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Hope Miles, FNP
Kendra Misbach, FNP
Kelsey Moore, NP
Travis Newman, NP
Marjorie Wiseman, NP

SPECIALISTS: *Joseph J. Van Valer, MD*
Andrew Kapsalis, DPM, AACFAS

Dear patient,

Welcome to American Health Network. Thank you for choosing us for your primary care. We're pleased to serve you.

Please fill out the new patient packet included with this letter. You can return your completed packet to us by:

- Mail it to one of our offices at an address shown below.
- Drop it off at the office of your choice.
- Fax it to us at 1-765-213-6348.

Be sure to let us know if you have an urgent need. We'll schedule your appointment as soon as we can.

Please bring these items to your first appointment:

- Photo ID
- Insurance cards
- Prescription drug bottles
- Vitamins or over-the-counter medicines you may be taking

Please arrive 15 minutes before your appointment.

We can also help speed up the process of enrolling in Medicaid. To find out more, please talk to our billing office. Call 1-765-213-6330 during our regular business hours.

We're here to serve you.

- Regular business hours: 8 a.m.–5 p.m., Monday to Friday
- Urgent care clinic: 9 a.m. – 12 p.m., Saturday
- Emergency care: A doctor is on call 24 hours a day, 7 days a week

Please Note:
Our practice will not be able to accept any new patients that choose not to vaccinate themselves or their children.

Questions?
Please call our New Patient Coordinator at 1-765-281-3443. We look forward to seeing you soon.

Sincerely,

The doctors and staff of American Health Network

family medicine and specialty care services

3631 N. Morrison Rd, Muncie, IN 47304
P.765.281.3443

14745 Commerce Road, Daleville, IN 47334
P.765.213-6390

New patient information form Date: ______________________

Please check all that apply to you:

_____ I have an urgent need. (Details:______________________________)

_____ I'd like to be seen in the next 30 days.

_____ I don't have a preference for my doctor.

_____ I've been assigned to the following doctor by my health benefit plan:

Doctor:____________________ Health benefit plan:____________

_____ I prefer the Muncie location. ___ I prefer the Daleville location.

_____ I'm pregnant or need to confirm a pregnancy. If yes, when was your last period?____________________ Do you take prenatal vitamins? _____

_____ I'd like to see the same doctor as a family member or close friend.

Family member or friend's name:_____ Doctor: ________________

Please list any family members who are American Health Network patients now and their doctor:

____

Who was your last doctor?____________________ When was your last visit?____________________

Why are you changing?______________________ Where was your last doctor? ____________________

Patient information				
Last name, first name and middle initial:	Sex:	Date of birth:		
Address:		City, State, ZIP:		
Home phone:	Work phone:		Mobile phone:	
Email address:		Would you like to be able to email the office? [ ] Yes [ ] No		
Emergency contact person and relationship to you:			Contact phone:	
Employer: ____________________ Are you a student? [ ] Yes If yes, school name: ______________________				

Responsible party information (if different from above)			
Name:	Sex:	Date of birth:	
Address:		City, state, ZIP:	
Home phone:	Work phone:		Mobile phone:
Relationship to patient:		Employer:	

Primary insurance		
Company name:	Policy number:	Group number:
Subscriber name:	Date of birth:	Relationship to patient:

Secondary insurance (if any)		
Company name:	Policy number:	Group number:
Subscriber name:	Date of birth:	Relationship to patient:

Health history questions

For office use only:
Date and time of appointment: ___________________________
Doctor: ___________________

Patient name: ___________________________ Date: _________________

Date of birth: ___________________________

We'll keep all information given in this document private. It will become part of your medical record.

What health conditions do you have now or have you had in the past?

1)	5)
2)	6)
3)	7)
4)	8)

What medicines do you take? (Use another sheet, if needed.):

Name:	***Strength:***	***How often you take it:***
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		

What pharmacy do you use?___________________ Location:__________________________________

Are you allergic to any medicines?□ Yes □ No If yes, please list.

Name of medicine:	Reaction you had:
1)	
2)	
3)	
4)	
5)	

What surgeries have you had and when? Please include dates.

1)	5)
2)	6)
3)	7)
4)	8)

Health history questions (part 2)

Patient name: ___________________________ Date: _________________
Date of birth: ___________________________

We'll keep all information given in this document private. It will become part of your medical record.

Family history – Does anyone in your family have any of these conditions?

□ Asthma	Who? _________________	□ High blood pressure	Who? _________________
□ Cancer	Who? _________________	□ Mental illness	Who? _________________
□ Diabetes	Who? _________________	□ Stroke	Who? _________________
□ Heart disease	Who? _________________	□ Thyroid problems	Who? _________________

Any other family health conditions not listed above? ______________________________________

Social history

Are you: □ Married □ Single □ Widowed □ Divorced □ Partnered
Do you smoke? □ Yes □ No If yes, how much?_________How many years? ________
What age did you start smoking? _______ Are you interested in quitting? □ Yes □ No
Do you drink alcohol? □ Yes □ No If yes, how much?_________ How often? ________
What kind?_________ Are you interested in quitting? □ Yes □ No
Do you drink caffeine? □ Yes □ No Type: □ Coffee □ Soda □ Tea □ Chocolate
Do you use a service animal? □ Yes □ No If yes, for what reason? ____________
Do you need an interpreter? □ Yes□No If yes, what kind or language? ____________
Note: We offer interpreters at no charge. Please call our office at least 48 hours before your appointment to set it up.

