DEMOGRAPHIC INFORMATION, New Patient

Patient Information **PCP:** _____

Patient Name:_____

Mailing Address: _____

Primary Phone: _____ ☐ ok to leave brief msg? ☐ ok to leave detailed msg?

Second Phone: _____ ☐ ok to leave brief msg? ☐ ok to leave detailed msg?

Work Phone: _____ ☐ ok to leave brief msg? ☐ ok to leave detailed msg?

Employed? ___yes, full time ____yes, part time ____no ____retired ___other

Date of Birth: _____ Social Security Number: _____

Marital Status: _____ Email Address *(only if wants web-enabled)*: _____

Insurance Information

Primary Insurance: _____

Primary Insurance Phone Number: _____

Primary Insurance Address**:** _____

Policy Holder Name: _____ Date of Birth : _____

Subscriber ID_____ Group Number: _____ SSN:_____

Relation to Patient _____

Secondary Insurance: _____

Secondary Insurance Phone Number: _____

Secondary Insurance Address: _____

Policy Holder Name: _____ Date of Birth: _____

Subscriber ID: _____ Group Number: _____ SSN:_____

Relationship to Patient: _____

Responsible Party

Guarantor Name: _____ **Birth Date:** _____

Guarantor Address: _____ **Social Security:** _____

Other Information

Please list an emergency contact number other than home number*

Emergency Contact Name:_____Phone Number:_____ Relationship: _____

Local Pharmacy Name: _____ Pharmacy Phone: _____

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

Race_____ Ethnicity_____Primary Language_____

Do you have Advanced Directives? ("Living Will", etc.) ___yes ___no If yes please specify: _____

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. 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.

****NEW PATIENTS ONLY: How did you hear about our office?**

_____

Signature: _____ Date: _____

Please review this information, make any corrections necessary, and return form to the front desk when complete

Community HEALTH CARE Pediatrics

7452 Fulton Road NW, Suite B, Massillon, OH 44646 (330) 833-4596

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 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 _____/_____/_____**
☐	☐	Office visit notes only from ____/____/____ to ____/____/_____
☐	☐	Specific reports, photographs, results, or other medical information (Specify) : _____ from date _____/____/____ to ____/____/____

Privileged or specifically protected information:

YES	NO		
☐	☐	☐	Alcohol or drug abuse treatment
☐	☐	☐	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
☐	☐	☐	Communication between patient and a Social Worker

YES	NO	
☐	☐	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.
☐	☐	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.

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

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.

We provide equal access to medical care regardless of source of payment.

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 Community Health Care, Inc.

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: _____

Yearly Consent Forms

✓ 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. This agreement will remain in effect until revoked by me in writing. 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 to retrieve prescription records from external sources.

✓ Consent to verbally release records (HIPAA)

This is my authorization to allow VERBAL 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 patient's protected health information:

1. _____ Relationship:_____ Phone:_____
2. _____ Relationship:_____ Phone:_____
3. _____ Relationship:_____ Phone:_____
4. _____ Relationship:_____ Phone:_____

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

Signed: _____ Signing Date: _____

Print Name: _____

Date of Birth: _____

AUTHORIZATION TO TREAT A MINOR PATIENT

In the absence of a parent/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 PEDIATRICS** and consent to the examination and/or treatment of my child during office hours.

This authorization is:

- ☐ Effective only on _____(date)
- ☐ Effective from _____ to _____
- ☐ Effective until revoked in writing.

I reserve the right to revoke this authorization at any time in writing to COMMUNITY HEALTH CARE PEDIATRICS.

_____	_____
Print name of Parent/Guardian	Print name of witness
_____	_____
Signature of Parent/Guardian	Signature of witness
_____	_____
Date	Date

MEDICAL HISTORY QUESTIONNAIRE—New Patient

Child's Name: _____ Child's Date of Birth:_____**Today's Date:** _____

Date of Last Physical Exam: _____

List your child's symptoms or concerns in order of severity/importance:

1) _____**Date first experienced**_____
2) _____**Date first experienced**_____
3) _____**Date first experienced**_____
4) _____**Date first experienced**_____

What (if any) care did you seek for your child in the past for the above?

_____

_____

What was the outcome of the care your child had?

