Doctors Park Family Medicine
Patient Information Brochure

To Our Patients

Thank you for choosing Doctors Park Family Medicine as the healthcare provider for you and your loved ones. We appreciate the opportunity to assist you with your healthcare needs and pride ourselves on the excellent care and quality treatment you will receive from our fine staff. We accomplish this in several ways. This brochure has been created to help answer questions you may have regarding our office.

Office Hours:

Doctors Park Family Medicine is open Monday through Friday from 7:30 AM – 4:30 PM. For the convenience of our patients who may require fasting blood work, our lab opens at 8:15 AM Monday through Friday. (An appointment for lab work is required.) All Medicare patients requiring labs should use the CRH lab and/or the lab in the front of our building. **Our office phone number is 812-372-8281 option #4.**

** Call Here First **

There is a physician on call at all times if you should have an urgent need after hours that you believe cannot wait until the office reopens. Please call the hospital operator at 812-379-4441 outside of normal business hours to reach the doctor on call. However, because the on call doctor may not have access to your medical chart, if he determines that your symptoms are not of an emergent nature, you will be directed to contact the office the next business day. If you should experience symptoms such as chest pain, shortness of breath, profuse bleeding or a possible broken bone, please go directly to the Emergency Room.

Appointments:
812-372-8281 option #4

When scheduling an appointment with our physicians please explain the reason for your visit when you phone for your appointment. This will allow us to schedule the appropriate time needed by the doctor to address your healthcare needs. Please arrive 15 minutes prior to your appointment time so that we may obtain the information we require in order to bill your insurance carrier for you. Please bring your insurance cards and photo ID with you because we will need to make a copy of your cards for billing purposes. In addition please be sure to bring any medication bottles that you are taking so your doctor can review your medications with you.
Advanced scheduling to see your doctor is required. However, if you have an urgent need, please call as early as possible and we will make every effort to offer you a same day appointment. We do our best to stay on schedule, but emergencies may sometimes cause unexpected delays. You play a major role in helping us stay on schedule. If you are running 10 minutes late, we will need to reschedule your appointment so that you and our other patients are not inconvenienced. A room and the physicians' time have been reserved for your appointment. If you find that you are unable to keep your appointment, we do request that you notify our office as soon as possible, but no later than 24 hours prior to your appointment. This will allow us to utilize the time reserved for you for another patient who may be ill and need the doctor's services. We believe that maintaining good health requires timely medical care and follow-up. It is our policy that if a patient misses 3 appointments within a 6-month time period without providing prior notification to us, they may be discharged from our practice.

Treatment and Follow-Up:

When you are treated by the doctor you have chosen as your family physician, all subsequent appointments should be made with the same doctor when possible. However, should you develop a problem that requires immediate attention and your doctor is unavailable, you may be asked to see another physician in our office for that visit.

- Please inform our front desk staff of any changes in address, telephone numbers, and insurance coverage.
- Please inform your doctor or nurse of any change in medications or medical history.

Medical Test Results:

You will receive prompt notification of any test results that require immediate attention. Otherwise, please allow 7-10 working days for test completion, doctor review of the results, and oral or written communication from your nurse.

Prescription Refills
812-372-8281 option #1

Prescription refills will only be authorized during normal office hours. It is our policy that no narcotics or cough medications will be called in after hours or on weekends. Please evaluate your medication supply prior to your office visits and request your doctor to write your refill prescriptions at the time of your visit. If you have not seen your doctor within a 6-month period of time you will need an appointment to see your doctor before any refills can be authorized. If you should become ill or begin experiencing symptoms of illness, an appointment with a doctor for an evaluation is required before any medication can be prescribed. This is necessary to insure you receive the appropriate treatment course for you current illness.