Immunization (shots) history

Have you had a tetanus booster in the last 10 years? □ Yes □ No If yes, when? _________
Have you had a pneumonia vaccine? □ Yes □ No If yes, when? _________
Have you had a shingles vaccine? □ Yes □ No If yes, when? _________

American Health Network

215 Patient/Guardian Authorizations to Disclose Protected Health Information to Others

Patient Name: ______________________ **DOB:** _____________ **Today's Date:** __________

Primary Care Provider & Location: ____

To the patient: American Health Network will attempt to follow your instructions to the extent the healthcare provider believes such disclosure will not interfere with your treatment. This form will be used at all AHN locations. Please note that AHN does not need specific authorization to disclose information for treatment, operations or payment purposes consistent with its Notice of Privacy Practices.

Authorization by: ☐ Patient ☐ Legal Guardian (name):___________________________

American Health Network may disclose all of my Protected Health Information* (***including that about alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AIDS, or information related to psychiatric treatment or counseling, and related to communicable disease, unless I limit below***) **to**:

	Name	Relationship	Contact info (phone/address)	NextMD Access Y/N
1				
2				
3				

*** Limitation - The following Information may NOT be disclosed to any of the above**:

____

____

____

Duration/Expiration: ONLY the most recent signed DISCLOSURE AUTHORIZATION will be honored. This Authorization will stay in effect during my treatment at AHN unless it is revoked/revised by me in writing. I agree that AHN is not responsible for information that might be re-disclosed by those persons who I have authorized to receive information.

Patient/Guardian Signature: ____

Date: ____________________

Provide copy to the patient at his/her request.

____

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CANCELLATION AND MISSED APPOINTMENT AGREEMENT

We strive to render excellent medical care to you and the rest of our patients. Your care is of our utmost importance. In an attempt to be consistent with this, we have an Appointment Cancellation Agreement that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

We understand that circumstances may not make it possible for you to keep your appointments. As a courtesy to you, we make an outreach call to confirm your scheduled appointment. Appointments can be confirmed or canceled by calling our office at 765-281-3443 or communicating with us via NextMD at www.nextmd.com. If you are not currently registered for NextMD, please ask your provider or one of our American Health Network staff members for details.

We require that you give our office 24 hours' notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. If 3 appointments are missed, you may be asked to find another primary care physician for your medical needs and a fee of $50.00 may be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility.

If you have any questions, please do not hesitate to contact us at 765-281-3443.

____

Patient, Parent or Agent (must be 18 years of age or older) Date

____

Print Patient Name Patient's Date of Birth

204a - Authorization to Release Medical Records from NON- AHN Facility to AHN

(This form can be used if another healthcare provider requires written pateint authorization to obtain patient records needed by AHN)

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO AHN

I. RECORDS TO BE RELEASED FROM:

Name of HealthCare Provider: ______________________________

Address: ______________________________

(Street Name) *(City)* *(State)* *(Zip)*

II. RECORDS TO BE RELEASED TO:

I hereby request and authorize the above named Healthcare Provider **to release my records to**:

Doctor ____________________ of American Health Network ("AHN") located at address:

____

(Street Name) *(City)* *(State)* *(Zip)*

Telephone #: ____________________ Fax #: ____________________

III. THE RECORDS OF (Patient name):

Last ____________________ First ____________________ MI __________

Date of Birth: ____________________ **ONLY LAST FOUR (4) DIGITS OF SS#:** __________

Address: ______________________________

(Street Name) *(City)* *(State)* *(Zip)*

Telephone #: ____________________ Fax#: ____________________

IV. RECORDS TO BE RELEASED:

a) **Please release the following information (check those that apply)**:

☐ Provider Notes	☐ X-ray Reports
☐ Special Diagnostic Test Results	☐ Chemical/Alcohol Treatment Records
☐ AHN Lab Reports	☐ ALL Medical Records
☐ Billing Records	☐ Other (specify)

b) **Unless I HAVE LIMITED BELOW,** I understand that this **also** pertains to records regarding testing and treatment **for alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AIDS,** and for **psychiatric treatment or counseling or communicable disease.**

c) **Limitations:** Confine to **summary information** from records regarding treatment for the following condition or injury:

______________________________ On or about (date(s): ______________

d) O**ther:** ______________________________

I UNDERSTAND (1) AHN will not condition treatment, payment, enrollment, or eligibility for benefits on this whether you sign this authorization.(2) I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN BASED UPON IT, AS DESCRIBED IN THE AHN PRIVACY NOTICE. (3) THAT THIS AUTHORIZATION WILL EXPIRE IN 60 DAYS FROM THE DATE SIGNED, UNLESS I SPECIFY OTHERWISE, (4) THAT THE RECIPIENT OF THESE RECORDS MAY FURTHER DISCLOSE INFORMATION BECAUSE OF THIS AUTHORIZATION AND THEN IT MAY NO LONGER BE PROTECTED BY THE FEDERAL PRIVACY REGULATIONS, AND THAT AHN WOULD NOT BE RESPONSIBLE FOR THIS ACTION, and (5) I AM ENTITLED TO ASK FOR AND RECEIVE A COPY OF THIS DOCUMENT.

Date: ______________

Expiration (if none, at 60 days): ______________

Patient Signature: ______________________________

Signature if other than patient: ______________________________
(Parent/Guardian/Legal Representative, if patient unable to sign- Relationship)

Common