8240 Naab Rd, Suite 416
Indianapolis, IN 46260
Office 317.306.5588
www.magnificatfamilymedicine.com

PATIENT INFORMATION SHEET

Date: _____

Patient Name: _____
First Middle Last Maiden

I prefer to be called: _____ Date of Birth: _____ ☐ Male ☐ Female

Home Phone: _____ Cell Phone: _____ Work Phone: _____
**Please circle preferred contact number*

Home Address: _____
Street City State Zip Code

Marital Status: _____ Email: _____

Patient Social Security Number: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

Person responsible for account: _____ Consent to receive text/email alerts? ☐ Yes ☐ No

PARENT OR GUARDIAN (If patient is a minor)

Name: _____
First Middle Last Maiden

Relationship to Patient: _____ Social Security Number: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Home Address: _____
Street City State Zip Code

Employer: _____ Occupation: _____

Employer Address: _____
Street City State Zip Code

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

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INSURANCE INFORMATION (We need to have a copy of your insurance card on file)

Primary Insurance: _____ ID#: _____ Group#: _____

Insurance PO Box (on back of card): _____ Payor ID (EDI): _____ Phone: _____

Primary Subscriber Name: _____ Rel. to Patient: _____

Subscriber Date of Birth: _____ Subscriber Phone: _____

Effective Date of Coverage: _____ Visit Co-Pay (if known): _____

☐ I do not have insurance. I am a Self-Pay patient.

AUTHORIZATION FOR MEDICAL INFORMATION

I authorize that Magnificat Family Medicine, LLC, may communicate with me and/or the individuals listed below regarding appointments/scheduling, lab results, as well as but no limited to, brief treatment and follow-up instructions, and which may be communicated by the following: (please initial where applicable)

Home answering machine/voicemail	_____	Please list name(s) & phone number(s) of other persons authorized to receive patient information:
Cell phone voicemail	_____	
Work voicemail	_____	
Clinic secure email account	_____	
Secure text message	_____	
Online patient portal (when available)	_____	_____

The patient, or parent/guardian, is responsible for all fees, regardless of insurance coverage. This includes, but is not limited to: co-insurance, co-payments, amounts applied to 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 medical records to consulting specialists or facilities for the continuation of care as deemed necessary by my physician. I authorize the release of my medical records to my spouse, authorized person, and/or parent/guardian for the purpose of reconciliation of my account.

Patient or Authorized Person's Name: _____

Patient or Authorized Person's Signature: _____

Date signed: _____

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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 or Birth: _____ Age: _____

Race:
☐ African-American
☐ Arab
☐ Asian
☐ Caucasian
☐ Filipino
☐ Hispanic
☐ Other: _____

Ethnicity:
☐ Hispanic
☐ Non-Hispanic

Primary Language:
☐ Arabic
☐ Chinese
☐ English
☐ French
☐ Korean
☐ Spanish
☐ Other: _____

Please provide us with information about previous tests and immunizations (including date or year of most recent).

☐ Flu Shot: _____ ☐ Pneumococcal Vaccine: _____

☐ Colonoscopy: _____ ☐ Mammogram: _____

Tobacco Use:
☐ Never
☐ Current every day smoker
☐ Current occasional smoker (not smoke every day)
☐ Former smoker

Patient/Authorized Person Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I understand the Magnificat Family Medicine, LLC's 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: ***magnificatfamilymedicine.com***.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Dated Signed: _____

If completed by patient's authorized person (parent/guardian), please print your name and sign below:

Authorized Person's Name: _____

Relationship to Patient: _____

Authorized Person's Signature: _____

Date Signed: _____

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MAGNIFICAT FAMILY MEDICINE OFFICE & FINANCIAL POLICES

Thank you for choosing Magnificat Family Medicine as your medical provider. The following guidelines and policies will help ensure our great relationship.

Patient Portal: The most effective and efficient way for established patients to communicate with our office is by using our patient portal. This is available online at ***health.healow.com/Magnificat*** or on your mobile device using the **Healow app**. Our Practice Code is BFBCDD. New patients should contact our front office to schedule an appointment and create a patient profile with us.

Appointments: To be seen by a Magnificat Family Medicine provider, an appointment is required. Urgent appointments may be available same or next day. Appointments for established patients can be requested or changed through the Patient Portal or by contacting our office by phone. New patients should call the office.

After hours and Emergencies: For a true emergency call 911. For all other urgent symptoms that cannot wait until next business day will have their calls routed to an after-hours answering service. If you have an urgent medical need, you may follow the prompts to speak with a medical professional.

Urgent or Sudden Illness/Injury: Urgent appointments may be available same or next day. Call to schedule during business hours. You may be scheduled for an office visit, telemedicine visit, or speak with a medical professional for a plan of action.

Cancellations: To cancel a scheduled appointment without penalty, 24-hours' notice is required so that your slot may be filled. We recommend you send a message through the patient portal to cancel or reschedule. You may also call the front office. Failure to give proper notice will result in a $25 no-show fee.

No Show Policy: No-Call, No-Show appointments are subject to a $25 fee. Two no-shows or improper cancellations will likely result in dismissal from the practice. New Patients who no-show their first visit may not reschedule for 366 days and will be charged a $25 fee before rescheduling.

