Cough
- ☐ Diphtheria
- ☐ Influenza
- ☐ Rheumatic Fever
- ☐ Mononucleosis
- ☐ Bone/Joint Disease
- ☐ Rheumatism
- ☐ Neuritis
- ☐ Polio
- ☐ Bright's Disease
- ☐ Syphilis
- ☐ Jaundice
- ☐ Migraines
- ☐ Valley Fever
- ☐ Cancer
- ☐ German Measles
- ☐ Chicken Pox
- ☐ Scarlet Fever
- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Typhoid Fever
- ☐ Arthritis
- ☐ Bursitis/ Sciatica
- ☐ Meningitis
- ☐ Gonorrhea
- ☐ Anemia
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ Diabetes

HEAD

- ☐ Headaches
- ☐ Dizzy Spells
- ☐ Lightheadedness
- ☐ Blackout spells

EYES

- ☐ Wear Glasses/ Contacts
- ☐ Pain
- ☐ Blurring
- ☐ Spots Before Eyes
- ☐ Dry Eyes
- ☐ Brightness Bothers You
- ☐ Inflammation
- ☐ Redness
- ☐ Double Vision
- ☐ Watery
- ☐ Burning, Itching
- ☐ Fatigue Easily

EARS

- ☐ Earaches
- ☐ Ringing/ Buzzing
- ☐ Discharge From Ears
- ☐ Perforated Eardrum
- ☐ I Don't Hear Well

NOSE

- ☐ Bleeding
- ☐ Stuffiness
- ☐ Sneezing
- ☐ Runny Nose
- ☐ Drips into Throat
- ☐ Allergies

THROAT

- ☐ Sore Throats
- ☐ Trouble Swallowing
- ☐ Bleeding Gums
- ☐ Hoarseness

NECK

- ☐ Stiffness
- ☐ Goiter
- ☐ Pain
- ☐ Thyroid Trouble

CHEST

- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Skin Test - When _____
- ☐ Positive or ☐ Negative
- ☐ Cough Up Blood, Sputum
- ☐ Pleurisy
- ☐ Wheezing
- ☐ Asthma
- ☐ Cough

HEART

- ☐ Chest Pains
- ☐ Shortness of Breath
- ☐ Palpitations
- ☐ Fluttering
- ☐ Skipped Beats
- ☐ Difficulty Breathing While Asleep
- ☐ Blood Clots
- ☐ Cramps in Legs
- ☐ Swelling in Feet, Ankles
- ☐ Swelling in Hands
- ☐ Swelling in Face
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Heart Murmur

ABDOMEN

- ☐ Pain, Cramping
- ☐ Nausea
- ☐ Vomiting
- ☐ Gas, Bloating
- ☐ Bleeding
- ☐ Heartburn

☐ Specific Foods That Bother You

List _____

_____

_____

- ☐ Yellow Jaundice
- ☐ Rectal Pain/ Bleeding
- ☐ Constipation ☐ Diarrhea
- ☐ Mucous in Bowels
- ☐ Hemorrhoids
- ☐ Blood in Bowels
- ☐ Black, Tarry Stools
- ☐ White stools ☐ Smell Badly

ENDOCRINE

- ☐ Diabetes
- ☐ Large Thirst
- ☐ Hot or Cold Bothers You
- ☐ Crave Salt

EXTREMETIES

- ☐ Joint Pain
- ☐ Swelling
- ☐ Red Joints
- ☐ Foot Pain
- ☐ Knee Pain
- ☐ Stiffness
- ☐ Hot Joints
- ☐ Back Pain
- ☐ Ankle Pain

SKIN

- ☐ Rashes
- ☐ Lesions

HEMATOLOGIC

- ☐ I Have Had a Blood Transfusion
- ☐ I Have Been Refused as a Blood Donor
- ☐ Anemia
- ☐ Bruise Easily
- ☐ Don't Stop Bleeding When Cut

