**Lisa Hanner-Robinson, MD**
1310 W. Bloomfield Rd., Suite C
Bloomington, IN 47403
(812) 334-2772 • jdvmedical.com

Joie De Vivre
MEDICAL

# REGISTRATION FORM

## PATIENT INFORMATION

Today's Date: _____
Legal Last Name: _____ First: _____ M.I_____
Birth Date: _____ Gender: _____Marital Status:_____
SSN: _____ Primary Phone: _____Secondary Phone: _____
Address: _____ Zip Code:_____
E-Mail Address: _____
Occupation: _____ Employer: _____ Employer Phone: _____

**If patient is a minor, custodial parent's:**

Name: _____ Birth Date: _____ Phone: _____

Name: _____ Birth Date: _____ Phone:_____

## INSURANCE INFORMATION

**Primary Insurance**

(If different from patient) Subscriber's Name: _____ Date of Birth:_____

Address: _____ Relationship to Patient: _____
Group No: _____ Patient's Member ID: _____

**Secondary Insurance**

(If different from patient) Subscriber's Name: _____ Date of Birth: _____

Address: _____ Relationship to Patient: _____
Group No: _____ Patient's Member ID: _____

## IN CASE OF EMERGENCY

Name: _____ Relationship to Patient: _____
Primary Phone: _____ Secondary Phone: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand I am financially responsible for any balance or services not covered by my insurance. I also authorize Joie de Vivre Medical or the insurance company to release any information required to process my claims.

_____ _____
Patient / Guardian Signature Date

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# NOTICE OF PRIVACY PRACTICES

**Effective Date:** June 1, 2026

**THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, HOW YOU MAY ACCESS THIS INFORMATION, AND YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.**

## Our Commitment to Your Privacy

Joie de Vivre Medical is committed to protecting the privacy of your protected health information (PHI). We are required by federal law to maintain the privacy and security of your health information, provide you with this Notice of our legal duties and privacy practices, notify you if a breach of your unsecured PHI occurs, and follow the terms of this Notice.

## Your Rights

You have the right to inspect and receive a paper or electronic copy of your medical record, request corrections to your health information, request confidential communications, request restrictions on certain uses and disclosures, receive an accounting of certain disclosures, obtain a paper copy of this Notice, and choose someone to act on your behalf when legally authorized. If your records are provided electronically, they will be transmitted in a password-protected file whenever possible, and the password will be provided separately to help protect the security of your information. If you pick up a copy of your medical records in person, you or your authorized representative must provide a valid photo identification before records will be released. If you pay for a service in full out of pocket, you may request that we not disclose information related to that service to your health plan for payment or health care operations, and we will honor that request unless disclosure is required by law.

## Our Responsibilities

We will use or disclose your protected health information only as permitted or required by law or as described in this Notice. Uses or disclosures not covered by this Notice generally require your written authorization, which you may revoke at any time unless we have already relied on it.

## How We May Use and Disclose Your Health Information

### Treatment, Payment, and Health Care Operations

We may use and disclose your health information to provide treatment, coordinate your care with other healthcare providers, obtain payment for services, verify insurance coverage, obtain prior authorizations, conduct quality improvement activities, train staff, perform audits, maintain accreditation, comply with legal requirements, and operate our medical practice efficiently.

**Appointment Reminders and Business Associates**

We may contact you by telephone, voicemail, text message, email, mail, or patient portal regarding appointments, test results, prescription refills, preventive care, billing matters, and other health-related services. We may also disclose your information to business associates who perform services on our behalf, such as billing companies, electronic health record vendors, consultants, attorneys, accountants, transcription services, and information technology providers. These organizations are required to safeguard your protected health information.

**Family Members and Others Involved in Your Care**

Unless you object, we may share relevant health information with a family member, close friend, caregiver, personal representative, or another individual involved in your care or payment for your care when permitted by law.

