**J.B. Winters, D.O., LLC**

**855 Eaton Avenue**

**Hamilton, OH 45013**

**Phone: 513.892.9222**

**Fax: 513.892.9009**

[**www.jbwintersdo.com**](http://www.jbwintersdo.com/)

Dear Patients,

Welcome to my practice.  I am a board certified internist who specializes in the primary care needs of adults.  The D.O. after my name stands for doctor of osteopathic medicine.  A D.O. is similar to an M.D. but has additional training in manual medicine.  I see patients at Fort Hamilton Hospital.   Mary Williams, CNP assists me in the office and provides coverage when I am unavailable.  We will be working together to provide you with more comprehensive care.

I provide 24 hour availability by cell phone (513) 582-6531 to all of my patients.  If you feel that you are having a true emergency call 911.  Please use the emergency cell phone only for urgent questions that cannot wait until the next business day.  Non emergent questions and prescription refills will be handled only during business hours 9am-4pm Monday through Friday.

We do our best to maintain on time appointments.  Unforeseen delays do occasionally occur.  We appreciate promptness for your appointments.  If you need to cancel an appointment, please allow 24 hours notice.  Missed appointments are subject to a $35 fee.  Repeated missed appointments may result in discharge from the practice.

It is your responsibility to notify us of any changes in your address, phone number, and insurance information.  Please pay balances on time.  Co-payments are due at the time of service.  We understand that financial difficulties do occur.  Please keep us informed so that we can work with you on these matters.  We offer payment plans and are happy to answer any questions you have about your bills.  Unsettled accounts will be sent to collections and are grounds for dismissal from the practice.  You are responsible for any additional fees the practice may incur sending your accounts into collections.

I plan to be in Hamilton long term and hope to be your physician for years to come.  Please feel free to address me with any concerns about your care.

Sincerely,

J.B. Winters, D.O.

I have read and understand the above.

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Signature Date

**J.B. Winters, D.O. LLC**

**REGISTRATION FORM**

(Please Print)

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| Date of Birth: |  | | | | | | | | | | |  | | | | | | | | | Email Address: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **PATIENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Patient’s Last Name: | | | | | |  | | | | First: | | | | | | | | | | | | |  | | | Middle: | | | | | | | | Mr.  Mrs. | | | | | Miss  Ms. | | | | | | Marital status (circle one)  Single / Mar / Div / Sep / Wid | | | | | | | | | | | | | |
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| Street Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | Social Security No.: | | | | | | | | | |  | | | | | | | | Home Phone No.: | | | | | | | |
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| P.O Box: | | | | | | | | | | | | | | | | | |  | | City: | | | | | | | | | | | | | | | | | | | |  | State: | | | | | |  | | | | | | | Zip Code: | | | | |
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| Occupation: | | | | | | | | | | | | |  | | Employer: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | Employer Phone No.: | | | | | |
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| How did you hear about us: | | | | | | | | Family  Friend  Close to home/work  Yellow Pages  Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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| Other family members seen here: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **INSURANCE INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Please give your insurance card to the receptionist.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Person responsible for bill: | | | | | | | | | | | | | |  | | Birth Date: | | | | | |  | | | Address (if different): | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | Home Phone No.: | | | | |
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| Is this person a patient here?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Occupation: | | | | |  | | Employer: | | | | | | | | | | | | | | | | |  | | | Employer Address: | | | | | | | | | | | | | | | | | | | | | | |  | | | | | Employer Phone No.: | | | |
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| Is this patient covered by insurance  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Please indicate primary insurance: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Subscriber’s Name: | |  | | Subscriber’s S.S. No.: | | | | | | | | | | | | |  | | Birth Date: | | | | | | |  | | Group No.: | | | | | | |  | | Policy No.: | | | | | | | | | | | | | | | | | | | |  | Co-Payment: |
|  | |  | |  | | | | | | | | | | | | |  | |  | | | | | | |  | |  | | | | | | |  | |  | | | | | | | | | | | | | | | | | | | |  |  |
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| Patient’s relationship to subscriber:  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Secondary insurance  (if applicable): | |  | Subscribers name: | | | | | | | | | | | | | |  | | Group No.: | | | | | | | | | | | | | | | | |  | | Policy No.: | | | | | | | | | | | | | | | | | | | | |
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| Patient’s relationship to subscriber:  Self  Spouse  Child  Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **IN CASE OF EMERGENCY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Name of local friend or relative: | | | | | | | | |  | | Relationship to Patient: | | | | | | | | | | | | | | | | | |  | | | Home Phone No.: | | | | | | | | | |  | | | | | | | Work Phone No.: | | | | | | | | | |
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| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. J.B. Winters or insurance company to release any information required to process my claims. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| *Patient/Guardian Signature* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | *Date* | | | | | | |

**MEDICATION / SURGICAL HISTORY / ILLNESS INFORMATION**



|  |  |
| --- | --- |
| Patient’s name: |  |
|  |  |
| Phone Number: |  |
|  |  |
| Date of Birth: |  |
|  |  |
| Pharmacy: |  |

Medication Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any medications you are currently taking below.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name (brand & generic)** |  | **Dosage (strength & frequency)** |  | **Prescribing Doctor** |
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Prescription Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prescription ID No: \_\_\_\_\_\_\_\_\_\_\_\_

