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 $40.00 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

CONSENT FORM

Consent to release records (HIPAA)

I consent to allow discussion of my condition, care, reminders of appointment times, or other medical information regarding the following patient**:**

_____Me
_____My child or ward, name: _____
_____Other: _____

The following are AUTHORIZED to receive the health information *(verbal or in print),* please provide relationship and phone number

IN ACCORDANCE WITH HIPAA LAW, I AUTHORIZE THE USE AND DISCLOSURE OF ANY MEDICAL INFORMATION WITH A THIRD PARTY TO COORDINATE OR MANAGE MY HEALTHCARE OR ANY RELATED SERVICES.

	NAME	RELATIONSHIP	PHONE #
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

DISCLAIMER: ***THIS CONSENT WILL REMAIN IN EFFECT FOR 1 YEAR UNLESS REVOKED IN WRITING*****.** A copy of Community Health Care's HIPAA policy is available upon request. It is the responsibility of the patient/parent/guardian to notify Community Health Care of any changes that need to be made to this form.

Signed: _____ Signing Date: _____
SIGNATURE

Print Name:_____ Date of Birth: _____

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

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

FROM: Physician/facility releasing Records:	TO: Physician/person/facility to receive records:
Name _____ Address _____ City/State/Zip _____ Phone _____ Fax _____	Name **Community Health Care Pediatrics** Address 7452 Fulton Road NW, Suite B City/State/Zip: Massillon, OH 44646 Phone 330-833-4596 Fax 330-833-1817

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

Community HEALTH CARE

AUTHORIZATION TO TREAT A MINOR PATIENT

In the absence of a parent/legal guardian

I, _____, the parent/legal guardian of _____

(Child's DOB:_____), hereby authorize any listed below:

_____

_____

_____

_____

to accompany my above-named child to office visits at Community Health Care and consent to the examination and/or treatment of my child during office hours.

This authorization is:

☐ 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
Pediatrics
WWW.CHCI.COM

Rita Kazlauskas, M.D.
Diane S. Belardo, M.D.
Erin Weber, M.D.
Darcy Drevon, APRN
Ashley Korosa, APRN

Community Health Care is a group of board-certified primary care physicians and nurse practitioners. Community Health Care Pediatrics is a part of that group. We provide healthcare for patients from newborn to age 18. 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:	8:30 am-7:00 pm
Tuesday:	8:30 am-7:00 pm
Wednesday:	8:30 am-5:00 pm
Thursday:	8:30 am-5:00 pm
Friday:	8:30 am-5:00 pm
Saturday:	Seasonal Hours

Telephone communication

Telephone communication is available 24 hours a day by calling **330-833-4596.** 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 or a $10.00 charge for “no-show” visits with the nurse.

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
- RSV 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.