Community HEALTH CARE

Patient Information

Patient Name: _____

Mailing Address: _____

Primary Phone: _____ Social Security Number: _____

Second Phone: _____

Work Phone: _____

Employed? ___Yes, full time ____Yes, part time ___No ____Retired _____other

Date of Birth: _____ Email Address: _____

Insurance Information

Primary Insurance: _____

Primary Insurance Phone Number**:** _____

Primary Insurance Address: _____

Policy Holder Name: _____ Date of Birth: _____

Subscriber ID: _____ Group Number: _____

Relation to Patient: _____

Secondary Insurance: _____

Secondary Insurance Phone Number: _____

Secondary Insurance Address: _____

Policy Holder Name: _____ Date of Birth: _____

Subscriber ID: _____ Group Number: _____

Relationship to Patient: _____

Responsible party if patient is a minor: _____

Responsible party Address if patient is a minor: _____

Other Information

*Please list an emergency contact number other than home number**

Emergency Contact Name: _____Phone Number: _____ Relationship: _____

Pharmacy Name: _____ Pharmacy Phone: _____

If you have a mail away pharmacy, list here: _____

OPTIONAL: Race_____Ethnicity_____Primary Language_____

Is your child a dependent of an active or veteran serviceperson? _____Yes _____No

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I verify that I have reviewed this form, and that the above information is true and accurate, to the best of my knowledge.

SIGNATURE: _____ **DATE:** _____

FINANCIAL POLICY

Name: _____ **DOB:** _____

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by the office manager. We accept cash, checks, Mastercard, Visa, and Discover. Returned checks are subject to a $30.00 NSF FEE.

The person that brings the child to the office for the appointment is expected to make payment at the time of service regardless of any custody agreement.

Auto accident claims must be paid at the time of service or be billed through your medical insurance coverage.

We are not providers for Workers' Compensation, and do not do any type of Workers' Compensation paperwork or billing.

We will submit your insurance claims for you with a current signature on file. Your insurance is a contract between you, your employer, and the insurance company. Not all services are a covered benefit. Covered services are based on each individual insurance plan and is the responsibility of the patient to know what services are covered.

Once a claim has been submitted, any remaining balance is your responsibility. For uninsured patients, payment is due at the time of service. If you are experiencing a financial hardship that may affect payment of your account, please contact us for assistance.

I authorize Community Health Care to release all information necessary to secure payment. I understand I am financially responsible for all charges whether or not paid by insurance.

_____ _____

Signature Date

Authorization for Disclosure of Protected Health Information (HIPAA)

Please print all information. Form must be signed and dated.

Patient Name: _____ Date of Birth: _____

I authorize Community Health Care to disclose, discuss, or provide protected health information about me to the individual(s) listed below:

Individual: _____ Phone: _____
Relationship: _____

Individual: _____ Phone: _____
Relationship: _____

* **Secure Communication** - Note that some fax and email transmission methods are not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not include a recipient fax number or email address if this is of concern to you.

* **RX History-** We have the right to request historical prescription information and may do so to treat.

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the person or persons identified above:

☐ Entire patient record; **or** check **only** those items of the record to be disclosed:

- ☐ Office notes
- ☐ Lab results, pathology reports
- ☐ X-rays
- ☐ Appointments
- ☐ Nursing home, home health, hospice, and other physician records
- ☐ Record of HIV and communicable disease testing
- ☐ Record of mental health or substance abuse treatment
- ☐ Referrals
- ☐ Only disclose the following: _____

- This authorization will expire 365 days from date of signature unless you specify an earlier termination.
- You have the right to terminate this authorization at any time by submitting a written request to the Office Manager where the patient receives treatment. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

_____ _____

patient or authorized representative signature date

You have the right to receive a copy of signed authorizations upon request.

CIRCLE OF CARE

Does your child see any specialists? ____Yes ___No

If yes, please list below:

Specialist Name	Type of specialty
_____	_____
_____	_____
_____	_____

Does your child have a legal guardian other than a parent? ___Yes ___No

If yes, list who is the guardian: _____

How did you hear about Community Health Care?

_____Radio

_____Friend/Family Member

_____Internet

_____Insurance Company

_____Television Ad

_____Word of Mouth

Community HEALTH CARE

944 East Cherry St. Canal Fulton, OH 44614, (330) 854-4574

Child's Name: _____ **Child's birthdate:** _____
Child's Address: _____

FROM: Physician/facility releasing Records:	TO: Physician/person/facility to receive records:
Name _____	Name **Community Health Care**
Address _____	Address 944 East Cherry St.
City/State/Zip _____	City/State/Zip: Canal Fulton, Ohio 44614
Phone _____ Fax _____	Phone: 330-854-4574 Fax: 330-854-0829

Purpose for release: _____

Documents to be released electronically or in print (check yes or no for EACH of the following items):

Yes	No	
☐	☐	**Standard Medical record: Office visit notes, labs, diagnostic imaging (non-privileged information) From ___/___/___ to ___/___/___**

Privileged or specifically protected information:

YES	NO		YES	NO	
☐	☐	Alcohol or drug abuse treatment	☐	☐	HIV/AIDS diagnosis and treatment: I specifically give permission to share information in my record about my HIV/AIDS diagnosis and/or treatment information. Initial here _____to specifically authorize its release as required.
☐	☐	Sexually transmitted diseases			
☐	☐	Domestic violence Victim's counseling			
☐	☐	Sexual assault Victim's counseling			
☐	☐	Psychiatric health---mental health information including communication between patient and a psychiatrist, psychologist, or other mental health care specialist	☐	☐	Genetics testing: I specifically give permission to share information in my record about my genetics testing (excludes therapeutic generic tests). Initial here_____to authorize its release.
☐	☐	Communication between patient and a Social Worker			