**Please list any surgeries/procedures you have had performed below.**

|  |  |  |
| --- | --- | --- |
| **Surgical History** |  | **Date** |
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| --- | --- |
| **Please list any chronic illnesses below.** | **Date** |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PATIENT NAME: | | |  | | | |  | DATE: |  |
|  | | | | | | | | | |
| BIRTHDATE: |  | | |  | SOCIAL SECURITY NO.: |  | | | |
|  |  | | |  |  |  | | | |
| Email Address: | |  | | | | | | | | |

Please answer the following question so that we may contact you in the most effective way possible.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. If we call you at home and you are not available, may we leave information such as positive/negative test results, appointments, billing matters and healthcare information with another person? | | | | | | | YES NO |
|  | | | | | | | |
| If YES, please state name of person(s) and relationship: | | | | | | | |
|  | | | | | | | |
| Name: |  | | Relationship: |  | Phone No: |  | |
| Name: |  | | Relationship: |  | Phone No: |  | |
| Name: |  | | Relationship: |  | Phone No: |  | |
|  | | | | | | | |
| 1. Do you have an answering machine at your home? | | | | | | | YES NO |
|  | | | | | | | |
| 1. If YES, may we leave a message regarding positive/negative test results, appointments, billing matters and healthcare information? | | | | | | | YES NO |
|  | | | | | | | |
| 1. Do you have a cell phone with voicemail? | | | | | | | YES NO |
| Phone No.: | |  | | | | | |
|  | | | | | | | |
| 1. If YES, may we leave a message regarding positive/negative test results, appointments, billing matters and healthcare information? | | | | | | | YES NO |
|  | | | | | | | |
| 1. Do you have voicemail through your employer? | | | | | | | YES NO |
|  | | | | | | | |
| 1. If YES, may we leave a message for you to return our call? (No information will be left) | | | | | | | YES NO |
|  | | | | | | | |
| 1. May we send you a correspondence in our business envelopes? | | | | | | | YES NO |

Authorization is valid until you inform our office otherwise in writing.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PATIENT SIGNATURE: |  |  | DATE: |  |

If the above answers are NO, what is the best way to contact you?

|  |
| --- |
|  |

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**PATIENT RESPONSIBILITY**

Dear Patients:

It is your responsibility as a patient to be proactive in your care, providing correct and current insurance information, and reimbursement for your care. If at the time of your visit you cannot provide our office with the correct billing information, so that we may bill your insurance in a timely manner; it will be your responsibility to file the claim with your insurance company. In this case, you will also be responsible for providing your insurance information to any outside facilities for blood work, cultures, radiology studies, etc. Patients without insurance must make payment at time of service.

We also require that any demographic changes such as address, phone numbers, place of employment, marital status, be reported to our front office personnel at the time of your visit.

We sincerely thank you for your cooperation in this matter.

Dr. Winters

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Signature: |  | Date: |  |

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**NOTICE OF PRIVACY PRACTICES**

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

Our commitment at this office is to treat our patients with professionalism and care, being sure at all times to preserve the privacy and security of all Protected Health Information.

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

1. It may be necessary to share your diagnosis, laboratory analysis, or other clinical information with another physician or facility that may be participating in your care.
2. For billing purposes, your insurance company or Workers Compensation may request copies of Protected Health Information.
3. For payment purposes, our billing service and/or collection service may receive information.

We are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures other than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided by law.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our office.

I have read and understand the above Notice of Privacy Practices.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signed: |  |  | Date: |  |
|  | (Patient or Legal Guardian) |  |  |  |

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**



|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient’s Name: |  | | | | | | Date of Birth: | |  |
|  |  | | | |  | | |  | |
| Previous Name: |  | | | | | Social Security #: | |  | |
|  |  | | | |  | | |  | |
| I request and authorize my previous physician | | |  | | | | | | |
|  | |  | |  | | | | | |
| Previous physician phone: | |  | | to release healthcare information of the patient named above to: | | | | | |

J.B. Winters, D.O. LLC 855 Eaton Avenue Hamilton, OH 45013 Phone 513.892.9222 Fax 513.892.9009

|  |  |  |
| --- | --- | --- |
| Healthcare information relating to the following treatment, condition, or dates: | |  |
|  | | |
|  | |  |
|  | |  |
|  | |  |
| Other: | Two most recent office visit notes, most recent labs and all diagnostics. | |

Information to exclude (mark if applicable)

Requested information will include HIV testing/treatment, AIDS related conditions, drug or alcohol abuse, drug related conditions, alcoholism or addiction treatment, and psychiatric/psychologic conditions unless specifically excluded.

Chemical Dependency/Substance Abuse

Sexually Transmitted Diseases

Psychiatric/psychological Conditions

For purpose of: Changing Primary Care Physician

When my information is used to disclose pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule.

This authorization will be expire 12 months after the date signed. I can choose to revoke this authorization at any time by submitting the request in writing to JB Winters DO LLC. This revocation will not apply to disclosures completed prior to submitting this request.

Refusal to sign this authorization will not affect my treatment, payment, or eligibility for benefits.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Signature: |  | | | | Date Signed: | |  |
|  |  | | |  | | |  |
| Print Patient Name: | |  | | | | | |
|  | | | | | | | |
| Relationship to Patient: | | |  | | Witness: |  | |