Franciscan Physician Network

Patient Information

Last Name_____

First Name_____ Middle Initial_____

Soc Sec #_____ Sex o M o F

Birth date_____ Age_____

Address_____

City_____ State_____ Zip_____

Home Phone (_____) _____

Work Phone (_____) _____

Cell Phone (_____) _____

Email address _____

Marital status o Single o Married o Widowed o Divorced

Ethnicity o Hispanic o Non-Hispanic o Unknown
o I prefer not to answer

Race o American Indian/Alaskan Native o Asian
o Black or African American o White/Caucasian
o Native American/Other Pacific Islander o Other
o I prefer not to answer

Religion _____

Patient employed by _____

Employment Status o Full-time o Part-time o Not-employed

Occupation _____

Work address _____

Guarantor/Responsible Party Consenting for Care

Relationship to Patient _____

Last Name_____

First Name_____ Middle Initial_____

Address_____

City_____

State_____ Zip_____

Soc Sec #_____ Sex o M o F

Birth date_____ Age_____

Home Phone (_____) _____

Work Phone (_____) _____

Guarantor employed by _____

Employment Status o Full-time o Part-time o Not-employed

Occupation _____

Work address _____

EMERGENCY CONTACT (closest relative or friend not living with you)

Emergency contact _____

Relationship to patient _____

Emergency contact phone number_____

Contact Address _____

City _____ ST _____ Zip_____

Primary Insurance

Relationship to patient_____

Insurance Company_____

Affordable Health Care/Marketplace Insurance o Yes o No

Insurance Address_____

City _____ ST _____ Zip _____

Group # _____

Group Name _____ Eff Date _____

Policy # _____

Subscriber Last Name_____

Subscriber First Name_____ MI____

Subscriber's Address_____

City _____ ST _____ Zip _____

Social Security #_____

Birth date _____ Sex o M o F

Subscriber's Phone (_____)_____

Subscriber employed by _____

Primary Care Physician _____

Secondary Insurance

Relationship to patient_____

Insurance Company_____

Insurance Address_____

City _____ ST _____ Zip _____

Group # _____

Group Name _____ Eff Date _____

Policy # _____

Subscriber Last Name_____

Subscriber First Name_____ MI____

Subscriber's Address_____

City _____ ST _____ Zip _____

Social Security #_____

Birth date _____ Sex o M o F

Subscriber's Phone (_____)_____

Subscriber employed by _____

Preferred Pharmacy_____**Street/City**_____

Are you interested in starting a MY CHART account? o Yes o No

Signature_____ **Date**_____ Revised 03/07/2014

1. GENERAL CONSENT TO MEDICAL TREATMENT

I hereby request and consent Franciscan Physician Network (this practice) and their employees and agents ("Provider") to attend me during my treatment and perform routine tests and procedures and to provide certain health care services as prescribed for my health and well-being. I acknowledge that no representations, warranties, or guarantees as to results of cures have been made to me by Provider, nor have I relied upon any such representations, warranties, or guarantees. I understand that physicians who hold limited licenses to practice medicine and are currently in residency programs and/or other health career students may assist with my care and treatment, within the scope and limitation of the applicable health education program, during my office visit. Resident physicians and other students of health care will be supervised by instructors or office staff.

2. CONSENT TO PHOTOGRAPH

I hereby consent to present a photo identification to confirm my identity as a patient who will receive treatment from Provider.

Photographs may be taken with a Franciscan Physician Network owned camera for assessment and treatment of medical conditions. I understand that the photographic image will be stored in my confidential medical record.

Initial here if you are declining to have your photograph taken for treatment purposes: _____

3. MyChart ELECTRONIC HEALTH RECORD ACCESS/COMMUNICATION INFORMED CONSENT

If available, I hereby request access to MyChart and understand that in order to gain access to MyChart I will be given a confidential password. I agree to keep it confidential and not share it with anyone else. I understand that my use of MyChart is subject to certain terms and conditions. I agree to review MyChart terms and conditions before accessing MyChart and further agree that by accessing MyChart I am agreeing to abide by the MyChart terms and conditions. To gain proxy access for children 12-18, a separate MyChart proxy access form will be used.