CENTRAL NERVOUS SYSTEM

- ☐ Seizures
- ☐ Convulsions
- ☐ Weakness
- ☐ Tremors
- ☐ Stroke
- ☐ Paralysis
- ☐ Spasms
- ☐ Shaking
- ☐ Sharp Shooting Pain in Arms/Legs
- ☐ Numbness or Tingling
- ☐ Lose Balance Easily

GENITOURINARY

- ☐ Kidney or Bladder Infections
- ☐ Kidney Stones
- ☐ Burning Urination
- ☐ Pus, Blood, or Cloudy Urination
- ☐ Urgency to Empty Bladder
- ☐ Trouble Starting Stream
- ☐ Urinate often
- ☐ Wetting the Bed
- ☐ Weak Stream
- ☐ Spray or Double Stream
- ☐ Dribbling
- ☐ Irregular Menstrual Cycle
  _____ Days Apart
- ☐ Excessive Cramping
- ☐ Water Retention
- ☐ Bleeding Between Periods
- ☐ Unusually Heavy Flow
- ☐ Vaginal Discharge
- ☐ Duration of Period

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Patient Questionnaire

Please complete the following by PRINTING the requested information or checking the appropriate box(es).

Patient Name	Age	Sex	Weight	Date

Please describe the problem you wish to have us evaluate:

Has this problem been previously treated? If so, when, by whom, and how?

Known allergies to medications, foods, x-rays, dyes, latex, etc:

Current Medications, including over the counter drugs:

List any serious accidents or injuries:

Family History: (please state whether the following are living, deceased (at what age) , and any health problems they have)

Father:
Mother:
Brother/ Sister:
Children:
Relatives:

Social History:

How Many Alcoholic Beverages Do You Consume Per Day: _____
Tobacco: ☐ Cigarettes ☐ Chewing Tobacco ☐ Cigars ☐ Pipe ☐ Snuff
How Much Per Day: _____

Sleep:

Do you have trouble sleeping? ☐ Yes ☐ No
Do you snore? ☐ Yes ☐ No
Has anyone ever told you that you stop breathing when you sleep? ☐ Yes ☐ No
Do you have trouble staying awake during the day? ☐ Yes ☐ No

MONROE PRIMARY CARE

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Other _____

_____

I hereby authorize you to release any medical information regarding me to the following persons:

_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of *PHI* disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)
		☐			Typ	How
		☐			Typ	How
		☐			Typ	How
		☐			Typ	How
		☐			Typ	How
		☐			Typ	How
		☐			Typ	How
		☐			Typ	How
		☐			Typ	How

(1) Check this box if the disclosure is authorized

(2) Type key: T=Treatment Records: P=Payment Information; O=Healthcare Operations

(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

Notice of Privacy Practices

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____

Date of Birth _____

Signature _____

Date _____

PATIENT FINANCIAL POLICY

The following statement is our Financial Policy as it pertains to Patients. It is required that the patient and/or responsible party read and sign this statement prior to any treatment. All patients and/or responsible parties must also complete and sign our "CONSENT TO TREATMENT" form prior to treatment.

SELF PAY

Payment in full is expected at the time of service. Payment arrangements must be made prior to service with the Business Office. **We accept cash, checks. Discover, Visa, or MasterCard.**

INSURANCE

Monroe Hospital reserves the right to accept or deny assignment of insurance benefits; if we accept assignment of benefits it is the patient's responsibility to supply our office with a copy of a current insurance card. Please note that an insurance policy is a contract between you and your insurance company. The balance remaining after your insurance processes the account is your responsibility. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, you will be expected to pay your balance. Please keep in mind that some, and perhaps all of the services provided may be non-covered services. Also be aware that some services may not be considered reasonable and/or necessary under the Medicare Program or other medical insurance. **We currently do not ask for co-pays or deductibles at time of service. We do ask for co-pays for patients seen in the Emergency Department.**

MEDICAID

It is your responsibility to supply us with a copy of your current card at the time of service. In the case of an emergency we must receive this information within 24 hours of service. The patient is responsible for the full/entire balance if the information is not received. We accept Indiana Medicaid only. If you are an out-of-state Medicaid recipient, you may make arrangements with the Business Office to set up a payment schedule.