**Special Situations**

We may use or disclose your protected health information when required or permitted by law for public health activities, health oversight, approved research, organ and tissue donation, medical examiners and funeral directors, workers' compensation, law enforcement, judicial or administrative proceedings, military or national security activities, correctional institutions, disaster relief efforts, and other purposes authorized by federal or state law.

**Reproductive Health Information**

We will comply with all applicable federal and state laws governing the privacy of reproductive health information and will not use or disclose protected health information related to lawful reproductive healthcare for prohibited purposes.

**Substance Use Disorder Records**

If we maintain records that are subject to the federal confidentiality requirements of 42 CFR Part 2, those records will receive the additional protections required by applicable law.

**Uses Requiring Your Authorization**

Most uses and disclosures of psychotherapy notes, marketing activities involving protected health information, and any sale of protected health information require your written authorization unless otherwise permitted by law. You may revoke your authorization in writing at any time, except to the extent we have already acted upon it.

**Changes to This Notice**

We reserve the right to revise this Notice at any time. Any revised Notice will apply to all protected health information maintained by our practice and will be available in our office.

**Questions or Complaints**

If you have questions about this Notice or believe your privacy rights have been violated, please contact the at **(812) 334-2772**. You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Filing a complaint will not affect your care, and we will not retaliate against you for exercising your rights.

**Thank you for choosing Joie de Vivre Medical as your healthcare provider.**
**Lisa Hanner-Robinson, MD and Staff**

**Lisa Hanner-Robinson, MD**
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## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**Patient Name:** _____
**Date of Birth:** _____

**Notice of Privacy Practices**

Joie de Vivre Medical is committed to protecting the privacy of your protected health information (PHI). Our Notice of Privacy Practices explains how we may use and disclose your health information, your rights regarding your health information, and our responsibilities under applicable privacy laws.

By signing below, I acknowledge that I have been provided the opportunity to review or receive a copy of Joie de Vivre Medical's Notice of Privacy Practices. I understand that I may request a copy of the Notice of Privacy Practices at any time.

I understand that Joie de Vivre Medical reserves the right to update its Notice of Privacy Practices. The most current version will be available in the office and on the practice website.

**Patient Communication Preferences**

I authorize Joie de Vivre Medical to contact me regarding appointments, healthcare services, test results, prescriptions, billing matters, and other healthcare-related communications using the contact information provided by me.
Preferred method(s) of communication:
☐ Phone Call
☐ Voicemail
☐ Text Message
☐ Email
☐ Patient Portal
☐ Mail

Preferred Phone Number:

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Preferred Email Address:

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**Acknowledgment**
I understand that signing this acknowledgment does not authorize the release of my medical information to another person or organization. A separate Authorization for Release of Protected Health Information form is required for disclosures not otherwise permitted by law.
I understand that I may refuse to sign this acknowledgment. However, by signing below, I confirm that I have been given the opportunity to review or receive Joie de Vivre Medical's Notice of Privacy Practices.
Patient Name (Print):

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Patient Signature:

---

Date:

---

If signed by a personal representative:
Representative Name (Print):

---

Relationship/Authority:

---

Representative Signature:

---

Date:

---

For Office Use Only:
☐ Patient provided Notice of Privacy Practices
☐ Patient declined to sign acknowledgment
☐ Notice was unavailable due to emergency circumstances
Staff Initials: _____
Date: _____

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# MEDICAL RECORDS ACCESS AND DELIVERY POLICY

## Purpose

Joie de Vivre Medical is committed to providing patients with timely access to their protected health information (PHI) while maintaining the privacy and security of medical records in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and applicable federal and state laws.

## Requesting Medical Records

Patients or their legally authorized representatives may request access to or copies of medical records by completing a Medical Records Request Form or Authorization for Release of Protected Health Information form.

Requests must include sufficient information to identify the patient, specify the records requested, and identify the preferred method of receiving the records.

Before releasing medical records, Joie de Vivre Medical will verify the identity of the patient or authorized representative to protect the confidentiality of the patient's information.