Late Notice & Policy: You should arrive for your scheduled appointment time early. Patients arriving five minutes after their appointment time will likely be rescheduled. Late arrivals will be treated as a no show.

Treatment of Minors: Patients under the age of 18 must be accompanied by a parent or guardian. Written permission for treatment of a minor by a parent or guardian is acceptable. Phone verification with parent/guardian may be required.

Complete Physical Exams: Note: insurance benefits vary. Most insurance policies cover one wellness/health maintenance visit per year. Additional visit charges may occur at your wellness visit (if other issues or problems are addressed) that your insurance plan may not cover. It is your responsibility to know your insurance plan and coverage.

Prescriptions and Refills: Bring any prescription refill requests to your appointment. If you will need a refill before your next appointment, call your pharmacy first to see if a refill is available. If not, send a refill request through the patient portal a minimum of 7 days before you run out. If your prescription requires a prior authorization, it is your responsibility to notify the office. Prior Authorizations may take 5 to 7 business days to execute.

Controlled Substances: An office visit is required to fill scripts for ALL controlled substances. A controlled substance agreement must be on file. You may be required to complete additional lab test prior to a prescription being approved. All controlled substances require a provider visit for refill. No exceptions.

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Referrals: Referrals to outside medical specialists will be issued within one week of your visit. If you have not been contacted within 7 days by the specialist to which you have been referred, please follow up with our office by patient portal message or phone.

Patient Rights and Responsibilities and Notice of Privacy Practices: A copy of this form is available to you by request or on our website: ***magnificatfamilymedicine.com/patient-forms***.

Lab Work: You may choose to have your lab work done at the facility of your choice. As a convenience to our patients, a third-party vendor provides most lab services onsite. You and/or your insurance will be billed directly by them. If you have questions about the lab's invoice, contact their billing department. Magnificat does not have access to their billing information. If you are having your labs done at an outside lab, it is your responsibility to ensure we have the results prior to your next visit.

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 liability insurance but will provide you with a receipt to do so.

Worker's Compensation: We are not authorized for workplace accident/injury care or treatment. Contact your employer for instructions on how to file a worker's compensation claim. We regret any inconvenience this may cause.

Disability, Insurance Forms, Attending Physician Statements, FMLA, all other forms: A fee of $25 will be assessed for the completion of all medical forms. Because many forms require physical and medical examination, an office visit may also be required to perform the exam and ascertain all necessary information.

Medical Records: Medical records will be provided to you upon request. A letter of release must be on file prior to compilation. Basic records are $50 and includes postage and handling up to 100 pages. For longer records of more than 100 pages, please reference the complete fee schedule which may be found at: ***www.magnificatfamilymedicine.com/billing-information***. Records may be mailed or electronically sent to you at your direction. Please allow up to 15 business days for this request to be processed. Medical records may be sent to any other medical provider at no cost. We do not accept or provide records or imaging on CDs.

Insurance: We accept most insurance. Knowing coverage and benefits, in-network or tier status of your specific plan is your responsibility. We file primary insurance forms from our office as a courtesy. Your demographic information must be on file and up to date. It is your responsibility to inform us of any changes in coverage, address, etc. At the time of your appointment, bring your insurance card and photo ID as well as any other necessary forms or documents. At the time of service, you will be responsible for all fees not covered or outlined as your responsibility by your insurance plan. This may include co-pays, co-insurance, deductibles, and non-covered services. You will receive a statement from our office for any balance due.

Self-Pay Patients: Patients who choose the self-pay option (not submitting to insurance) are entitled to a 35% self-pay discount. The general self-pay fee for an office visit, due at the time of the visit, is $177. You may receive an additional bill if other services were rendered incurring additional costs. Telemed visits require a $75 copay in advance of your appointment.

Statements and Balance Due: All balances owed are due upon receipt. We encourage using our patient portal to make payments toward your account. You may also view additional information on our website at ***magnificatfamilymedicine.com/billing-information***. Payment may also be made by phone during business hours or by mail. ALL open balances, unpaid fees, and/or late charges must be paid PRIOR to your next visit. Failure to do so may result in disruption of service.

Past Due Accounts: If your balance becomes 61 days past due, and you may be subject to dismissal from the practice and sent to collections.

Return Checks: A $49 fee will be charged for any check returned for any reason.

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New Patient Booking Procedure: All patients scheduling an establishing care appointment must put a credit card on file. Your credit card will be charged $25 only in the event of no-show or improper cancellation (see above).

Dismissal: If you are "dismissed" from the practice it means you can no longer schedule appointments, receive refills, or consider Magnificat Family Medicine to be your primary care physician. Records will be sent to your new doctor without fee upon request.

Possible Reasons for Dismissal include, but are not limited to:

- Repeated no-shows for scheduled office appointments.
- Failure to adhere to office or financial policies.
- Disruptive or threating behavior or having a disrespectful manner towards staff or other patients.
- Delinquent patient account balance.

I acknowledge that I have received, understand, and will abide by the **Magnificat Family Medicine Office and Financial Policies.** I understand these policies may change and the most current version will be available by request.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Dated Signed: _____

If completed by patient's authorized person (parent/guardian), please print your name and sign below:

Authorized Person's Name: _____

Relationship to Patient: _____

Authorized Person's Signature: _____

Date Signed: _____