We would like to take this opportunity to welcome you to our practice by providing history about the team you have entrusted to share in what we hope is a long and healthy relationship.

Milltown Family Physicians (MFP) formed in 1980, when Dr. John Miller began a solo practice in Wooster. In 1991, shortly after the current Milltown Professional Building was completed, Dr. Amy Jolliff joined his practice. A clinical nurse practitioner joined the practice and Milltown Family Physicians was incorporated. Currently, we have three clinical nurse practitioners.

In the 1990's an addition to the professional building was completed and is the current location of the practice. We have five physicians which includes Dr. Amy Jolliff 1991, Dr. Christopher B. Ranney and Dr. Eric A. Smith in 2007, Dr. Paul Nielsen in 2010, Dr. John Schinner in 2017 and Dr. Kristin Wenger in 2022. The office was remodeled in 2010, along with adding more exam rooms, the practice was able to move all paper charts off-site to permanent storage as they were using EHR. In 2014, the practice underwent a major renovation, adding more than 4,000 additional square feet.

The physicians who make up the current MFP group each have special areas of interest that bring something unique to our practice: Dr. Jolliff serves as Wayne County Coroner and also Medical Director of Brookdale; Dr. Ranney is additionally board certified in sports medicine, serving as the team physician for many local area athletics; Dr. Smith is trained in both acupuncture and hypnosis therapy and specializes in women's health. He also serves as medical director of the Viola Startzman Free Clinic and Wayne County Health Department; Dr. Nielsen specializes in preventative medicine and mental health care issues. He serves as Medical Director at Glendora Care Center, Smithville Western Care Center, and The Avenue. He also serves as Co-Director of Pulmonary Rehabilitation at Wooster Community Hospital. Dr. John Schinner is a Board Certified Family Physician who is dedicated to quality patient care. Dr. Kristin Wenger is Board Certified in Family Medicine and also does osteopathic manipulation therapy.

Milltown Family Physicians currently serves about 22,000 patients; its staff sees 150+ patients daily in the office, and the practice has many in-office procedure and labs. Our mission is to be a community oriented independent practice committed to the highest quality patient focused care for all ages. As Staff and Providers we choose to promote the traditional doctor-patient relationship throughout a lifetime. MFP website is www.milltownfamily.com where patients have access to many resources and information regarding Milltown Family Physicians.

Welcome to Milltown Family,
Janet Kurtz,
Practice Administrator

128 East Milltown Road, Suite 105
Wooster, Ohio 44691
330-345-8060

Date: _____

Name: _____ Place of Birth: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Employer/ Occupation: _____

Race/Ethnic Origin (circle one): Caucasian / Hispanic / African American / Native American / Asian

Language(s) spoken: _____ Email address: _____

Reason for Seeking Care: _____

How do you consider/rate your current health (circle one): Excellent Good Fair Poor

Known Allergies (please list all and explain your reaction): _____

_____

_____

Immunizations (dates of last Tetanus, Hepatitis A & B): _____

Current Medications (list name, strength, and dosage – please list any herbal preparations you are taking also):

_____ _____ _____

_____ _____ _____

_____ _____ _____

PAST MEDICAL HISTORY

Childhood Illnesses (circle all that apply) Chicken Pox Measles Mumps Other (please explain) _____

_____

Accidents or Injuries (please give age and/or date of if known): _____

_____

Serious or Chronic Illnesses: _____

_____

Hospitalizations/Surgical Procedures (please indicate year and reason if possible): _____

_____

_____

_____

OBSTETRIC/GYNEOCOLOGY HISTORY

Gravida_____ Term _____ Preterm _____ No. of Deliveries: Cesarean _____ Vaginal _____
(# of pregnancies) (# of term pregnancies) (# of preterm pregnancies)

Ab/Incomplete: _____ Children Surviving: _____
(# of abortions/miscarriages)

When was your last Pap Smear? _____ Mammogram? _____

Have you ever had an abnormal Pap Smear? (circle) Yes / No

If yes, please explain:_____ Do you practice self breast exams? (circle) Yes / No

FAMILY HISTORY

Please use the following abbreviations to specify on the lines below:

Father = F Mother = M

Brother = B Sister = S

Father's Father = FF Mother's Father = MF

Father's Mother = FM Mother's Mother = MM

Father's Brother = FB Mother's Brother = MB

Father's Sister = FS Mother's Sister = MS

Heart Disease: _____

High Blood Pressure: _____

Stroke: _____

Diabetes: _____

Blood Disorders: _____

Breast Cancer: _____

Cancer (other): _____

Arthritis: _____

Obesity: _____

Alcoholism: _____

Mental Illness: _____

Seizure Disorder: _____

Kidney Disease: _____

Other: _____

SOCIAL HISTORY

Who do you currently live with? _____

Do you currently use tobacco? (indicate all that apply) Pipe _____ Chew _____ Cigarettes _____ (# of packs per day) _____

Ever tried to quit? _____ Age you started? _____ Number of years smoked? _____

If you have every considered quitting, have you thought about quitting within the next six (6) months? _____

Do you drink alcohol? Yes or No Beer _____ Wine_____ Liquor_____ How much? _____/week _____/month_____

Have you ever had a drinking problem? _____

Do you use recreational drugs? Yes or No If yes, please list: _____

Do you wear protective ear and/or eye gear when working outside or while around loud equipment? Yes or No

Do you wear sunscreen while outdoors? Yes or No

Do you practice wearing a seatbelt? Yes or No

Do you wear a helmet while engaging in outdoor activities, such as biking? Yes or No

Revised 4-28-2015

128 East Milltown Road, Suite 105
Wooster, Ohio 44691
330-345-8060

PAPER COPY ONLY
NO CD OR FLASH DRIVE

Greater than 50 pages, MAIL all records.
Less than 50 pages, FAX to 330-345-0072.

Authorization for Release of Medical Information

Patient Name: _____ Last 4 SS#_____

Date of Birth: _____ Phone: (_____) _____

Address: _____

City: _____ State: _____Zip: _____

Reason for Disclosure: _____

Release To:

Milltown Family Physicians, Inc. & Athleticare
128 East Milltown Road, Suite 105
Wooster, Ohio 44691
(330) 345-8060

Request From:

Physician/ Facility Name(s):_____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____Fax:_____

The type and amount of information to be used or disclosed is as follows: (include dates when appropriate)

_____ Complete Health Record

_____ Lab Results / Radiology Reports

_____ Immunization Records

_____ Consultation Reports

_____ Colonoscopy/OP report

_____ Other (please specify): _____

I authorize Milltown Family Physicians Inc. & Athleticare to receive the health information indicated above that is contained in my patient record from the above mentioned provider/facility. I understand this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses.

This consent is subject to revocation at any time. This authorization and consent will expire one year from the date of authorization written below. Once your healthcare information is released, a new disclosure of your healthcare information by the recipient may no longer be protected by law.

_____ _____
Signature of Patient or Legal Representative Printed Name

_____ _____
Relationship to the Patient Date

128 East Milltown Road, Suite 105
Wooster, Ohio 44691
330-345-8060

PATIENT CONSENT AND STATUS UPDATE

Date:

Patient Name:

Patient Date of Birth:

Phone Number:

May we leave a message at your preferred number?
( ) YES ( ) NO

Has there been any change in your status or demographics? (Ex. Marital, Address, Insurance, etc.) If yes, please complete below.

Who may we talk to about your medical concerns?
(Relationship to you)

1.

2.

3.

-this consent will expire 1 year after date of signature

_____ _____

Patient Signature **Date**

PATIENT ETHNICITY

Name: _____ **Date Of Birth:** _____

Email Address: _____

As part of the government's electronic medical records program, we are now expected to record your race and ethnicity (or your preference not to report this information) one time on your chart. Please mark your race and ethnicity below, and return this slip to the receptionist. Thank you for your understanding.

Race:

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ More than one race
- ❑ Native Hawaiian
- ❑ Other Pacific Islander
- ❑ White
- ❑ Prefer not to report

Ethnicity:

- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino
- ❑ Prefer not to report

If you would like us to record the same race and ethnicity that you listed above for any of your family who are patients here, please list their names and date of birth below:

Name	DOB

At this time we are also updating your contact information.

Employer/Occupation: _____

Preferred Pharmacy: _____

Emergency Contact :

Name (First and Last): _____

Phone Number: _____

Relationship: _____

Emergency Contact :

Name (first and last): _____

Phone Number: _____

Relationship: _____

Please advise us if the contact information is different for other members of your family.

