Community OB-GYN

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: _____Birthdate:_____

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
COMMUNITY OB-GYN, BARBERTON

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

FROM: Physician/person/facility to receive records:	TO: **COMMUNITY OB-GYN**
Name_____	201 5th St NE, Suite 15, Barberton OH 44203
Address_____	Phone: 330-400-4511 Fax: 234-706-5897
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 ____/____/____

☐ *I decline the opportunity to have my past medical records transferred to this practice.*

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 genetic 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

Community OB-GYN

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 OB/GYN.

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

Community OB-GYN

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

Signed: _____ Signing Date: _____
SIGNATURE

Print Name:_____ Date of Birth: _____

Community HEALTH CARE

Community Health Care has updated our billing process. This will allow us to communicate with you via SMS/text and email messaging along with or instead of a mailed statement. These new features will enhance our commitment to you in providing quality health care services.

This in no way changes our commitment in how we recognize your individual needs in paying your account balance.

Your signature confirms you have been notified of these changes.

First Name: _____ Date of Birth: _____

_____ _____

Signature Date

I have been notified that Community Health Care, Inc. and its vendors may send SMS/text and email messages, voice messages, and make outbound calls from a human being or auto-dialer, related to billing matters. I will be given the option to opt out of advanced communications, including SMS/text and email messaging, at the time of the first communication.

First Name: _____ DOB: _____

CIRCLE OF CARE

What providers do you see?

☐ **None**

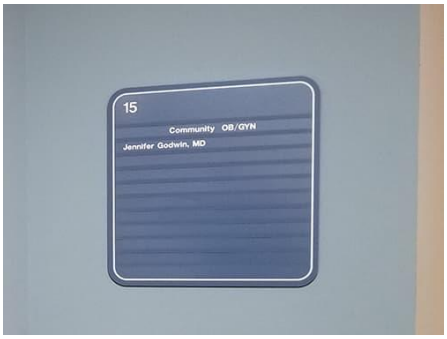
Provider Name	Kind of specialty

☐ **Do you have a caregiver? ___no ___yes**

If yes, list who takes care of you:_____

☐ **Do you have a Legal Guardian?** __no _yes

If yes, list who is your guardian:_____



Community OB-GYN

Jennifer Godwin, M.D., FACOG

201 5th St NE, Suite 15, Barberton OH 44203 330-400-4511

http://www.chci.com/communityobgynbarberton

COMMUNITY HEALTH CARE/Community OB-GYN is a group of board-certified OB-GYN physicians. We provide ob-gyn health care for women in Barberton, Norton, Akron, and surrounding areas. Our mission is to provide you with personalized, skilled, compassionate health care and wellness. We strongly believe in patient education and preventative care. Good medical care requires a team effort from you and us as your medical provider. We will work together to help you achieve good mental and physical health; this requires open and honest communication among all members of this team.

Office Hours

Monday:	8am- 4pm
Tuesday:	8am- 4pm
Wednesday:	8am- 4pm
Thursday:	8am- 4pm
Friday:	7am- 3pm

We provide the following:

- Same day appointment availability.
- Patient portal - Communication available 24 hours a day for non-emergent health concerns and requests.
- Telephone communication - Our phone lines are available to help you 24 hours a day for non-life threating health concerns. When you call us at **330-400-4511** during or after business hours, we will answer your call and appropriately handle your needs as soon as possible. After hours calls should be reserved for situations that cannot wait until regular office hours. We encourage you to please call our office before going to the Emergency Department for non-life threating health concerns.

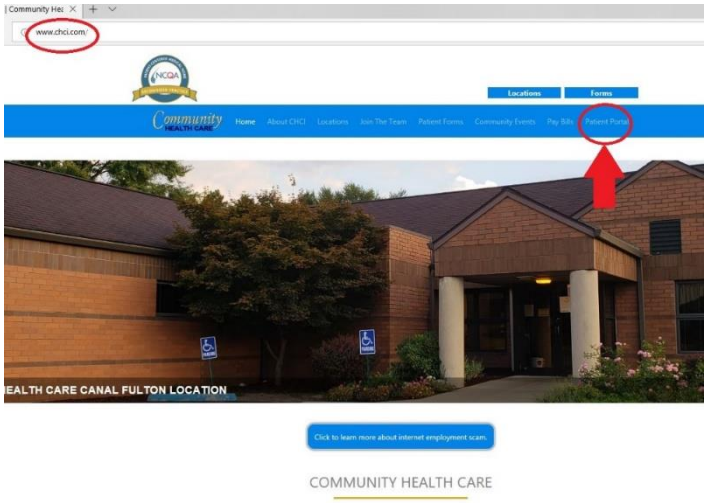
Test Results

- The length of time it takes to get test results back depends on the type of test performed and the location that it was done.
- If you have not heard back from our office within TWO WEEKS, please call us.

Prescriptions and Refills

- Please bring your medication bottles with you to every appointment (prescription, over-the-counter, and herbal).
- Please bring all prescription refill requests to your scheduled appointment.
- For prescription refill requests between appointments, please call during regular business hours.
- We require 24 - 48 hrs. to process all prescriptions refill requests.

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.

