Meadows Medical Center
700 E Firmin St Suite 195 Kokomo IN 469022350

Patient Forms

Basic Information

Full Name _____
First Middle Last Suffix

Sex ◯ Male ◯ Female ◯ Unknown

Date of Birth ____ / ____ / ____

Primary Phone ◯ Home ◯ Mobile ◯ Work

Phone Number _____

Email _____

Social Security Number _____

Address Line 1 _____

Address Line 2 _____

City _____

State _____ **Zip** _____

Marital Status _____

Maiden Last _____

Driver's License State _____

Driver's License # _____

Demographics

Sexual Orientation _____

Gender Identity _____

Hispanic or Latino? ◯ Yes ◯ No ◯ Decline to Specify

Ethnicity _____

Race _____

Language _____

Emergency Contact

Relationship to Contact _____

Full Name _____
First Middle Last

Primary Phone ◯ Home ◯ Mobile ◯ Work

Phone Number _____

Email _____

Address Line 1 _____

Address Line 2 _____

City _____

State _____ **Zip** _____

Financial Information

Responsible Party

Who will be financially responsible for you? ◯ Myself ◯ Someone else

If you chose "Someone Else", please fill out the following:

Relationship to Contact _____

Full Name _____
First Middle Last

Primary Phone ◯ **Home** ◯ **Mobile** ◯ **Work** **Phone Number** _____

Method of Payment

What will be your method of payment? ◯ Insurance ◯ Self-Pay

If you chose "Insurance", please fill out the following:

PRIMARY INSURANCE POLICY

Insurance Company _____ **Policy Number** _____

Insurance Plan _____ **Insurance Phone Number** _____

Group Number _____

Insurance Company Address _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

Relationship to Primary Policy Holder _____

If you are not the primary policy holder, please fill out the following:

Full Name _____
First Middle Last

Sex ◯ Male ◯ Female ◯ Unknown **Date of Birth** _____ / _____ / _____

Policy ID Number _____ **Social Security Number** _____

Policy Holder Address _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

If you are unable to provide your insurance information, please provide a reason before continuing.

SECONDARY INSURANCE POLICY

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company _____ **Policy Number** _____

Insurance Plan _____ **Insurance Phone Number** _____

Group Number _____

Insurance Company Address _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

Relationship to Secondary Policy Holder _____

If you are not the secondary policy holder, please fill out the following:

Full Name _____
First Middle Last

Sex ◯ Male ◯ Female ◯ Unknown **Date of Birth** ____ / ____ / ____

Insurance ID Number _____ **Social Security Number** _____

Policy Holder Address _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

Additional Information

Please list your preferred pharmacies in order of preference

Pharmacy Name	Pharmacy Address

How did you hear about us? _____

Meadows Medical Center
DR. DANA STEWART, MD

AUTHORIZATION TO TRANSFER MEDICAL RECORDS

1. PATIENT INFORMATION.

NAME: _____
ADDRESS: _____
_____
DATE OF BIRTH: _____

2. AUTHORIZATION FOR RELEASE. I, _____, parent of _____ hereby authorize:
NAME: _____
ADDRESS: _____
_____
PHONE: _____ FAX:_____
to release, disclose, and deliver the medical information described below to:

AUTHORIZED RECIPIENT:
Meadows Medical Center, LLC 700 E Firmin St, Suite 195
Kokomo, Indiana 46902
Phone: 765-252-4575 Fax: 765-252-4844

3. SPECIFIC AUTHORIZATION. I specifically authorize the release of:

_____ ALL medical information relating to the above-named patient including but not limited to the following categories protected by state or federal law: (1) Substance abuse (drug or alcohol) treatment; (2) Mental health treatment; and (3) HIV-AIDS-related information, if such information is contained in the records. This authorization includes reports, correspondence, test results, and any other information in the records, whether generated by the authorized provider or another entity.

_____ Health information for the date(s)_____

_____ Immunization record

_____ Growth charts

_____ Other _____

Patient/Parent Signature: _____
Date:_____

This Authorization expires one year after it is signed or on this date: _____

Patient Name:_____

Date of Birth:_____

The purpose of this disclosure is for:
_____ transfer of care to provider/clinic
_____ specialty care as deemed necessary by the provider/clinic
_____ second opinion on medical diagnosis and/or treatment

I do not give permission for any other use or redisclosure of this information.

4. REDISCLOSURE. This release does not authorize redisclosure of medical information beyond the limits of this consent. The Recipient of this information is prohibited from using the information for other than the stated purpose, and from disclosing it to any other party without further authorization. The following written statement should accompany certain disclosures:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and 45 CFR Parts 160 and 164). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and 45 CFR Parts 160 and 164. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I specifically understand and agree that the REDISCLOSURE requirements set out above will apply to these records.

I specifically understand and agree that the recipient may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign the authorization.

5. VALIDITY. I understand that this authorization will automatically expire one year from the date of my signature, and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure described above. I agree that any release which has been made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.

I authorize the release of information as indicated above.

Patient/Parent Signature: _____

Date: _____

This Authorization expires one year after it is signed or on this date: _____

Meadows Medical Center, LLC

Notice of Privacy Practices

Your Information.
Your Rights.
Our Responsibilities.

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.**

My signature below acknowledges that I have been given a copy of Meadows Medical Center Notice of Privacy Practices.

Signature: _____

Date:_____

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

Our Uses and Disclosures

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

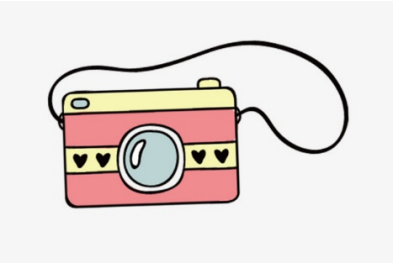
This Notice of Privacy Practices applies to the following organizations.

Meadows Medical Center, LLC

Meadows Medical Center, LLC
700 E. Firmin St, Ste 195
Kokomo, IN 46902
765-252-4575 ext 101
email: info@meadowsmc.org
meadowsmedicalcenter.com

September 1, 2018; updated November 5, 2020

Photo Release Form



We have created a page **for Meadows Medical Center** on Facebook, Instagram, LinkedIN and Twitter. The purpose of these pages is to stay connected to our patients and their families. This is a fun way to share things going on in Meadows Medical Center and to update you on important information. Please fill out the bottom of this form to grant us permission to post pictures of your child on our social media sites. Please go to our Facebook page titled Meadows Medical Center and give us a like to stay in touch! We look forward to staying connected with you!

With your signature, you consent as follows:

I am the legal guardian of_____. I give permission to Meadows Medical Center to photograph and post to social media.

I understand and agree to give Meadows Medical Center permission to post photos to our social media pages. (e.g. Facebook, Instagram, LinkedIn, Twitter, etc.) I am not entitled to compensation and understand that Meadows Medical Center is not liable for the use of any or all pictures of my child.

Signature:_____ Date:_____