



## 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: \_\_\_\_\_ Marital Status: \_\_\_\_\_ 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: \_\_\_\_\_

## 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 \_\_\_\_\_

Have you been to any specialists, been hospitalized, or been to the ER since your last visit here? \_\_\_\_\_no \_\_\_\_\_yes

Do you have "Advanced Directives (Living Will, etc.)"? \_\_\_\_\_no \_\_\_\_\_yes If yes please specify: \_\_\_\_\_

Do you have a caretaker (someone else who takes care of most of your needs)? \_\_\_\_\_no \_\_\_\_\_yes,  
who: \_\_\_\_\_

Does someone have court-ordered legal custody of you? \_\_\_\_\_no yes: who \_\_\_\_\_

Are you on active duty/veteran, or a spouse/dependent of an active or veteran serviceperson? \_\_\_\_\_no \_\_\_\_\_yes

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:

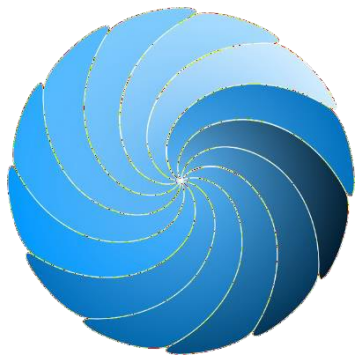
- Office notes
- Lab results, pathology reports
- X-rays
- Appointments
- Only disclose the following: \_\_\_\_\_
- Nursing home, home health, hospice, and other physician records
- Record of HIV and communicable disease testing
- Record of mental health or substance abuse treatment
- Referrals

- 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

Do you see any specialists? \_\_\_Yes \_\_\_No

If yes, please list below:

**Specialist Name**

**Type of specialty**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you 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

\_\_\_\_\_Insurance Company

\_\_\_\_\_Friend/Family Member

\_\_\_\_\_Television Ad

\_\_\_\_\_Internet

\_\_\_\_\_Word of Mouth



Name: \_\_\_\_\_

birthdate: Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

<b>FROM:</b> Physician/facility releasing Records: Name _____ Address _____ City/State/Zip _____ Phone _____ Fax _____	<b>TO:</b> Physician/person/facility to receive records: Name <b>Community Health Care Louisville</b> Address <u>1302 W Main St. Suite A</u> City/State/Zip: <u>Louisville, Ohio 44641</u> Phone <u>330-875-5544</u> Fax <u>330-875-8150</u>
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Purpose for release: \_\_\_\_\_

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

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Standard Medical record: Office visit notes, labs, diagnostic imaging (non-privileged information)</b> From ____/____/____ to ____/____/____

Privileged or specifically protected information:

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol or drug abuse treatment	<input type="checkbox"/>	<input type="checkbox"/>	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.
<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases			
<input type="checkbox"/>	<input type="checkbox"/>	Domestic violence Victim's counseling			
<input type="checkbox"/>	<input type="checkbox"/>	Sexual assault Victim's counseling			
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric health---mental health information including communication between patient and a psychiatrist, psychologist, or other mental health care specialist	<input type="checkbox"/>	<input type="checkbox"/>	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.
<input type="checkbox"/>	<input type="checkbox"/>	Communication between patient and a Social Worker			

I understand and agree that:

<ul style="list-style-type: none"> <li>The information which I authorize for release may be re-disclosed by the recipient and no longer protected by federal privacy regulations</li> <li>I may be charged a fee for information that is sent directly to me</li> <li>I decline the opportunity to inspect or copy the information released</li> </ul>	<ul style="list-style-type: none"> <li>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</li> <li>This authorization is voluntary</li> <li>My treatment will not be conditioned on the completion of this authorization</li> <li>My questions about this authorization form have been answered</li> </ul>
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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