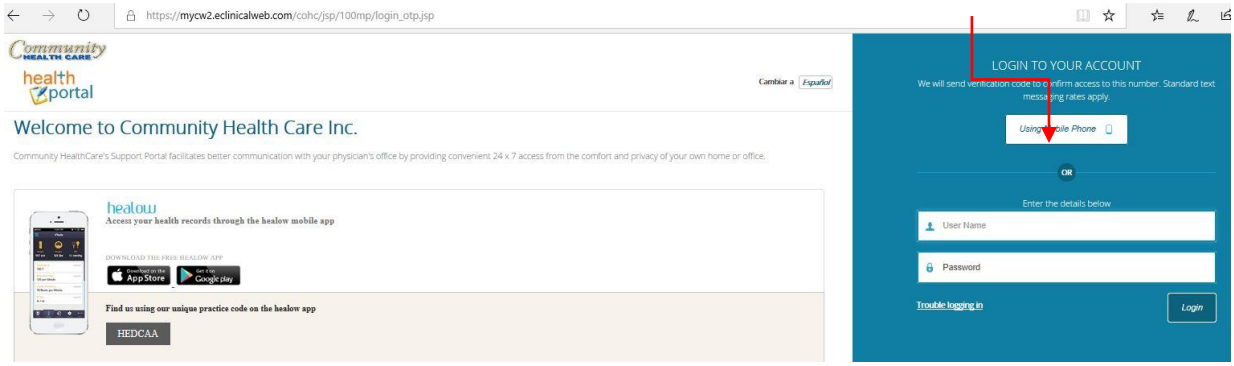
You will be able to:

- 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, 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”

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.

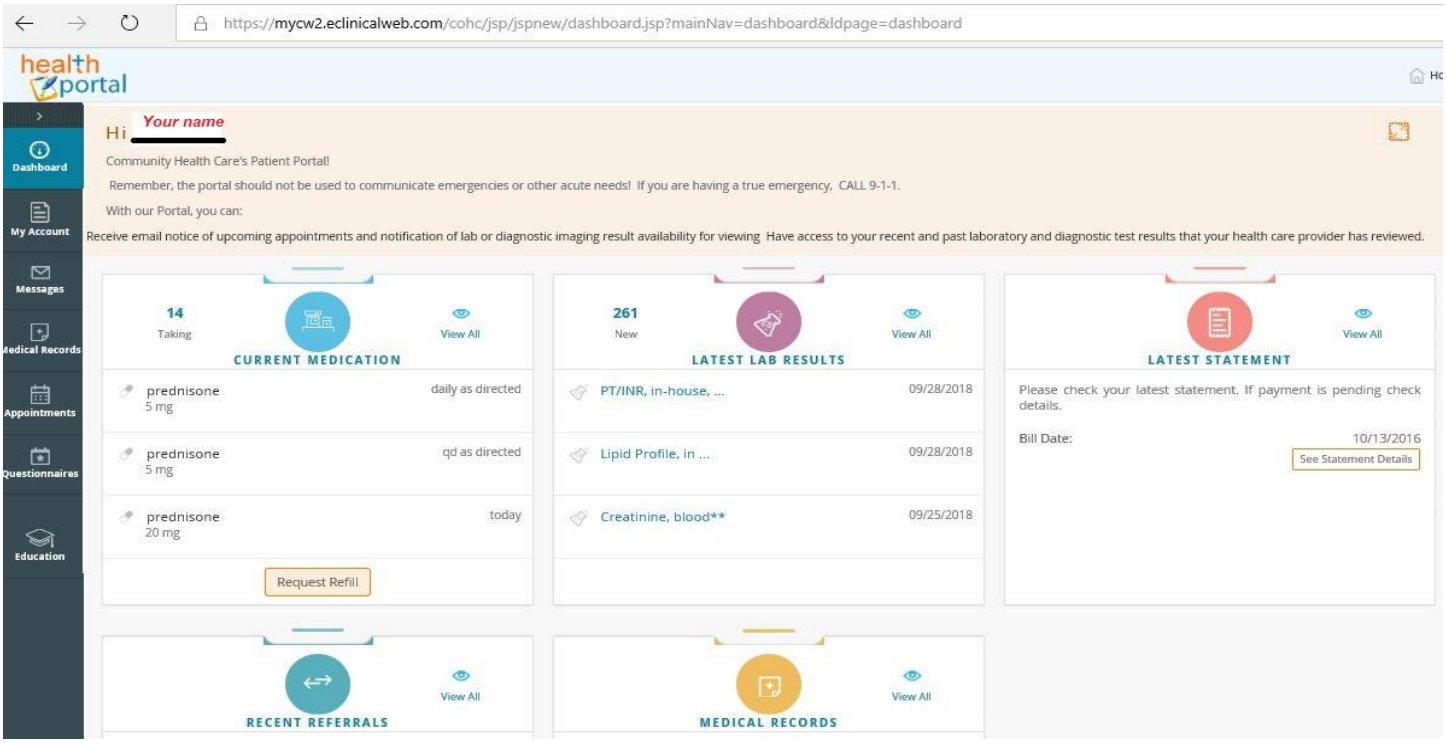
    a. **LAB/DIAGNOSTIC IMAGING**: Any labwork you might be looking for is listed in LABS/DIAGNOSTING IMAGING, also along the left margin. Click on the NAME of the lab test to see your results and any comments from the provider.

    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.

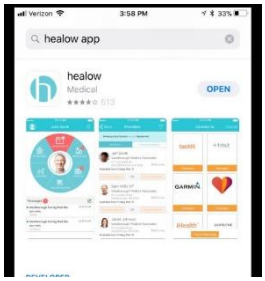
Should you have any difficulty with the portal, please call our office and we will assist you.

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