Medical Records:
812-372-8281 option #5

Your medical records are strictly confidential. The Health Information Portability and Accountability Act (HIPAA) restricts us from releasing any information without your written permission, for reasons other than payment, treatment and healthcare operations.
There may be times when you may request that we provide copies of your records to other entities. We do incur an expense to provide you with this service and that cost will be passed onto you. Our fee for copies is $1.00 per page for one to ten copies/ $0.50 per page for eleven to fifty copies/ and $.20 per page for fifty-one copies or more. These medical records requests are handled by an outside source and may take up to ten (10) days for processing. If the cost for the copies is not reimbursed by the receiving entity that you have authorized to obtain these records you will be responsible for payment before the records can be released.

Form Completion:

There is a standard fee for any form completion including FMLA forms. This amount is per form and based on the number of pages per form. This amount is due at the time forms are submitted to our office. Please allow 3 working days for processing.

Questions:

We have an excellent nursing staff that is well trained in assisting patients. Should you have a specific question regarding treatment and the nurse is unavailable to take your call, you may leave a detailed message and she will return your call as soon as she has had an opportunity to talk with your physician. Please be sure to leave all phone numbers where you may be reached and you will be contacted no later than 5:00 PM the following day.

Phone Triage:
812-372-8281 option #2 – Nurse for Dr. Niedbalski, Dr. Lustig, Dr. Salinas, and NP Laura Lasell

812-372-8281 option #3 – Nurse for Dr. Guse, Dr. Shedd, Dr. Lovell, and Dr. Hatcher

Insurance and Payment for Services:
812-372-8281 option #6

Payment is expected at the time of service. It is our policy and a requirement of our provider contract with your insurance company to collect all co-pays and deductibles at the time of your visits from you. For your convenience we accept cash, checks, and all major credit cards. We also offer online bill-pay. As a courtesy we are contracted with several insurance providers and we will file your insurance claim for you. Please provide any new information regarding your insurance to the front desk. Accurate insurance information is vital for processing your claims. Please remember that insurance is considered a method of reimbursing the member for fees paid to the doctor and is not a substitute for payment. Payment for the account remains your responsibility.
We strive to have a mutually respectable relationship with all of our patients. As part of that relationship we believe it is important that you maintain your account with our office in good standing. Should your account become delinquent and you default on payment of your debt, your account will be turned over to an outside collection agency. Should this become necessary you will be responsible for all additional expenses incurred to collect this outstanding debt and you may be discharged from the practice.

From the physicians and Staff at Doctors Park Family Medicine

Thank you for allowing us to care for you.

HEALTH HISTORY

PATIENT NAME ______________________ BIRTHDATE ____/____/____ PATIENT # ______________

To help us meet all your healthcare needs, please fill out **both sides** of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's date ______________________

Place of birth ______________________

Highest level in school ______________________

Occupation ______________________

Previous occupations ______________________

Marital status ______________________

Hobbies ______________________

Exercise/recreation ______________________

Habits:

- Smoking (type & amount per day) ______________________
- If former smoker, date quit ______________________
- Alcohol (type & amount per week) ______________________
- Caffeine (type & amount per day) ______________________
- Street drugs (type & amount per day) ______________________

Usual weight ______________________

Date of last dental exam ______________________

Please list all allergies (foods, drugs, environment)

____

____

____

Have you ever taken Fen-Phen/Redux? ______________________

When was your last physical exam? ______________________

Name of doctor ______________________ Phone ______________

Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred: ☐ none

____

____

____

____

Please list all medicines you are currently taking (include nonprescription drugs): ☐ none