MyChart IS NOT available for this practice site (FPN staff to indicate): _____
MyChart IS available at this practice site (FPN staff to indicate): _____

Initial here if you are declining electronic access to your medical record: _____
Initial here if you consented previously to MyChart and wish to continue using MyChart: _____
Initial here if you are declining MyChart use for children between the ages of 12 and 18: _____

4. FINANCIAL AGREEMENT

I hereby agree to pay Provider their charges for all services rendered during my treatment. I shall also be responsible for any attorney fees required to collect for these services, to which may be added interest at the current legal rate. I hereby assign directly to Provider payment to any health insurance benefits, including but not limited to any and all applicable Medicare and Medigap benefits, applicable to this treatment and authorize the release of information necessary to determine coverage and to permit reimbursement on my behalf to Provider. Such payments, however, shall not exceed my balance owed to Provider. I hereby certify that any information which I have given in applying for coverage under Title XVII and/or Title XIX of the Social Security Act, or any insurance or other information which I provided is true and correct.

5. TELEPHONE/CELL PHONE NUMBER

I hereby consent to the use of my telephone and/or cell phone number to communicate with me concerning my healthcare and financial obligations for the medical services provided.

6. REVOCATION OF CONSENT

I may revoke this consent at any time except to the extent that any Franciscan Physician Network practice has already taken action in reliance on it.

7. INDIANA LAW AND JURISDICTION

I understand that I am being provided treatment in the State of Indiana and I agree that if I should have any claim with regard to my care or treatment, such will be decided in accordance with Indiana law and such action will be brought and decided in a Court in the State of Indiana.

For any line item of this consent I have initialed in the designated area indicating a declination, I understand that indicates I do not agree with that section and do not consent to the options described in that section.

I agree that I have read this form carefully and agree that everything in this agreement applies to current and future health care services provided by Franciscan Physician Network.

_____	_____	___/___/_____
Patient Printed Name	Date	Patient Date of Birth
_____	_____	
Patient Signature	Date	
_____	_____	
Patient's Legal Guardian or Responsible Party Signature (if applicable)	Date	
_____	_____	
Witness	Date	

Patient last 4 of Social Security Number: _____

Franciscan PHYSICIAN NETWORK

Effective Date: February 7, 2013

Franciscan ALLIANCE

Patient Instructions for Communication Preferences

Patient Name (*Please Print*):_____

Patient Address:_____

Date of Birth:_____ Last 4 Digits of Social Security #_____

I authorize my doctor or staff to **leave messages** including certain medical information:

☐ NO Do not leave messages on my answering machine or voice mail. I prefer that my doctor or staff speak to me personally regarding any medical information.

☐ YES May leave messages on my answering machine or voice mail:

☐ at HOME ☐ at WORK ☐ on my MOBILE / CELL PHONE

☐ YES May share information with the following individuals:

☐ My spouse or significant other _____
☐ My son or daughter _____
☐ Any relative _____
☐ Other _____

This information may include information such as:

☐ Lab test and x-ray results
☐ Information regarding prescription refills
☐ Information regarding appointments
☐ Instructions regarding treatments or medications
☐ All information, no exceptions
☐ Billing information

I understand that I may notify the doctor's office at any time of changes to this request, which would require a new form and authorization to be completed.

_____ Signature

_____ Date

Scan to NOTIFICATION PREFERENCES – AMBULATORY

Effective Date: September 23, 2013

Franciscan ALLIANCE

NOTICE OF PRIVACY PRACTICES

Acknowledgement Form

By signing below, I acknowledge that I have been offered or received a copy of the Notice of Privacy Practices ("Notices"). I understand that I may obtain a written copy of this Notice at any time upon request or via the website at franciscanalliance.org

Name of Patient	Date of birth
Patient or Legal Guardian Signature	Date
Witness Signature	Date

