



MERCY MEDICAL ASSOCIATES
PATIENT REGISTRATION FORM

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_ Sex M/F Marital Status M / S / D / W / Sep Race: \_\_\_\_\_ Ethnicity \_\_\_\_\_

Employed: (Y/N) - (PT/FT) Name of Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Spouse Name \_\_\_\_\_ Spouse DOB \_\_\_\_\_

Advance Directives: Do you have a Living Will? Yes \_\_\_ No \_\_\_

Emergency Contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Insurance Information:

Primary Insurance: \_\_\_\_\_ ID # \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Employment Status: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID # \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Employment Status: \_\_\_\_\_

Additional Information:

Name of Primary Care Physician: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician (if applicable) \_\_\_\_\_ Office Phone (\_\_\_\_) \_\_\_\_\_

Please read and initial each line. If you have questions, please ask us at the front desk for assistance.

- 1. \_\_\_\_\_ I have given the office my current and correct insurance information.
2. \_\_\_\_\_ I understand that I could be charged \$25 for a missed appointment (no show) if a 24-hour notice of cancellation is not given.
3. \_\_\_\_\_ I understand that I could possibly be discharged from the practice for failing to give 24 hour cancellation notice for three or more scheduled appointments.
4. \_\_\_\_\_ I understand that my co-payment is due at each visit and a \$15 administration fee will be charged to me, if this agreement is not met.

NOTICE: I attest that the above information is correct to the best of my knowledge. I authorize the release of any medical or other information necessary to process the claim. I also request payment of insurance benefits either to myself or to the party who accept assignment. I authorize payment of insurance benefits to the physician or supplier for all services rendered. I also understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered or fees associated with my care. I also agree that I am responsible for any collection fees should my account be turned over to a collection agency.

Signature of Person Responsible \_\_\_\_\_

Date \_\_\_\_\_

MERCY MEDICAL ASSOCIATES  
HIPAA

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 for appointments and test results

Check all that apply

- Home/ Cell Telephone Home/ Cell Number \_\_\_\_\_  
\_\_\_ Leave message with appointment date and time  
\_\_\_ Leave message with test results  
\_\_\_ Leave message with call back number only  
\_\_\_ Do not leave message
- Work Telephone Work Number \_\_\_\_\_  
\_\_\_ Leave message with appointment date and time  
\_\_\_ Leave message with test results  
\_\_\_ Leave message with call back number only  
\_\_\_ Do not leave message
- Written Communication  
\_\_\_ Mail to my home address \_\_\_\_\_  
\_\_\_ Mail to my work address \_\_\_\_\_

Patient/ Parent Signature \_\_\_\_\_ Date \_\_\_\_\_  
Print Name \_\_\_\_\_ Birth date of patient \_\_\_\_\_

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and the 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 request 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 reasons other than treatment, payment or operations may be permitted without prior consent in an emergency.**

**The following names listed are those that I give Mercy Medical Associates the authorization to give health information regarding blood work, appointments, and test results to:**

\_\_\_\_\_  
Relationship \_\_\_\_\_  
\_\_\_\_\_  
Relationship \_\_\_\_\_  
\_\_\_\_\_  
Relationship \_\_\_\_\_  
\_\_\_\_\_  
Relationship \_\_\_\_\_

\_\_\_ **DO NOT PROVIDE** health information regarding blood work, appointments, and test results to anyone but me.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices (Version Effective 4/14/03).

Signature of Patient/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_  
(To be completed if patient refuses to sign acknowledgement)  
Date \_\_\_\_\_ Name of person providing notice \_\_\_\_\_

# Mercy Health Partners of Southwest Ohio

## Notice of Privacy Practices

Effective 4/14/2003

**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.**

If you have any questions, please contact our Privacy Officer, whose name and number is at the bottom of this notice.

### Who will follow this notice?

Mercy Health Partners of Southwest Ohio provides health care to our patients, residents, and clients in partnership with physicians and other professionals and organizations. The information privacy practices in this notice will be followed by:

- Any health care professional, including any member of our medical staff, who treats you at any of our locations.
- All departments and units of our organization, including Mercy Hospital Anderson, Mercy Hospital Clermont, Mercy Hospital Fairfield, Mercy Franciscan Hospital-Mt. Airy, Mercy Franciscan Hospital-Western Hills, Mercy St. Theresa Center, Mercy Franciscan Terrace, Mercy Franciscan at Schroder, Mercy Franciscan at West Park, Mercy Medical Associates' offices, Mercy Health Solutions' offices, Life Management Systems EAP's offices, Mercy Anderson Ambulatory Surgery Center, Mercy Home Care, HealthSpan and Milford Diagnostic imaging.
- All employees, staff or volunteers of our organization, including staff at Mercy Health Partners of Southwest Ohio, our regional office, and Catholic Healthcare Partners, our parent organization, with whom we may share information.
- Any business associate or partner of Mercy Health Partners of Southwest Ohio with whom we share health information.

### Our pledge to you.

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of your care and services to provide quality care to you and to comply with legal requirements. This notice applies to all of the records of your care that we maintain as a designated record set, whether created by facility staff or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office. We are required by law:

- to keep medical information about you private.
- to give you this notice of our legal duties and privacy practices with respect to medical information about you.
- to follow the terms of the notice that is currently in effect.

### Changes to this Notice.

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting areas, and on our Web site at [www.e-mercy.com](http://www.e-mercy.com). You can receive a copy of the current notice at any time. The effective date is listed just below the title. You will be offered a copy of the current notice and you will also be asked to acknowledge in writing your receipt of this notice.

