Medina OB/GYN

A subsidiary of Community OB-GYN

Patient Information

Patient Name: _____

Mailing Address: _____

Primary Phone: _____

Second Phone: _____

Work Phone: _____

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

Date of Birth: **«DOB»** 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: _____

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_____

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: _____

_____

Are you 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:** _____

MEDICAL RECORDS RELEASE *TO* OUR OFFICE

MEDINA OB-GYN PHYSICIANS

Patient's Name: _____ **Patient's birthdate: _____**

Patient's Address: _____

FROM: Physician/person/facility to receive records:	TO: **MEDINA OB-GYN PHYSICIANS**
Name_____	3985 Medina Rd, Suite 200, Medina OH 44256
Address_____	Phone: 330-952-2251 Fax: 330-952-2261
City/State/Zip_____	
Phone_____ Fax_____	

Purpose for release: _____

Documents to be released digitally 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 _____/_____/_____**
☐	☐	All OB-GYN Records
☐	☐	Specific reports, photographs, results, or other medical information (Specify) : _____ from date _____/____/____ 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 have received a copy of this authorization.
- 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: ____/____/____ .
If not specified, this authorization will expire 12 months from the date it was received.

_____ _____

Patient or Patient's Legal Guardian Date

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FINANCIAL POLICY

Name: _____ DOB: _____

We are committed to providing you with the best possible care. We are anxious to help you receive your maximum allowable benefits if you have medical insurance. In order to do this, we need your assistance and your understanding of our **FINANCIAL POLICY**. We will also be asking you to periodically update your information.

Payment for services is **DUE AT THE TIME SERVICES ARE RENDERED**, unless payment arrangements have been approved in advance by our office manager. **We accept CASH, CHECKS, MASTERCARD, VISA, and DISCOVER**. Returned checks are subject to a $30.00 NSF FEE. Non-payment of returned checks may result in your termination as a patient of Medina OB/GYN Physicians.

If there is a divorce involved, please remember that our policy requires that regardless of which parent is responsible for the bills, **PAYMENT IS DUE AT THE TIME OF SERVICE**. The person that brings the child to the office for the appointment is expected to make payment. As you should be able to understand, we will not get involved with divorce disputes. Please feel free to discuss this with our office manager if you have any questions.

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

We will submit your insurance forms for you with a current signature on file permitting us to do so. Please remember that:

1. Your insurance is a contract between YOU, YOUR EMPLOYER, and the insurance company. We are not a party to that contract.
2. Not ALL services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will NOT cover.

We must emphasize that as a provider of medical services, our relationship is to YOU, not your insurance company. While the filing of patient insurance forms is a courtesy we extend to our patients, all charges are YOUR responsibility from the date the service is rendered.

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

We realize that temporary financial problems may affect your timely payment of your account. If such problems DO arise, we encourage you to contact us promptly for assistance in the management of your account.

_____ _____

Signature Date

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CONSENT FORM

✓Consent to bill insurance

I hereby assign all medical and or surgical benefits to which I am entitled including all major medical, Medicare, Medicaid, private insurance, and any other health plans to Community Health Care Inc. A photocopy of this assignment is to be considered as valid as the original.
I understand I am financially responsible for all charges whether or not paid by insurance.
I authorize Community Health Care to release all information necessary to secure payment.

_____

✓Consent to verify prescription records

I also consent to my physician or nurse practitioner to retrieve prescription records or drug formulary records from external sources.

_____

✓Consent to release records (HIPAA)

I also 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

1. IN ACCORDANCE 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
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

DISCLAIMER: ***THIS CONSENT WILL REMAIN IN EFFECT UNTIL REVOKED IN WRITING*****.**

I have received today or at a previous visit a copy of Medina OBG/Community Health Care's HIPAA "Notice of Privacy Practices".

Signed: _____ Signing Date: _____

SIGNATURE

Print Name:_____ Date of Birth: _____

CIRCLE OF CARE

What providers do you see?