## Available Methods of Delivery

Joie de Vivre Medical provides medical records in the format requested by the patient when the requested format is readily available. Medical records may be provided through the following methods:

## In-Person Pickup

Patients may request to pick up paper copies of their medical records at the office. The patient or authorized representative must present valid identification at the time of pickup.

## Electronic Delivery

Patients may request electronic copies of their medical records. Electronic records may be provided through secure electronic methods, including encrypted email, secure file transfer, patient portal, or other available electronic systems.

When records are transmitted electronically by email or another electronic method, Joie de Vivre Medical will provide the records in a password-protected file whenever possible. The password will be communicated separately from the file transmission to help protect the security of the patient's protected health information.

## Direct Access to Electronic Records

Patients have the right to access their medical records electronically when the records are maintained electronically and the requested format is readily producible. Joie de Vivre Medical will provide electronic records directly to the patient or to another individual or organization designated by the patient when a valid authorization is provided.

Patients are not required to use a third-party company or service to obtain their medical records. Joie de Vivre Medical may use secure technology solutions to assist with record delivery when appropriate; however, patients may request records directly from the practice.

**Delivery to Other Healthcare Providers**

With appropriate patient authorization, Joie de Vivre Medical may send medical records directly to another healthcare provider, facility, or authorized organization involved in the patient's care.

**Fees**

Joie de Vivre Medical may charge reasonable, cost-based fees for copying, supplies, labor, and postage when permitted by applicable law. Patients will be informed of any applicable charges before records are provided.

**Processing Time**

Joie de Vivre Medical will process medical record requests within the timeframe required by applicable federal and state laws. If additional time is needed, the patient will be notified as required.

**Questions Regarding Medical Records**

For questions regarding medical record requests or access, please contact:

**Joie de Vivre Medical**
(812) 334-2772

Effective Date: _____

Approved By: _____

**Lisa Hanner-Robinson, MD**
1310 W. Bloomfield Rd., Suite C
Bloomington, IN 47403

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MEDICAL

**AUTHORIZATION FOR US TO OBTAIN ANY MEDICAL RECORDS OF ANY KIND**

Legal Name: _____ Date of Birth: _____

I authorize: (name of facility) _____
Phone/Fax: _____ to release healthcare information of the above-named patient to:

Joie de Vivre Medical
1310 West Bloomfield Road, Suite C
Bloomington IN, 47403
Fax 812-323-7347

**Please send the following records:**

*Charges for copies of documents shall be in accordance with Indiana Code 16-39-9 effective January 2006.*

☐ One year of current medical records for continuing medical care.
☐ Specific records from the following dates: _____ to _____
☐ Records for personal use. (The fee for records will include * $20.00 for the first 10 (ten) pages * $0.50 per page for pages eleven (11) through fifty (50) * $0.25 per page for pages fifty-one (51) and higher * The cost of mailing the records * An additional $10.00 fee to be applied if records are needed within two (2) working days.)

**Authorization Agreement**
I, the undersigned, understand that I may revoke this authorization at any time, in writing, but the request shall remain valid until revoked or upon the expiration of 60 days, whichever occurs first, except to the extent that action has been taken thereon. Information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by the HIPAA rule. I understand that I am giving permission to release medical information which may include treatment for physical and/or emotional illness, communicable disease, alcohol or drug abuse treatment, and/or HIV, AIDS, AIDS-related information, unless I otherwise restrict such release of information.

Authorization must be signed by the parent or legal guardian of any patient under 18, the legal guardian of any patient under guardianship, the personal representative of a deceased patient, of if no personal representative, the spouse or adult child of a deceased patient. If the patient is under 18 and records are protected by Federal Law (42 CFR Part 2) regarding drug and alcohol abuse, authorizations must be signed by both patient and parent or legal guardian. Emancipated minors may sign for themselves.