Milltown Family Physicians, Inc.
Notice of Privacy Practices
Patient Acknowledgement Form

Your privacy, including the confidentiality of your health information, is very important to us. Additionally, Federal law prohibits the unauthorized release of certain medical and health information. Before our office can use your Protected Health Information for treatment, Payment and health care operations, you must acknowledge that you have received a copy of our Notice of Privacy Practices informing you how our office may use and disclose your Protected Health Information.

You should carefully read our Notice of Privacy Practices to understand how we take steps to protect the privacy and confidentiality of your Protected Health Information. Federal law gives you the certain rights regarding the use and disclosure of your Protected Health Information. These rights include: (1) the right to request that we restrict how your Protected Health Information can be used or disclosed for treatment, payment, or health care operations; (2) the right to receive confidential communications of your Protected Health Information, if applicable; (3) the right to inspect and copy your Protected Health Information; (4) the right to amend your Protected Health Information; and (5) the right to receive an accounting of the disclosures of your Protected Health Information.

By signing this form, you acknowledge that you have received a copy of our Notice of Privacy Practices concerning the use and disclosure of your Protected Health Information.

Print Name of Patient/Legal Representative **Date of Birth**

Signature

Date

Milltown Family Physicians, Inc.
Notice of Advance Directive
Patient Acknowledgement Form

Today, advances in medicine and medical technology save many lives that only a few years ago might have been lost. Unfortunately, this same technology sometimes artificially prolongs life for people who have no hope of recovery.

An Advance Medical Directive is a legal document that allows you to give instructions for your future medical care, to request or refuse treatments and to express your feelings about other healthcare issues. The documents can be found on the Ohio State Bar Association website using the following link.

https://www.ohiobar.org/.../advance-directives.pdf

By signing this form, you acknowledge that you have received information on how to create an Advanced Directive.

Print Name of Patient/Legal Representative **DOB**

Signature

Date

128 East Milltown Road, Suite 105
Wooster, Ohio 44691
330-345-8060

Billing – Your Charges

Your fee is based upon multiple considerations. The first is your recognition of the value of our medical opinion. Other factors include time spent with you during your visit, the complexity of your medical condition and any treatment that is provided. But proper attention to your care also requires additional time spent beyond that of when you are in the office. Such time may be used or include:

- Create or maintain your permanent medical record.
- Review, interpret and document all lab test results and communicate those results, orally and/or in writing to you.
- Review current X-ray or scan reports, compare them with reports of previous scans, and, when the studies are abnormal, consult with the radiologist.
- Prepare and mail consultation reports and letters suggesting patients come in for a follow-up visit.
- Consult via phone about your case with referring or consulting physicians and other health care providers.
- Prepare referral letters to additional specialists, as needed.
- Prepare patient education materials.
- Conduct medical research relevant to your case.
- Communicate with pharmacies about your prescriptions.
- Complete insurance applications and claim forms.
- Conduct utilization review negotiations with hospitals and insurance companies.
- Review and manage hospital records.
- Draft letters of necessity to obtain medical services, instruments or prescriptions that you need.
- Draft reports and forms, including home health care orders and nursing facility orders.

All these activities add to our cost of providing you with quality healthcare services. Still, we are committed to providing you our services at the lowest cost possible.

We hope this explanation of our fees has been helpful. With you, our patient, we look forward to a lasting and health relationship.

Sincerely,
Milltown Family Physicians

128 East Milltown Road, Suite 105
Wooster, Ohio 44691
330-345-8060

Financial Policy

Welcome and thank you for choosing Milltown Family Physicians, Inc. for your medical care. We are committed to providing you with the highest quality medical care possible in a cost effective manner. Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographical area. We are pleased to discuss with you any questions you may have concerning a bill.

At the time of service, any outstanding balances on your account are due if no payment arrangements have been made. As a courtesy to our patients, we accept cash, personal check, money order, and all major credit cards. We also provide our patients the ability to pay for their accounts over the phone: **(330) 345-8060** or on our patient portal.