☐ **None**

Provider Name	Kind of specialty
	Primary Care:

☐ **Do you have a caregiver? ___no __yes**
If yes, who takes care of you:

_____

☐ **Do you have a Legal Guardian? ___ no __yes**
If yes, list who is your guardian:

_____

MEDICAL HISTORY QUESTIONNAIRE—New Patient

Name: _____ DOB: _____ Today's Date: _____

Personal Medical History

Have you ever been diagnosed with?

Stroke	**Yes** ☐	**No** ☐
Thyroid Disease	**Yes** ☐	**No** ☐
Asthma	**Yes** ☐	**No** ☐
Anemia/Blood Transfusion	**Yes** ☐	**No** ☐
Blood Clots: Circle-> Leg or Lung	**Yes** ☐	**No** ☐
Heart Attack/Murmur/Mitral Valve Prolapse	**Yes** ☐	**No** ☐
High Blood Pressure	**Yes** ☐	**No** ☐
Diabetes or Gestational Diabetes	**Yes** ☐	**No** ☐
Seizures/Convulsions/Epilepsy/Migraines	**Yes** ☐	**No** ☐
Fracture (location)	**Yes** ☐	**No** ☐
Bowel Issues/Crohn's/Diverticulitis	**Yes** ☐	**No** ☐
Hepatitis/Yellow Jaundice	**Yes** ☐	**No** ☐
Thrombophilia Specify:	**Yes** ☐	**No** ☐

Kidney Infections/Stones	**Yes** ☐	**No** ☐
Sexually Transmitted Disease (type)	**Yes** ☐	**No** ☐
Female Cancer Specify:	**Yes** ☐	**No** ☐

Allergies: _____

Any other Medical Problems: _____

Medications: _____

_____

Supplements/Vitamins/Minerals/Other: _____

_____

Current Social History

Smoke	**Yes**	☐	**No**	☐	**How Long**		**Year Quit**	
Alcohol	**Yes**	☐	**No**	☐	**How Many**			
Exercise	**Yes**	☐	**No**	☐	**How long**			
Domestic Violence	**Yes**	☐	**No**	☐				

Obstetric History

Total # of Pregnancies	Full Term	Premature	Miscarriages	Ectopic	Multiple Births	Living
Month/Year	Delivery Type	How far along (wks)	Complications		Sex	Wt

Previous Surgeries

Type	**Date**	**Type**	**Date**

Family History

Has any blood relative ever been diagnosed?

Breast Cancer	**Yes** ☐	**No** ☐	**Who**	
Colon Cancer	**Yes** ☐	**No** ☐	**Who**	
Ovarian Cancer	**Yes** ☐	**No** ☐	**Who**	
Uterine Cancer	**Yes** ☐	**No** ☐	**Who**	
Other Cancer	**Yes** ☐	**No** ☐	**Who**	
Blood Clots (DVT or PE)	**Yes** ☐	**No** ☐	**Who**	
Miscarriages	**Yes** ☐	**No** ☐	**Who**	
Diabetes	**Yes** ☐	**No** ☐	**Who**	
Heart Disease	**Yes** ☐	**No** ☐	**Who**	
Osteoporosis	**Yes** ☐	**No** ☐	**Who**	
Endometriosis	**Yes** ☐	**No** ☐	**Who**	
Infertility	**Yes** ☐	**No** ☐	**Who**	
Von Willebrand	**Yes** ☐	**No** ☐	**Who**	
Bleeding/Discharge	**Yes** ☐	**No** ☐	**Who**	
Cystic Fibrosis	**Yes** ☐	**No** ☐	**Who**	