____

____

____

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred): ☐ none

____

____

____

Chief Complaints

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

____

____

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Condition			Condition			Condition		
Measles	no	yes	Migraine headaches	no	yes	Hives or Eczema	no	yes
Mumps	no	yes	Tuberculosis	no	yes	AIDS or HIV+	no	yes
Chickenpox	no	yes	Diabetes	no	yes	Infectious Mono	no	yes
Whooping Cough	no	yes	Cancer	no	yes	Bronchitis	no	yes
Scarlet Fever	no	yes	Polio	no	yes	Mitral Valve Prolapse	no	yes
Diphtheria	no	yes	Glaucoma	no	yes	Stroke	no	yes
Smallpox	no	yes	Hernia	no	yes	Hepatitis	no	yes
Pneumonia	no	yes	Blood or Plasma transfusions	no	yes	Ulcer	no	yes
Rheumatic Fever	no	yes				Kidney Disease	no	yes
Heart Disease	no	yes	Back trouble	no	yes	Thyroid Disease	no	yes
Arthritis	no	yes	High or low blood pressure	no	yes	Bleeding tendency	no	yes
Venereal Disease	no	yes				Any other disease (please list) ______	no	yes
Anemia	no	yes	Hemorrhoids	no	yes			
Bladder Infections	no	yes	Date of last chest x-ray ______			______		
Epilepsy	no	yes	Asthma	no	yes	______		

Family History

Has any blood relative had any of the following: (Circle "no" or "yes", leave blank if uncertain)

			Relationship				Relationship
Cancer	no	yes	______	Stroke	no	yes	______
Tuberculosis	no	yes	______	Epilepsy	no	yes	______
Diabetes	no	yes	______	Allergies	no	yes	______
Heart Disease	no	yes	______	Anemia	no	yes	______
High blood pressure	no	yes	______	Bleeding tendency	no	yes	______

Family History (cont.)
(Circle "no" or "yes", leave blank if uncertain)

		Relationship
Asthma	no	yes
Chronic lung disease	no	yes
Drug or alcohol problem	no	yes
Mental Illness	no	yes
Leukemia	no	yes
Migraine headaches	no	yes
Obesity	no	yes
Thyroid Disease	no	yes
Ulcer	no	yes
Depression	no	yes
High Cholesterol	no	yes
Kidney Disease	no	yes
Glaucoma	no	yes
Gout	no	yes

	Present age, or age of death	If living, health (good, fair, poor) If deceased, cause of death
Father		
Mother		
Siblings		
Spouse		
Children		

Do you have now or have you had within the past year: (Circle "no" or "yes", leave blank if uncertain)

Weakness or paralysis	no	yes
Tire easily or weakness	no	yes
Recent weight changes	no	yes
Change in appetite	no	yes
Sensitivity to cold or heat	no	yes
Persistent fever	no	yes
Night sweats or hot flashes	no	yes
Skin rash	no	yes
Skin trouble or changes	no	yes
Change in nails or hair	no	yes
Headaches	no	yes
Easy bleeding or bruising	no	yes
Double vision	no	yes
Blurred vision	no	yes
Eye pain	no	yes
Infected eyes	no	yes
Do you wear glasses or contacts	no	yes
When was your last eye exam ______		
Ringing in the ears	no	yes
Discharge from ears	no	yes
Ear pain	no	yes
Decrease in hearing	no	yes
Frequent nosebleeds	no	yes
Frequent colds	no	yes
Sinus trouble	no	yes
Loss of smell	no	yes
Persistent hoarseness	no	yes
Sore throat	no	yes
Sore tongue or gums	no	yes
Lump or discharge from breast	no	yes
A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	no	yes

Shortness of breath	no	yes
Bloody sputum	no	yes
Wheezing	no	yes
Chest pain or discomfort	no	yes
Purple fingers or lips	no	yes
Swelling of hands, feet or ankles	no	yes
Difficulty in breathing	no	yes
Palpitations or fluttering of the heart	no	yes
Leg cramps on walking or at night	no	yes
Enlarged veins	no	yes
Difficulty swallowing	no	yes
Heartburn	no	yes
Frequent belching	no	yes
Abdominal cramping	no	yes
Nausea	no	yes
Vomiting	no	yes
Vomited or coughed up blood	no	yes
Chronic diarrhea	no	yes
Chronic constipation	no	yes
Rectal bleeding	no	yes
Black tarry stools	no	yes
Dark urine	no	yes
Yellow jaundice	no	yes
Frequent urination (day)	no	yes
Frequent urination (night)	no	yes
Increase in thirst	no	yes
Painful urination	no	yes
Leakage of urine	no	yes
Difficulty in starting urine	no	yes
Blood in urine	no	yes
Lack of sex drive	no	yes
Hemorrhoids	no	yes
Backaches	no	yes