I understand and agree that:

- The information which I authorize for release may be re-disclosed by the recipient and no longer protected by federal privacy regulations
- I may be charged a fee for information that is sent directly to me
- I decline the opportunity to inspect or copy the information released
- I may take back this authorization at any time by notifying the office from whom I am requesting this information, provided that the information has not already been released
- This authorization is voluntary
- My treatment will not be conditioned on the completion of this authorization
- My questions about this authorization form have been answered

This authorization expires 12 months from the date it was signed OR as specified: ___/___/___

☐ I decline the opportunity to have my previous records transferred.

_____ _____
Patient or Patient's Legal Guardian Date

AUTHORIZATION TO TREAT A MINOR PATIENT

In the absence of a parent/legal guardian

I, _____, the parent/legal guardian of Child's name_____

Child's DOB_____, hereby authorize any person listed below, upon presentation of photo identification:

_____, Relationship to Minor:_____

_____, Relationship to Minor:_____

to accompany my above-named child to office visits at Community Health Care and consent to the examination and/or treatment of my child. I understand that this authorization may be withdrawn at any time prior to the end of the effective date listed below and does not extend authorization for any surgical or invasive procedures.

This authorization is:

- ☐ Effective for one full year from signature date
- ☐ Effective from _____to _____

_____	_____
Print name of parent/legal guardian	Print name of witness
_____	_____
Signature of parent/legal guardian	Signature of witness
_____	_____
Date	Date

Community Health Care is a group of board-certified primary care physicians and nurse practitioners. We provide healthcare for patients of all ages. Our goal is to provide personalized, total healthcare.

We believe that good medical care requires the best efforts from you, your family, and all of us. We must work together to help your child to achieve good mental and physical health. This requires open and honest communication among all concerned. We believe in patient education and preventive care. We want you to know, understand, and be comfortable with the health goals we are trying to reach with your child.

Availability

Office Hours:
Monday: 8:00 am-8:00 pm
Tuesday: 8:00 am-8:00 pm
Wednesday: 8:00 am-8:00 pm
Thursday: 8:00 am-5:00 pm
Friday: 8:00 am-5:00 pm
Saturday: 8:30 am-11:00 am

Telephone communication

Telephone communication is available 24 hours a day by calling **330-854-4574.** After hours calls should be reserved for situations that cannot wait until regular office hours. We encourage you to call our office before going to the Emergency Department for non-life threating health concerns.

We provide the following

- Same day appointments.
- Telehealth appointments.
- Evening and/or weekend appointments.
- Scheduling availability across multiple locations in Stark, Summit, Medina, and Wayne counties.
- Patient portal- 24-hour access to your health information.
- If you cannot keep your appointment, please notify us as soon as possible. There will be a $50.00 charge for “no-show” visits with the provider.

Test Results

- The length of time it takes to get test results back depends on the type of test performed and where it is performed.
- If you have not received your results within two weeks, please call our office.

Prescriptions and Refills

- Bring your child/children’s medication bottles with you to every appointment (prescription, over the counter, and herbal) and request any prescription refills.
- For prescription refill requests between appointments, please request refills through the patient portal or call during regular business hours
- We require 24 - 48 hrs. to process all prescription refill requests.

Services We Provide:

General Evaluation Services

- Well-child examinations
- Illness evaluation and treatment
- Newborn Care
- Routine Immunizations
- Behavioral Health Services
- Bedwetting evaluation and treatment
- Attention Deficit evaluation
- Lactation Counseling

Patient Education, Preventive Care, and Counseling

- Diagnosis-specific written materials
- Medication and injection training
- One-on-one instruction
- Well-child educational materials for parents
- Lifestyle and dietary counseling
- Health maintenance and disease awareness
- Depression screening and management

Laboratory Services

- Urinalysis
- Urine pregnancy testing
- Strep testing
- Flu testing
- Covid testing

Welcome to Community Health Care's Online Patient Portal

You will be able to:

- Receive email reminders of upcoming appointments and request non-urgent appointments.
- See the results of tests ordered from the office and view provider comments on the tests.
- Send and receive messages to and from your doctor or nurse practitioner.
- Review your visit summary.
- Receive educational materials from your provider.
    - You will receive an email message from "reminders@eclinicalworks.com" anytime there is a message for you on the portal. Do not reply to this email. It does not go back to your provider's office. You will never be asked to provide personal information from these emails.

How to set up your account:

1. Provide our office staff with your email address. An email will be sent to you with information on how to set up your portal account.
2. Follow the instructions to complete your account set-up.
3. After you set-up your account, you will be directed to our welcome page.
4. On the left side of the screen, you will see a menu of available options.

Should you have any difficulty with the portal, please call our office and we will assist you.

Download the Healow APP today

- Download the Healow app from your smartphone app store.
- Use your portal username and password to register and create an easy-to-use code. If asked, our practice code is HEDCAA.

Features:

- Check your medication list. Set alarms to remind you to take your medication.
- Goals and trackers for weight and exercise.
- Appointment reminders.
- Send and receive messages to and from your doctor or nurse practitioner.
- View lab and test results.
- You can link additional family members, and other specialists portals that support Healow.

If you have any issue with downloading the app or with any of its features, please contact the office and we will assist you.