_____

Is your child currently receiving any treatments for the above conditions? (List specialists, if any)_____

_____

****

PAST MEDICAL HISTORY (if yes, please circle and indicate approximate date):

Abnormal chest Xray	Ear infections
Abnormal EKG	Emotional problems
Abnormal labwork	Epilepsy
ADHD	Hay fever
Allergies	Heart Murmur
Anemia	Leukemia
Angina	Panic attacks
Anxiety disorder	Rashes
Arthritis	
Asthma	
Bleeding disorder	Other issues:
Blindness	
Broken bone(s)	
Cancer: Type_____	
Depression	
Diabetes Type I	
Diarrhea (chronic)	

Medical History Questionnaire, continued.

PAST SURGICAL HISTORY (list all surgeries your child has had, plus dates):

SURGERY	DATE

FAMILY HISTORY:

CONDITION	RELATION

ASSISTIVE DEVICES (please circle all that apply):

Hearing Aid	Walker	Other:
Wheelchair	Braces	

IMMUNIZATIONS: Please bring a copy of your child's immunization record.

ALLERGIES:

✓ **DRUG allergies:** Are you aware of any medication allergies? **Yes** **No** If yes, list the medicines below.

✓ **ENVIRONMENTAL allergies:** 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:_____

✓ **FOOD allergies:** please circle all that apply.

Eggs	Dairy	Wheat	Soy	Shellfish	Fruit	Vegetables	Peanuts

Other: _____

MEDICATIONS: We will discuss your current medications at your visit. If your child is a new patient receiving this form ahead of your visit, bring ALL YOUR CHILD'S MEDICATIONS with you to your child's appointment.

CIRCLE OF CARE: Does your child see any specialists? If yes, list here: _____

LEGAL GUARDIAN: Does the child have a legal guardian other than parent? If yes, please give name:

_____

Rita Kazlauskas, M.D.

Diane S. Belardo, M.D.

Erin Weber, M.D.

Darcy Drevon, CNP

WELCOME!

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 health care for patients of all ages. Our goal will always be to provide personalized, total health care.

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 STRONGLY in patient education and preventive care. We want you to know, understand, and be comfortable with the health goals we are trying to reach for your child.

Appointments

Appointments are scheduled in advance; however, if you must be seen on an emergency basis, every effort will be made to see your child as soon as possible. If you cannot keep your appointment, please notify us as soon as possible--- at least 24 hours in advance--- so another patient may be scheduled for that time. Repeatedly missed appointments will be grounds for dismissal from our practice. There will be a $50.00 charge for “no show” appointments with the provider or $10.00 “no show” charge for missed appointments with the nurse.

Your child’s first visit may be scheduled for a longer period so we can obtain any past medical history. When you schedule any appointment, the receptionist will inquire about the nature of your child’s visit so your appointment can be scheduled for an appropriate and sufficient amount of time, and so all needed medical equipment or supplies will be available at the time of your child’s appointment.

Also please let us know if siblings need to be seen at the same time, so we can schedule appropriately and avoid delays for families like yours who are waiting to see the doctor

Confidentiality

Your child’s medical record at our office is private, and maintained according to HIPAA law. We will not release the contents of those records to any doctor, hospital, school, clinic, insurance company, or relative without your written permission. This is to ensure your child’s privacy.

When we call your home to leave a message, and you are not at home, the message left will be very non-specific, to ensure privacy, and to ensure that information will be relayed correctly. When you return the call, we can speak to you in a very detailed way.

Nights and Weekends

Our phone lines are available to help you 24 hours a day. When you call us at 330-833-4596 after business hours, an after-hours medical call service will take your call and process it appropriately. After hours calls should be reserved for situations that cannot wait until regular office hours. Routine prescriptions will NOT be called into the pharmacy after hours.

If your child's situation is life-threatening, please go to the nearest appropriate emergency room. The E.R. physician will then contact one of the doctors in our group. If your child has a problem that is NOT life-threatening, please leave a message with our call center.

Some insurance plans require that you let us know via phone if you have taken your child to the emergency room. YOU must know what YOUR insurance requires. Failure to follow your insurance's Emergency Room usage rules may result with you being responsible to pay the entire emergency room bill.

Telephone Calls

In order to reduce interruptions to patients being examined, our staff will convey your message to your health care provider. Either the provider or our staff will call you back at the first available time. Try to call early in the day if your child experiences problems or if needs arise, especially if you feel your child needs an appointment, so we may schedule your child as soon as possible.

Doctor Absence

Our doctors occasionally take time off from work for illness, vacations, relaxation, activities with their families, or educational seminars. When your child's health care provider is absent from the practice, your child's health is still of the utmost importance to us, and the other health care providers of our group will do their very best to be available for your child's health care needs.

