



## 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: \_\_\_\_\_

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.)"? \_\_\_\_\_ Yes If yes please specify: \_\_\_\_\_ No

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:** \_\_\_\_\_

# 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 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

# 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.

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## ● 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.

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## ● 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

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
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

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

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

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Signed: \_\_\_\_\_  
SIGNATURE

Signing Date: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_



# CIRCLE OF CARE

What specialists do you see?

\_\_\_\_\_None

**Specialist Name**

**Kind of specialty**

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\_\_\_\_\_Do you have a caregiver?

\_\_\_no \_\_\_yes

If yes, who takes care of you:

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\_\_\_\_\_Do you have a Legal Guardian?

\_\_\_no \_\_\_yes

If yes, list who is your guardian:

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# RECORDS TRANSFER TO OUR OFFICE:

Patient's Name: \_\_\_\_\_ Patient's birthdate: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Physician/facility to send records to us: \_\_\_\_\_:

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Purpose for release: \_\_\_\_\_

Documents to be released electronically or in print (check for EACH of the following items):

\_\_\_\_\_ 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:

\_\_\_\_\_ 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

\_\_\_\_\_ HIV/AIDS diagnosis and treatment:

I specifically give permission to share information in my record about my child's 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 from my child's record about genetics testing (excludes therapeutic generic tests). Initial here \_\_\_\_\_ to authorize 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 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
- I have received a copy of this authorization.

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

# YOU'VE BEEN INVITED

## to enjoy the convenience of our Patient Portal!

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.

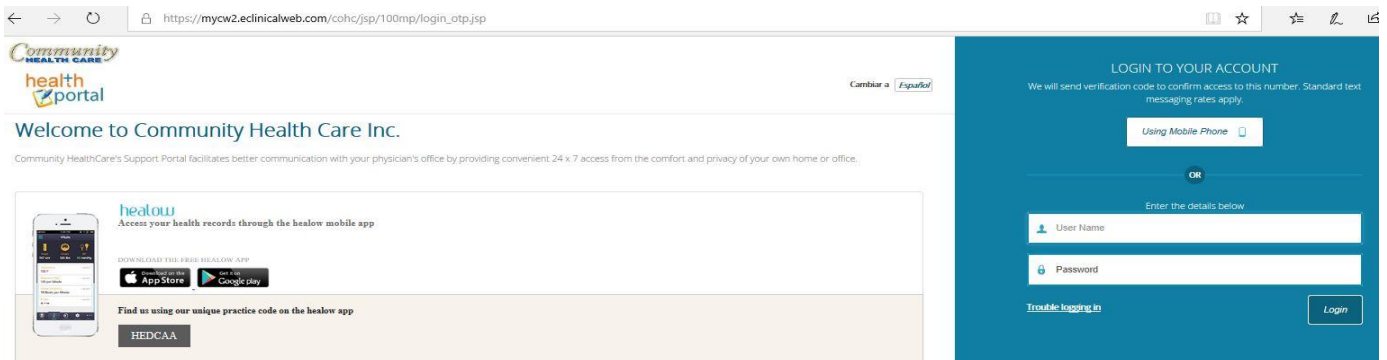
You will be able to:

- 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
- Receive educational materials from your provider
- Review your discharge instructions from your visit.

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

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](http://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 the first time you use the Portal ONLY. 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"

The screenshot shows the MyCW2 Clinical Web Portal dashboard. At the top, there is a navigation bar with the 'health portal' logo and a user greeting 'Hi Your name'. Below the greeting, there is a message: 'Community Health Care's Patient Portal. Remember, the portal should not be used to communicate emergencies or other acute needs! If you are having a true emergency, CALL 9-1-1. With our Portal, you can: Receive email notice of upcoming appointments and notification of lab or diagnostic imaging result availability for viewing. Have access to your recent and past laboratory and diagnostic test results that your health care provider has reviewed.' The dashboard is divided into several sections: 'CURRENT MEDICATION' (14 items, including prednisone 5 mg and 20 mg), 'LATEST LAB RESULTS' (261 items, including PT/INR, Lipid Profile, and Creatinine), 'LATEST STATEMENT' (Bill Date: 10/13/2016), 'RECENT REFERRALS', and 'MEDICAL RECORDS'. Each section has a 'View All' link. A 'Request Refill' button is visible under the medication section.

1. **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. Click on the NAME of the lab test 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. If asked, our practice code is HEDCAA.
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 minor emergencies, and handier to use than going to a computer for access to your Portal. Easy communication with our office, and no busy signals!**