## MEDICAL HISTORY QUESTIONNAIRE—New Patient

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

### Medical History: (if yes, please circle and indicate approximate date):

Abnormal chest Xray	Diverticulosis/itis	Irritable bowel
Abnormal EKG	Duodenal ulcer	Kidney disease
Abnormal lab work	Dysentery	Melanoma
Allergies	Ear infections	Menopause (female)
Alzheimer's	Emotional problems	Migraines
Anemia	Emphysema	Multiple sclerosis
Angina	Endometriosis (female)	Osteoporosis
Anxiety disorder	Epilepsy	Overactive thyroid
Arthritis	Fibroids	Panic attacks
Asthma	Gall bladder disease	Phlebitis
Bleeding disorder	Glaucoma	PMS
Blindness	Goiter	Prostate enlargement (male)
Blood clot	Gonorrhea	Polio
Breast disease	Gout	Raynaud's
Broken bone(s)	Hay fever	Skin cancer
Cancer: Type	Heart disease	Syphilis
Carpal tunnel	Heart murmur	Tuberculosis (TB)
Cataracts	Hemorrhoids	Underactive thyroid
COPD	High blood pressure	Other:
Depression	Herpes: type	Other:
Diabetes Type I	High cholesterol	Other:
Diabetes Type II	Hypoglycemia	Other:
Diarrhea (chronic)	Impotence	Other:

### Allergies:

<input checked="" type="checkbox"/> <b>DRUG allergies:</b> Are you aware of any medication allergies? <b>Yes</b> <b>No</b> If yes, list medicines below  							
<input checked="" type="checkbox"/> <b>ENVIRONMENTAL allergies:</b> Please circle all below that apply to you.							
Flowers	Grass	Tree pollen	Mold	Chemicals	Perfumes	Dyes	Animals
Soaps	Insect bites	Dust	Cosmetics	Fumes	Latex	Adhesives	
Other Environmental Allergies:							
<input checked="" type="checkbox"/> <b>FOOD allergies:</b> please circle all that apply.							
Eggs	Dairy	Wheat	Soy	Shellfish	Fruit	Vegetables	Nuts
Other:							

### Gyn and OB History (Females only!)

Issue	Comments
Periods	How often?
Sexual activity	Are you sexually active?
Pap	Date of last pap smear-
Mammogram	Date of last mammogram-
Bone density	Date of last bone density test-
Abnormal pap(s)	Ever had an abnormal pap? _____ If yes, do you know the issue?

STD	Have you ever had a sexually transmitted disease? If yes, what?
Birth control	What kind of birth control do you use?
Total Pregnancies	# of pregnancies
Total Living children	# of children born alive
Stillbirths	# of stillbirths
Miscarriages	# of miscarriages
Abortions	# of abortions
C-sections	# of C-Sections

**Past Surgical History:** (list all surgeries you have had, plus dates):

DATE	SURGERY
	Have you had a colonoscopy?            no                    yes    If yes, indicate date

**Hospitalizations:**

When	Why?

**Family History:**

Family Member	Now alive or deceased	Age	Health issues or cause of death
Father			
Mother			
Paternal GPA			
Paternal GMA			
Maternal GPA			
Maternal GMA			
Uncles			
Aunts			
Siblings			
Children			
Other			

**Social History:**

Issue	Details
Tobacco	Have you ever used tobacco?    Never                    Former                    Currently
Alcohol	Do you use alcohol?
Narcotics	Using prescription narcotics?
Street Drugs	Using illegal drugs?
Herbal/Supp	Are you using herbal drugs or nutritional supplements?
Dietary	What is your usual diet?
Caffeine	How many cups of coffee/cola/cafeinated drinks per day?
Adv Directives	Do you have a Durable Power or Atty for Health and/or a Living Will?
Marital status	Status:
Children	







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 you 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 you.

## Availability

### Office Hours:

Monday	8:00am- 7:00pm
Tuesday	7:30am- 7:00pm
Wednesday	8:00am- 5:00pm
Thursday	7:30am- 5:00pm
Friday	7:30am- 4:00pm
Saturday	Closed

## Telephone communication

Telephone communication is available 24 hours a day by calling **330-875-5544**. 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 threatening 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 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

- Wellness examinations
- Illness evaluation and treatment
- Newborn Care
- Routine Immunizations
- Behavioral Health Services
- Bedwetting evaluation and treatment
- Attention Deficit evaluation

## 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

## Surgical Services

- Simple laceration repairs
- Simple wart, mole, lesion, and growth removals
- Minor burn care
- Abscess treatment

## Gynecologic Services

- Well-woman exams, breast exams, pap smears
- Self-exam instruction
- Depo-Provera injections
- Family planning

## Specialized Treatment and Evaluations

- Simple Visual exams
- Diabetic retinal eye exams
- Routine X-Rays
- EKG
- Spirometry (lung function testing)
- Derma Scope skin exams

## **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.**