Reason Given by Patient if Refusing to Sign this Notice

Recorder's Signature

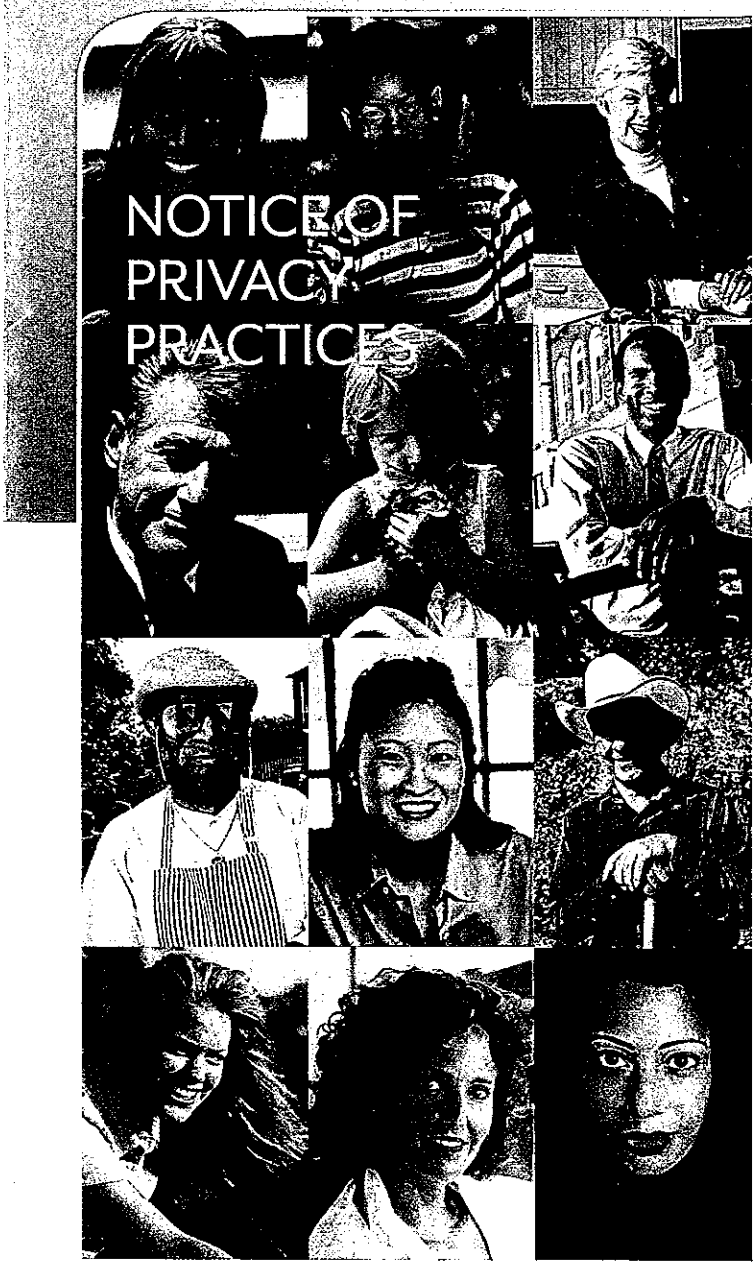
Scan to: HIPAA Notice of Privacy Practice

Patient Label

Contact the HIPAA Privacy Officer

If you have any questions about this notice, please contact the HIPAA Privacy Officer.

Call **(855) 459-7573**



This notice describes how medical information about you may be used and disclosed and how you get access to the information. Please review it carefully.

Franciscan ALLIANCE

FranciscanAlliance.org

REV. 9/2013

Franciscan ALLIANCE

WHO WILL FOLLOW THIS NOTICE

This notice describes our practices and that of:

- Any health care professional authorized to enter information into your chart
- All departments and units of Franciscan Alliance
- Any member of a volunteer group we allow to help you at Franciscan Alliance
- All employees, staff and other personnel of Franciscan Alliance
- All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or Franciscan Alliance's operational purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at Franciscan Alliance. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Franciscan Alliance. Other health care providers may have different policies or notices regarding use and disclosure of your medical information.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that are currently in effect.

HOW WE ARE REQUIRED BY LAW TO DISCLOSE MEDICAL INFORMATION ABOUT YOU

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We will use and disclose medical information about you when we have a "Duty to Report" under state or federal law, because we believe that it is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Public Health Risks. We will disclose medical information about you for public health reporting required by federal and state law. These activities generally include the following, to:

- Prevent or control disease, injury or disability
- Report births and deaths
- Report child abuse or neglect
- Report reactions to medications or problems with products
- Notify people of recalls of products they may be using
- Notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- Notify the appropriate government authority if we believe a Patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We will disclose medical information as required by law to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we will disclose medical information about you when properly ordered to do so by a court.

Law Enforcement. We will release medical information if asked to do so by a law enforcement official, and if permitted by law:

- In response to a court order
- If required by state or federal law
- To identify or locate a suspect, fugitive, material witness, or missing person
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct
- About criminal conduct at a Franciscan Alliance facility
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Protective Services for the President and Others. We will disclose medical information about you to federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or conduct special investigations.

WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, psychologists, nurses, social workers, therapists, technicians, medical students, or another provider's personnel who are involved in taking care of you. Different departments of Franciscan Alliance also may share medical information about you in order to coordinate the different things you need. We also may disclose medical information about you to people outside Franciscan Alliance, such as other health care providers involved in providing medical treatment for you and to people who may be involved in your medical care, such as family members, clergy or others we use to provide services that are part of your care.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at Franciscan Alliance, or other health care providers from whom you receive treatment, may be billed to, and payment may be collected from, you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received at Franciscan Alliance so your health plan will pay us or reimburse you for your treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose medical information about you for Franciscan Alliance's operations or to another health care provider or health plan, if you have a relationship with that health care provider or health plan. These uses and disclosures are necessary to run Franciscan Alliance and make sure that all of our Patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many Patients to decide what additional services Franciscan Alliance should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, social workers, therapists, nurses, psychologists, technicians, medical students, and other