WORKER'S COMPENSATION

Your employer must complete and sign a written authorization/incident report form. It is your responsibility to bring this completed form with you along with all billing information for your account (carrier name and address, contact person, telephone number and claim number if applicable). This information must be provided to us prior to treatment. If your account is not paid in full within 60 days, you are responsible and will be expected to pay your unpaid balance. Monroe Hospital will not accept a delay in payment due to a worker's compensation dispute and/or litigation. We may accept assignment of your health insurance benefits.

LIABILITY INJURIES

If you are being seen due to a liability injury, you must provide the following information for billing and verification of payment prior to treatment:

***Auto Accident:** If you are injured in your personal vehicle, you must provide us with the name and address of your auto insurance carrier, claims adjuster's name and phone number, claim number and date of accident. If your injury occurred in someone else's vehicle, we require all of the above information AND the following: **their** name, the name and address of **their** auto insurance company, **their** agent/adjuster's name, telephone number and **their** claim number. Monroe Hospital will bill the auto insurance company of the at-fault party involved in the accident as a courtesy only. As the patient, you are ultimately responsible for payment.

*** Slip and fall. Other accidents, Etc:** if you were injured on residential property or in a residential dwelling, we require the following:

- **Homeowner's** name, the name and address of **their** homeowner's insurance company, **their** agent/adjuster's name, telephone number, **their** claim number and the date of accident. If your injury occurred at a place of business, please provide the same information.
- If your account is not paid in full within 60 days, you are responsible and will be expected to pay your unpaid balance. Monroe Hospital will not accept a delay in payment due to settlement disputes and/or litigation. We may accept assignment of your health insurance benefits **only after your liability insurance has been paid/denied.**

***Veterans Administration Benefits:** VA Benefits are not considered insurance. Insurance such as Blue Cross, Medicare or any commercial insurance must be billed. There may be co-pays associated that the patient will be responsible for paying.

MINOR PATIENTS

The parent/guardian accompanying a minor is responsible for payment of the minor's account balance. A minor who is not accompanied by a parent/guardian will be denied any **non-emergency** treatment unless charges for the treatment have been pre-authorized. Consent of a parent or guardian is unnecessary if the medical treatment is for infectious, contagious, or communicable disease.

CONSENT TO FINANCIAL RESPONSIBILITY

Assignment of Benefits and Release of Records

I hereby assign to **Monroe Hospital** the medical benefits to which I, or my dependents are entitled. I also authorize Monroe Hospital to furnish my health insurance carrier all my patient information including but not limited to any and all medical records, notes, test results, x-ray reports, MRI reports or other documents related to my treatment (including itemization of any charges and payments on my account) that is deemed necessary to process this claim. I also authorize Monroe Hospital to release any and all patient information and medical records necessary to collect this debt. I also understand a returned check fee will be assessed to my account for any check declined by my financial institution.

Collection Costs and Procedures

If my account becomes delinquent, I agree to pay any additional charges to collect the unpaid bills, including but not limited to reasonable attorney fees, and court costs and collection agency fees. By signing this policy, I acknowledge that Monroe Hospital reserves the right to release any patient information and any medical records to their collection agency deemed necessary to assist their staff and their attorneys in the collection of this debt.

By signing below I affirm that I have read and understood Monroe Hospital's PATIENT FINANCIAL POLICY and agree to its contents.

Authorization for Treatment

I, the undersigned, hereby authorize Monroe Hospital to administer such treatment and/or procedures requested by myself or my doctor. I also authorize Monroe Hospital to release any information require by any insurance company in connection with the payment of the related hospital bill.

_____
Patient Signature

_____
Patient's Agent or Representative Signature

_____
Relationship to Patient

_____
Reason Patient Cannot Sign

_____
Date Signed

_____
Witness