Joint pain or stiffness	no	yes
Swollen joints	no	yes
Muscle cramps or spasms	no	yes
Sleeplessness	no	yes
Seizures	no	yes
Depression	no	yes
Memory loss	no	yes
Poor coordination	no	yes
Dizziness or fainting spells	no	yes
A living will or advance directive	no	yes
Men only:		
Discharge from penis	no	yes
Pain or lump in testicles	no	yes
Impotence	no	yes
Women only:		
Age period began ______		
How many days do periods last? ______		
How many days between periods? ______		
Is the flow heavy?	no	yes
Do you bleed or spot between periods?	no	yes
Do you have pain or cramps?	no	yes
Date of last period? ______		
Date of last pelvic exam? ______		
Date of last mammogram? ______		
Any itching in vaginal area?	no	yes
Pain with intercourse?	no	yes
Type of birth control used? ______		
Number of pregnancies ______		
Number of full term births ______		
Number of preterm births ______		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

X ______________________________ ______________________________
Signature of patient or parent if minor Date

Physician's Comment

Physician's Signature ______________________________

COLUMBUS REGIONAL HEALTH PHYSICIANS

2400 East 17th Street, Columbus, Indiana 47201

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003
Revised Date: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. **Uses And Disclosures We May Make Without Written Authorization.** We may use or disclose your health information for certain purposes without your written authorization, including the following;

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practices and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions about additional types of services we should provide.

Organized Health Care Arrangements. Members of the hospital's medical staff participate in the Columbus Regional Hospital Organized Healthcare Arrangement (OHCA). An OHCA is an arrangement that involves clinical and/or operational integration among legally separate covered entities in which it is often necessary to share protected health information for the joint management and operations of the OHCA. By participating in the OHCA, the hospital's medical staff will use this Notice of Privacy Practices. The medical staff may also share your protected health information for treatment, payment and healthcare operations without obtaining a written authorization for you. The medical staff are required to use all appropriate safeguards when using your protected health information or disclosing it to other providers

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following;

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases and other information.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or national security and intelligence activities.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.
- To correctional facilities or law enforcement officials if you are an inmate of a correctional institute or under the custody of a law enforcement official.

2. **Disclosures We May Make Unless You Object.** <u>Unless you instruct us otherwise,</u> we may disclose your information as described below.
   - To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.
   - To maintain our facility directory. If a person asks for you by name, we will only disclose your name, general condition, and location in our facility.
   - To contact you to raise funds for our hospital. You may opt out of receiving such communications at any time by notifying the Privacy Officer identified below.

3. **Uses and Disclosures with Your Written Authorization.** Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Officer identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. **Your Rights Concerning Your Protected Health Information.** You have the following rights concerning your health information. <u>To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.</u>
   - You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf (other than a health insurance plan) pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.
   - We normally contact you by telephone or mail at your home address. You may request that we contact you

by alternative means or at alternative locations. We will accommodate reasonable requests.

- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. You are not entitled to inspect and/or obtain a copy of psychotherapy notes, information compiled in reasonable anticipation of a criminal, civil or administrative action or proceeding, or certain information prohibited by law. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others. You may request that a denial be reviewed and another licensed health care professional will be chosen to review your request.
- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record or if we determine that the record is accurate and complete.
- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.
- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. **Breach Notification.** You will receive notification of any breach of your unsecured health information.

6. **Changes to This Notice.** We reserve the right to change the terms of this Notice at any time, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from Patient Registration, the Health Information Department or Privacy Officer.

7. **Complaints.** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

8. **Contact Information.** If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Privacy Officer:	Cindy Hughes
Phone:	(812) 373-3055
Address:	2400 East 17th Street Columbus, IN 47201
E-mail:	chughes@crhsystem.org

9. **Effective Date.** This Notice is effective September 23, 2013.