Insurance and Fees

This office desires to keep the cost of your child's medical care as low as possible. We are contracted with many HMO and PPO-type plans as a convenience to you, and we do billing for these plans. If your insurance requires a copayment, we are REQUIRED to collect that from you at the time of service. If you do not bring your copay, you may be asked to reschedule.

PLEASE BRING YOUR INSURANCE CARD TO EVERY VISIT. If you do not present your insurance card at your child's appointment, you may be asked to pay upfront at the time of service or asked to reschedule.

We accept cash, personal check, MasterCard, VISA, and Discover.

If you have no insurance, you will be expected to pay for your child's care at the time of service. Due to a multitude of insurance plans, we cannot be responsible to know the details of every plan. You, the parent or guardian, must know how YOUR insurance works. If referral or pre-authorization paperwork is needed, you must let us know.

Test Results

Parents whose children have had tests often wait anxiously for the results. We process those results as soon as we receive them. The doctor takes a look at the results and decides what action needs to be taken and what instructions need to be given to you. Without the doctor's review of the results, there is not much our staff can tell you. The length of time it takes to get results back depends on the type of test and where it was done. If you have not heard back from us within TWO WEEKS of the time the results were expected, please call us.

Prescriptions and Refills

Please come to your child's appointment prepared to ask for written prescriptions to cover you until your next scheduled appointment. Bring a list of all medications your child is on (prescription, over-the-counter, and herbal) to each of your visits.

If it is necessary to call for a refill between appointments, please call during normal office hours, Monday through Friday only. Not all of our physicians work the same hours every day, and the physician who must approve your child's refill may not be in at the time you call. We require 24 hrs.to fill refill requests.

There are times when the doctor may not grant your request for a refill of medication for your child. If you have not been in our office for a very long time and the medication is one that requires periodic physician monitoring, we may not refill your child's medication until the doctor checks your child.

Also please be aware that we do not routinely call antibiotics in over the phone. There are many illnesses that may have the same set of symptoms you are describing. The physician can more accurately diagnose and treat your child's problem by seeing, listening, examining, and asking more questions. This is in the best interest of your child's health.

You've Been Invited

Our Website

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
- See the results of tests ordered from the office and view provider comments on the tests

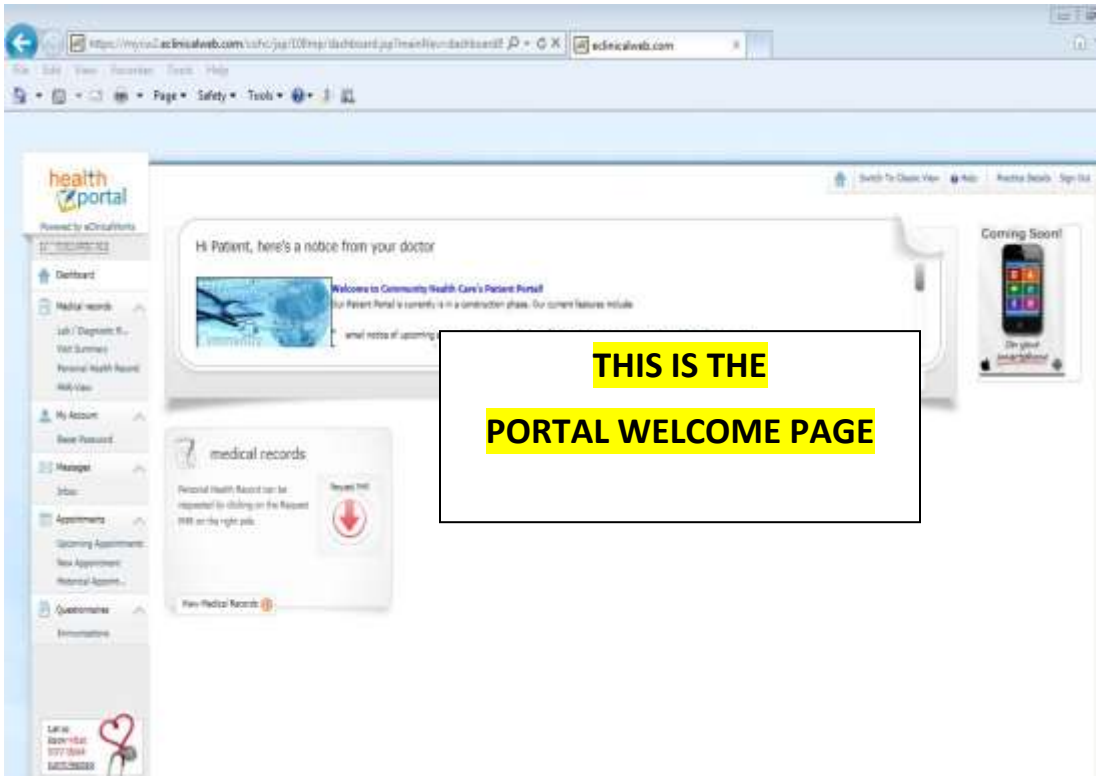
Other exciting features will be available as soon as they are operational.