### How we may use and disclose medical information about you.

- We may use and disclose medical information about you for **treatment** (such as sending medical information about you to a specialist as part of a referral); to **obtain payment for treatment** (such as sending billing information to your insurance company or Medicare); and to **support our health care operations** (such as comparing patient data to improve treatment methods.)
- We may use or disclose medical information about you **without** your prior authorization for several other reasons. We may disclose medical information to your primary care physician if he/she requests such information for your patient medical records maintained by him/her. Subject to certain requirements, we may give out medical information about you without prior authorization for **public health purposes, birth, death, domestic violence, abuse, neglect or other required reporting, health oversight audits or inspections, qualified research studies, funeral arrangements and organ donation, workers' compensation purposes, or to prevent or lessen serious and imminent threats to the health or safety of a person or the public or other emergencies.** We also disclose medical information **when required by law**, such as in response to a request from law enforcement, certain independent review organizations or the coroner's office, in specific circumstances, or in response to valid judicial or administrative orders.

We may disclose HIV test results without your consent for certain purposes, such as medical emergencies, organ donations, qualified research and other similar purposes. Any such disclosure must be accompanied by the following or a similar statement: "This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written, and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for the purposes of the release of HIV test results or diagnosis."

- We also may contact you for **appointment reminders**, or to tell you about or recommend **possible treatment options, alternatives, health-related benefits or services** that may be of interest to you, or to support **fundraising efforts**.
- If admitted as a patient, unless you tell us otherwise, we will list in the **patient directory** your name, location in the hospital (room number and phone number), your general condition and your religious affiliation, and will release all but your religious affiliation to anyone who asks about you by name. In our Emergency Department, we may, unless you tell us otherwise, release your status if a request is made using your name. Your religious affiliation may be disclosed only to a clergy member, and even if they do not ask for you by name.
- We may disclose medical information about you to a **friend or family member who is involved in your medical care**, or to disaster relief authorities so that your family can be notified of your location and condition.

**Other uses of medical information**

■ In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

**Your rights regarding medical information about you.**

■ In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. We must, however, provide a free copy of your medical information to the Bureau of Workers' Compensation, the Industrial Commission, the Department of Jobs and Family Services, or to you or your representative if the purpose of the request is to support a claim under the Social Security Act and if your request is accompanied by documentation to support such a claim.

■ If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the medical information maintained by us; or if we determine that the record is accurate. You may appeal, in writing, a decision by us not to amend a record.

■ You have the right to a list of those instances where we have disclosed medical information about you, other than for treatment, payment, healthcare operations or for where you specifically authorized a disclosure. Your written request must state the time period desired for the accounting, which must be less than a 6-year period and start after April 14, 2003. You may receive the list in paper or electronic form. The first disclosure list request in a 12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs.

■ If this notice was sent to you electronically, you have the right to a paper copy of this notice.

■ You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home. Your request must be in writing detailing the specific way or location for us to use to communicate with you.

■ You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request but we are not legally required to accept it. We will inform you of our decision on your request.

All written requests or appeals should be submitted to our Privacy Officer listed at the bottom of this notice.

**Complaints**

■ If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact the facility representative or our Privacy Officer (listed below). You may also contact the Catholic Healthcare Partners ReportLine, a 24-hour hotline, at 1-888-302-9224.

- Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Officer can provide you the address.

■ Under no circumstance will you be penalized or retaliated against for filing a complaint.

**Privacy Officer:**

4600 McAuley Place  
Cincinnati, Ohio 45242  
513-981-6280  
513-981-6101 (Fax)

**Facility Representatives:**

You may call the following numbers to be put in contact with the facility's HIPAA representative:

Mercy Hospital Anderson 513-624-4500	Mercy Franciscan Hospital-Mt. Airy 513-853-5000	Mercy Franciscan Terrace 513-761-9036	Mercy Medical Associates - Bethel 513-734-6979
Mercy Hospital Clermont 513-732-8200	Mercy Franciscan Hospital-Western Hills 513- 389-5047	Mercy Franciscan at Schroder 513- 867-4100	Mercy Medical Associates - Sardina 937-446-2531
Mercy Hospital Fairfield 513-870-7000	Mercy St. Theresa Center 513-271-7010	Mercy Franciscan at West Park 513-451-8900	



Dear Patient,

Effective January 1, 2011: The hospitals of Mercy Health Partners and the physicians of Mercy Medical Associates – Cardiology (formerly Greater Cincinnati Cardiovascular Consultants) have recently affiliated to form one of the area’s most comprehensive heart and vascular programs in Greater Cincinnati.

As part of this affiliation, there is a change to the billing process for diagnostic testing services.

- Certain diagnostic tests performed in our offices are now billed as a Mercy Hospital outpatient department; therefore, these tests will have a hospital charge.
- Any charges associated with your test will be paid under the outpatient hospital benefit coverage provided by your insurance.
- To determine your out-of-pocket expense, please review your insurance coverage for any coinsurance and/or deductibles that are applied to outpatient hospital testing.

Your insurance company will be billed for diagnostic testing services in two parts:

- They will receive one bill from Mercy Hospital for the diagnostic test performed.
- They will receive a separate bill from us for the physician interpretation of the test.

If you receive an explanation of benefits from your insurance company, you will see two bills for the services rendered on this date. The physician interpretation bill will be submitted to your insurance under our new legal name “Mercy Medical Associates-Cardiology.”

We are pleased that you have chosen our group for your cardiology healthcare needs and we look forward to our continued relationship.

Thank you.

The Physicians of Mercy Medical Associates – Cardiology

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PATIENT’S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