**Patient Signature: _____ Date: _____**

**Authorized Representative: _____Date: _____**

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**BILLING POLICY**

**Please review this information and initial the following statements:**

**_____ I understand that it is my responsibility to provide the office of Dr. Robinson with current, accurate billing information at the time of check-in and check-out to notify staff of any changes in this information.**

**_____ I understand that if I present an insufficient funds check for payment on my account, I will be charged a fee of $35. I further understand that to rectify my account I will be required to pay with cash, a money order, a cashier's check or a credit card.**

**_____ I understand that there is a $50 fee to complete disability paperwork associated with my care. However, if additional disability forms such as FMLA require completion, a separate fee of $25 is required prior to completion.**

**_____ I understand that I will be billed for any amounts due by me including copayments, coinsurance amounts and deductibles, and that I have a financial responsibility to pay those amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice," meaning it may be sent to an outside collection service if I do not fulfill my financial obligations. I understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.**

**_____ I understand that if I have a balance older than 30 days and plan on receiving healthcare at Joie de Vivre Medical, I will be required to pay at least half of that balance and any copays due at the time of service.**

**_____ I understand that Joie de Vivre, LLC will obtain the necessary prior authorizations before rendering service. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.**

**My signature below confirms that I have read and understand these billing policies and acknowledge my financial responsibility for services provided by Joie de Vivre Medical and Dr. Lisa Hanner-Robinson, MD.**

**Signature: _____ Date: _____**
**Printed Name: _____**

**Lisa Hanner-Robinson, MD**
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MEDICAL

## STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name: _____ Date of Birth: _____

Joie de Vivre, LLC appreciates the confidence you have shown in choosing us to provide for your healthcare needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. **HOWEVER, YOU ARE ULTIMATELY RESPONSIBLE FOR PAYMENT OF YOUR BILL.** You are responsible for payment of any deductible, copayment and coinsurance as determined by your contract with your insurance carrier. **WE EXPECT THESE PAYMENTS AT TIME OF SERVICE.** Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Joie de Vivre, LLC for providing rehabilitative services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Joie de Vivre, LLC, the full and entire amount of bill incurred by me or the above named patient; or if applicable, any amount due after payment has been made by my insurance carrier.

Patient Signature: _____ Date: _____
Guarantor Signature: _____ Date: _____
(If guarantor is not the patient or the patient is a minor)

**Copay Policy**
Some health insurance carriers require the patient to pay a copay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature: _____

**Consent for Treatment and Authorization to Release Information**
I hereby authorize Joie de Vivre, LLC, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures. I hereby authorize Joie de Vivre, LLC, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature: _____

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## APPOINTMENT, CANCELLATION, NO-SHOW & TEXT MESSAGE POLICY

To help us provide timely care to all patients, we ask that you review and acknowledge the following policies.

**Appointment, Cancellation & No-Show Policy**

- Please provide **at least 24 hours' notice** if you need to cancel or reschedule an appointment.
- Appointments that are not canceled or rescheduled at least 24 hours in advance may be considered a **no-show**.
- A **$50 no-show fee** may be charged for missed appointments without proper notice.
- Patients who arrive **10 minutes or more after their scheduled appointment time** may be asked to reschedule their appointment. **No exceptions.**
- Patients who have **2 consecutive no-shows, 3 no-shows within a 12-month period, or 4 appointment cancellations within a 12-month period** may be discharged from Joie de Vivre Medical. If this occurs, you will be notified by mail and/or telephone.

These policies help ensure appointment times remain available for other patients and allow us to provide timely, high-quality care.

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**Consent to Receive Appointment Reminder Text Messages (SMS)**

Joie de Vivre Medical may send appointment reminders by standard text message (SMS). These messages will **not** include private health information and will only contain information about your upcoming appointment.

You may confirm your appointment by text message. If you need to cancel or reschedule, **please contact our office directly by phone.**

**Standard message and data rates may apply.**

---

**Patient Acknowledgment**

By signing below, I acknowledge that I have read, understand, and agree to the Appointment, Cancellation, No-Show, Late Arrival, and Text Message (SMS) policies of Joie de Vivre Medical.

**Patient/Guarantor Name (Print):** _____

**Patient/Guarantor Signature:** _____

**Date:** _____