Previous Illness: System of Review in the last 6 months

General			**Endocrinology**		
Loss of Appetite	☐ **Yes**	☐ **No**	Dry Skin	☐ **Yes**	☐ **No**
Weight Loss >20#	☐ **Yes**	☐ **No**	Night Sweats	☐ **Yes**	☐ **No**
Weight Gain >20#	☐ **Yes**	☐ **No**	Hair Loss	☐ **Yes**	☐ **No**
Eye/Ear/Nose/Throat			Easy Bruising	☐ **Yes**	☐ **No**
Blurred Vision	☐ **Yes**	☐ **No**	Excessive hair growth	☐ **Yes**	☐ **No**
Frequent nose bleeds	☐ **Yes**	☐ **No**	**Psyche**		
Cold sores	☐ **Yes**	☐ **No**	Suicidal thoughts	☐ **Yes**	☐ **No**
GI			**Genitourinary**		
Diarrhea, frequent	☐ **Yes**	☐ **No**	Blood in urine	☐ **Yes**	☐ **No**
Bloody stools	☐ **Yes**	☐ **No**	Pain with urination	☐ **Yes**	☐ **No**
Nausea/ Vomiting	☐ **Yes**	☐ **No**	Leaking of urine	☐ **Yes**	☐ **No**
Constipation	☐ **Yes**	☐ **No**	Frequency of urine	☐ **Yes**	☐ **No**
Other:_____	☐ **Yes**	☐ **No**	Incomplete emptying	☐ **Yes**	☐ **No**
Cardio			Abnormal Periods	☐ **Yes**	☐ **No**
Chest Pain	☐ **Yes**	☐ **No**	Painful intercourse	☐ **Yes**	☐ **No**
Swelling of legs	☐ **Yes**	☐ **No**	Menstrual Cramps	☐ **Yes**	☐ **No**
Heart Palpitation	☐ **Yes**	☐ **No**	Vaginal Itching	☐ **Yes**	☐ **No**

Previous Illness: System of Review in the last 6 months

Respiratory			**Genitourinary**		
Shortness of breath with exertion	☐ **Yes**	☐ **No**	Vaginal Bleeding	☐ **Yes**	☐ **No**
Muscle			Length of menses		
Weakness	☐ **Yes**	☐ **No**	How often		
Other:_____	☐ **Yes**	☐ **No**	Menopause Age:_____	☐ **Yes**	☐ **No**
Blood transfusion	☐ **Yes**	☐ **No**	Birth control Method:____	☐ **Yes**	☐ **No**

You've Been Invited

To enjoy the convenience of Community Health Care's Patient Portal Program!

This program is FREE, and is being encouraged for all adult patients. During this program, your patience is appreciated as we trial and test the features and functionality of this system.

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 from and to your doctor or nurse practitioner

Other exciting features will be available as soon as they are operational.

When you connect to the Portal, you are NOT connecting to our actual office computer system, but to a secure website hosted elsewhere. Only very limited amounts of your information are stored in the portal. The Portal "talks" to our office computer system approximately every ten minutes.

Here's how it works:

1. Our staff will enter your email address into our system in the office, and an e-mail will be sent to you with your user logon name and password. Or if you prefer, this info can be given to you at our office.

2. 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.

3. Within three days, go to www.chci.com, our practice website, and click on the patient portal icon.

4. Enter the user logon and password from the e-mail you received.

5. "User validation" window will appear <u>the first time you use the Portal ONLY</u>. Fill in one field and click Submit.

6. The next screen allows you to pick a better password and a clue should you forget your password.

7. The final screen for first time users is a consent form. Read and click the box to confirm you have read it. This is the end of the "red tape"

8. **The next box you will see is the WELCOME PAGE.** On the left, you will see menu of the options available. As time passes, we will activate more features.