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!

healow is available for the iPhone® and Android ™ smartphones

Available on the App Store

Available on Google play

Download Healow for <u>FREE</u> from your online iPhone or Android Store. Put in your Portal User name and password, and have your health information at your fingertips! Easy communication with your Health Care Provider and our office. No busy signals!

Community Health Care Pediatrics Is A

PATIENT-CENTERED MEDICAL HOME

What is a "PATIENT-CENTERED MEDICAL HOME"?

A "Patient-Centered Medical Home" (PCMH) is *how* health care is delivered to patients. The medical home team in your child's doctor office manages care and services for your child—acting as the "hub" of your child's care. A medical home can lead to higher quality care for patients, and improved care can lead to lower costs for all of us. PCMH puts the patient at the center of the health care system, and provides primary care that is:

- Accessible
- Continuous
- Comprehensive
- Family-Centered
- Coordinated, and
- Compassionate

Why did Community Health Care Pediatrics become a PCMH?

Patient-Centered Medical Home (PCMH) is a major part of our continuous effort to improve quality, safety, and efficiency within our organization. By replacing episodes of care with whole person care, we can help coordinate your child's long term health. We believe strongly that providing you with health education and helping you understand your child's health situation can contribute to better outcomes. Being a PCMH does not affect your insurance coverage in any way. We will provide your child enhanced care through same-day appointments and extended, hours, and help improve interaction and communication with specialists, other care facilities, and the entire health care team.

OUR RESPONSIBILITIES AS A PCMH ARE:

- To listen to your questions and concerns and to explain disease, treatment, and results in an easy-to-understand way.
- To coordinate your child's overall care, sending you to trusted specialists if needed.
- To provide your child with same-day appointments whenever possible.
- To provide instruction on how to access the care your child needs when the office is not open.
- To provide clear instructions about your child's treatment goals and future plans for every visit.

YOUR RESPONSIBILITIES ARE:

- To ask questions and be active in your child's care.
- To provide your child's health history, symptoms, and other important information, including any changes in your child's health.
- To inform us whenever there is a problem with a medication your child is taking.
- To call our office first with your health concerns for your child unless it is an emergency.
- To inform us whenever you utilize any other health system on behalf of your child, such as the emergency room or a self-referral to a specialist.
- To have a clear understanding about treatment goals for child and future health goals for your child.l

PRINCIPLES OF PCMH:

- **A personal physician**---coordinates all care for your child and leads the team
- **A coordinated team**-Professionals who work together for your child's care
- **Whole person orientation-**responsibility for all your child's care needs and arranging with other professionals. This includes care for all stages of life; acute care, chronic care, preventive services.
- **Coordinated care**---your physician and your team incorporate all components of the complex health care system
- **Quality and safety---**Centralizing care in one place will assure your child's safety needs are always being met. We voluntarily engage in quality improvement activities to improve.

How do you contact your MEDICAL HOME?

You can contact your child's Medical Home Team to directly arrange an appointment or to discuss your child's health care needs by calling **330-833-4596**.

Our hours are normally:

Monday: 9:00am- 7:00pm

Tuesday: 9:00am- 7:00pm

Wednesday: 9:00am- 5:00pm

Thursday: 9:00am- 5:00pm

Friday: 9:00am- 5:00pm

Saturday: Seasonal Hours

We are closed on most major holidays. Outside of normal clinic hours, for urgent matters you can still call **330-833-4596**, and our call service will call you back.

It will be necessary for you (or someone else involved in your child's care) to let the Medical Home Team know if your child has been seen by another provider. This will allow us to continue to coordinate your child's healthcare needs.

Our "Patient Portal" also allows you to electronically communicate with your child's health Care team and to receive electronic reminders and messages about your child's conditions.

WELCOME TO OUR "HOME"!

Community Health Care Pediatrics

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.