In order to achieve our goal of providing you with the best care possible, we need your assistance and your understanding of our financial policy:

Payment in full is due at the time services are rendered:

- Co-pays are due during the check-in process for each office visit. Failure to produce payment at check-in may result in your appointment being rescheduled. All non-covered services and/or deductibles are the insured/patient's financial responsibility and are due within 30 days of the time of service.
- If you receive more than one type of service on the same day, you may be responsible for more than one co-pay.
- There is a $35 fee for returned checks to our office.

Self-Pay/Non-Insured Patients

- We offer a reasonable discount for our non-insured patients when paid in full at the time services are rendered. We will give you an estimate of what will be due prior to the appointment. Payment for services is due at the time of service.

In Network" vs. "Out Of Network" Insurance

- Your insurance coverage and benefits are a contract between you and your insurance company and therefore all disputes must be handled between you and your insurance company.
- We are contracted with multiple insurers to accept assignment of benefits.

Minor Patients:

- Parent(s) or guardian(s) must have an Authorization for Medical Treatment form signed and kept on file for when the minor arrives unaccompanied or brought in by someone other than parent/guardian for an appointment. If there is a guardianship arrangement, we must have legal documentation of said arrangement.
- The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information as well as providing payment for any co-pay due at the time of service.
- The guarantor/ insurance policy holder/ legal guardian is responsible for payment for services rendered to the minor patient.

- In compliance with HIPAA regulations, we are unable to discuss any details of services rendered or to produce an itemized bill for any parties that are not the legal guardian of the patient, unless otherwise documented.

Lab/Hospital Charges:

- Any service(s) provided by Wooster Community Hospital and affiliated labs is a contract between you and that lab or hospital. Any dispute with that lab or hospital should be handled with that lab or hospital and is not the responsibility of our practice.
- It is your responsibility to know which procedures your insurance will and will not cover at these facilities and to request an Explanation of Benefits (EOB) from your insurance carrier.

Payment Plans:

- Our office will be happy to work with you in order to pay any balance due to our practice.
- Please contact our billing department to work out a payment plan with our practice at **(330) 345-8060 Ext. 5.**

Collections and Outstanding Balances:

- Any outstanding balance after 90 days of the date of service may be referred to an outside collection agency. Patients with unpaid delinquent accounts or accounts that are sent to collections may be dismissed from our practice.
- Accounts that have been turned over to our collection agency are now the responsibility of the collection agency.

Refunds:

- Refunds are issued to the appropriate party.
- Patient refunds will not be processed until all active or past due charges are paid in full.
- Refunds will not be issued, unless requested, and will be credited to your account at our practice. Patients will be notified of this.

I understand and consent to Milltown Family Physicians, Inc. I will cooperate with the billing department of Milltown Family Physicians, Inc. to ensure payment for my services. I understand that I am responsible to notify Milltown Family Physicians, Inc. of any status changes (ex. Marital, living, insurance etc.) I understand that I will be responsible for any cost(s) associated with the collection of my account if I default on this agreement. I understand that the terms of this financial policy may be amended at any time without prior notification to me, the patient. In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for payment for all services rendered to the patient herein.

_____ _____

Printed name of patient/ parent/ guardian Date of Birth

_____ _____

Signature of patient/ parent/ guardian Date

128 East Milltown Road, Suite 105
Wooster, Ohio 44691
330-345-8060

MILLTOWN FAMILY PHYSICIANS MISSED APPOINTMENT POLICY

The physicians and staff at Milltown Family Physicians place a high priority and value upon our patients' time. When a person misses an appointment without allowing adequate notice, we cannot offer that time to others and; compromises our ability to provide care to others.

We consider the physician-patient relationship to be the most important element of our commitment to care. When a person misses their appointments repeatedly, we believe it is a poor predictor of a therapeutic future relationship.

"Missed appointments" are defined as scheduled visits that are not cancelled with enough time to offer the appointment to another patient. If notification is made on the same day as the anticipated care, the designation of "missed appointment" will depend upon the circumstances and may be waived by the providers or office manager.

If you need to cancel an appointment, please provide prior notice. If cancellation does not occur with a minimum of two (2) hours prior notice, the visit will be considered a missed appointment. There is a fee of $25 each for a Complete Physical Exam and a second or third missed appointment that occurs within 365 days.

If three (3) missed appointments occur within a year (365 days), then you will be asked to seek medical attention elsewhere.

Thank you for your cooperation and understanding.

Milltown Family Physicians, Inc.

_____ _____

Patient Name Date of Birth Date