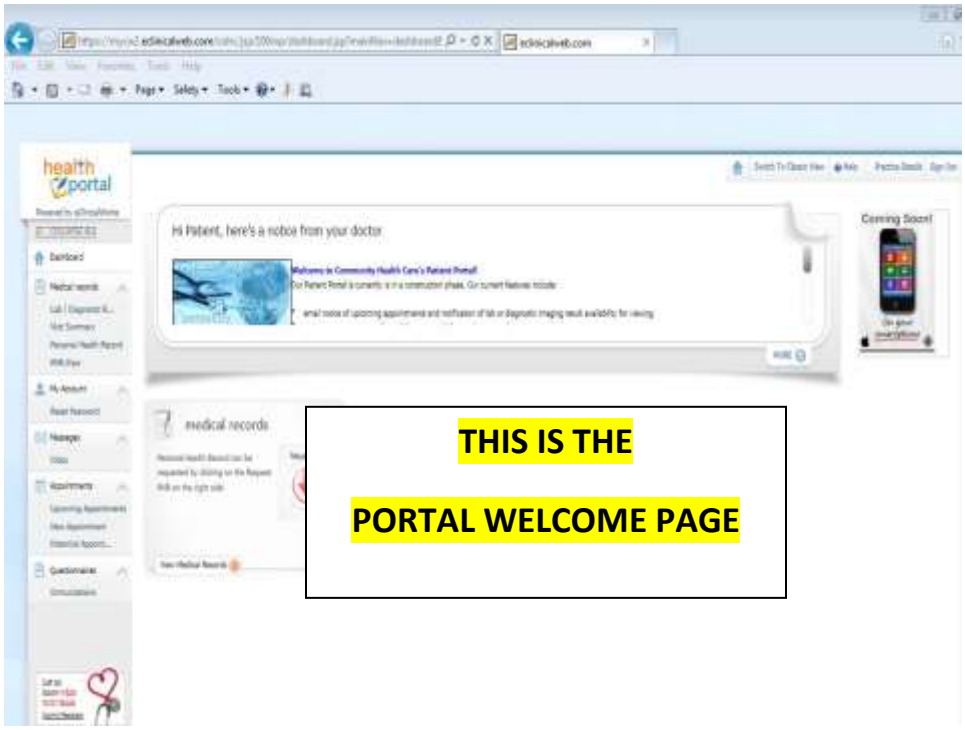
    a. **LAB/DIAGNOSTIC IMAGING**: Any labwork you might be looking for is listed in LABS/DIAGNOSTING IMAGING, also along the left margin. <u>Click on the NAME of the lab test</u> to see your results and any comments from the provider.

    b. **VISIT SUMMARY:** You can also get copies of your "homegoing instructions"/visit summary on the website.

    c. **APPOINTMENTS:** You can also look at "Current Appointments" to see when your next appointment is, and in "Past Appointments" to see dates you were seen in the office.

    d. ASK DOCTOR: You can send a NON-EMERGENCY message to your doctor, and receive messages from your health care provider.

    e. EDUCATION: Your provider can send you educational materials regarding your health.



You can log in anytime you want. Your confidentiality is important to us, and your data is secure. You will have access to your medical history, summaries of past visits, lab and diagnostic imaging results, online messages from your health care provider, and reminder messages about important preventive care you may need. You can print out any screen from your own computer.

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

Got a SMART PHONE? Get

healow
Health and Online Wellness

Your Web Portal on your phone!

1. Download Healow App for FREE from your online iPhone or Android Store.
2. Put in your Portal User name and password to register, and create an easy to use code.
3. Check your meds list---remove any you are no longer taking. You can also set alarms to remind you to take meds.
4. Goals and trackers for weight and exercise are available!
5. You'll have access dates of upcoming appointments, messages from doctor, lab results, etc.
6. You can also link family members and Portal from other specialists who support Healow.
7. Handy tutorial for use included in the Healow app.

Great for emergencies, and handier to use than going to a computer for access to your Portal. Easy communication with our office, and no busy signals!

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have received the notice electronically.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this document.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures: How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you: We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, or preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address law enforcement, and other government requests

We can use or share health information about you:

- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

About the Terms of this Notice

- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.
- This document is effective Sept 15, 2014
- Your privacy contact at Community Health Care is: Michelle Moellendick, 330-854-4281. Our corporate address is: 944 E. Cherry St, Canal Fulton, OH, 44614.
- We never market or sell personal information. We will never share any **substance** abuse treatment records without your written permission, unless required by law.