personnel for review and learning purposes. We may also combine the medical information we have with medical information from other health care providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific Patients are.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at Franciscan Alliance.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Fundraising Activities. We may use medical information about you to contact you in an effort to raise money for Franciscan Alliance and its operations. We may use medical information and disclose such to our foundation in connection with our fundraising campaigns so that Franciscan Alliance or our foundation may contact you in raising money for Franciscan Alliance. We would only use or disclose to our fundraising affiliate certain information, such as your demographic information (name, address, other contact information, age, date of birth, gender), dates of service, department of service information, treating physician, limited outcome information or health insurance status. If you would like to opt-out of any fundraising campaign, you may do so by contacting our fundraising department at (877) 220-0946. If you choose to opt-out of any campaign, you will have the option to opt back in to the fundraising campaign by contacting the fundraising department at the same phone number.

Facility Directory. We may include certain limited information about you in a facility directory while you are a Patient at a Franciscan Alliances' facility. This information may include your name, location, your general condition (e.g., critical, serious, fair or good) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This is so your family, friends and clergy can visit you at the facility and generally know how you are doing.

Individuals Involved in Your Care or Payment for Your Care. We may release certain limited information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you want to exercise this right please make your request known to any staff member.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all Patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with Patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for Patients with specific medical needs, so long as the medical information they review does not leave Franciscan Alliance. We may ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the hospital.

Health Information Exchanges. Franciscan Alliance may participate in various regional, state and/or federal Health Information Exchanges ("HIEs") to make certain patient information available electronically to participating hospitals, doctors and others participating in the HIE for purposes of treatment, payment and/or health care operations. Use of the HIE is limited to authorized users who confirm that they will comply with applicable federal and state privacy and security laws. You may request that we not provide your information to HIEs by opting out, in which case you need to contact the privacy officer identified at the end of this notice to receive an opt-out form and return it to us. If you opt-out, your opt-out will apply to all information from all participants in the HIE, even in an emergency.

SPECIAL SITUATIONS

Organ and Tissue Donation. If you are a potential tissue/organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about Patients of Franciscan Alliance to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Copies may be made available either in paper or electronic format. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Franciscan Alliance, Health Information Management Department. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, under some circumstances you may request that the denial be reviewed. Another licensed health care professional chosen by Franciscan Alliance will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Franciscan Alliance.

To request an amendment, your request must be made in writing and submitted to the Franciscan Alliance HIPAA Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the medical information kept by or for the hospital
- Is not part of the information which you would be permitted to inspect and copy
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "Accounting of Disclosures." This is a list of the disclosures we made of medical information about you. Your "Accounting of Disclosures" will not, however, list certain uses and disclosures that are exempted from the accounting requirement by federal or state law. To request this list or accounting of disclosures, you must submit your request in writing to the Franciscan Alliance HIPAA Privacy Officer. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Receive Notice of Breach. We are required by law to maintain the privacy of your medical information, to provide you with notice of our legal duties and privacy practices with respect to your medical information and notify you following a breach of your unsecured medical information. We will give you written notice in the event we learn of any unauthorized acquisition, use or disclosure of your medical information that has not otherwise been properly secured as required by HIPAA. We will notify you without unreasonable delay but no later than sixty (60) days after the breach has been discovered.

Right to Request Restrictions. You have the right to request a restriction or limitation on how we use and disclose your medical information. For example, you also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. Additionally, if you pay for a particular service in full, out of pocket, on the date of service, you may ask us not to disclose any related medical information to your health plan.

With the exception of disclosures to health plans for purposes of payment or health care operations that are not otherwise required by law for items or services paid in full, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Franciscan Alliance HIPAA Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Franciscan Alliance HIPAA Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain another copy of this notice at our website, at **www.FranciscanAlliance.org**

To obtain a paper copy of this notice, you may request a copy of the Notice of Privacy Practices from any admissions clerk, Release of Information Specialist in the Health Information Management Department or the Franciscan Alliance HIPAA Privacy Officer.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in each of our facilities. The notice will contain on the back page, in the lower right-hand corner, the effective date. In addition, each time you register at or are admitted to Franciscan Alliance for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Franciscan Alliance or with the Secretary of the Department of Health and Human Services. To file a complaint with Franciscan Alliance, contact the local HIPAA Privacy Officer at the number at the end of this notice. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. Use and disclosures that require your written permission include, but are not necessarily limited to, certain uses or disclosures of psychotherapy notes, marketing and sale of your protected health information. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.