



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: _____ Birthdate: _____

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.

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

Signed: _____

SIGNATURE

Signing Date: _____

Print Name: _____

Date of Birth: _____

Name: _____ Birthdate: _____



CIRCLE OF CARE

What specialists do you see?

None

Specialist Name	Kind of specialty

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:



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.

Printed name: _____

Birthdate: _____

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.

MEDICAL RECORDS RELEASE TO OUR OFFICE

Patient's Name: _____

Patient's birthdate: _____

Patient's Address: _____

FROM: Physician/person/facility to receive records: Name _____ Address _____ City/State/Zip _____ Phone _____ Fax _____	TO: _____ Name _____ Address _____ City/State/Zip _____ Phone _____ Fax _____
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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 ____/____/____

Office visit notes only from ____/____/____ to ____/____/____

Specific reports, photographs, results, or other medical information (Specify) :

from date ____/____/____ to ____/____/____

I decline the offer to have my previous medical records transferred here.

Privileged or specifically protected information:

YES

NO

Alcohol or drug abuse treatment

YES

NO

HIV/AIDS diagnosis and treatment:

Sexually transmitted diseases

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.

Domestic violence Victim's counseling

Sexual assault Victim's counseling

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.

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

I understand and agree that:

<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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
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This authorization expires 12 months from the date it was signed OR as specified: _____

Patient or patient's legal guardian

Date

MEDICAL HISTORY QUESTIONNAIRE—New Patient

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

Medical History: (if yes, please circle and indicate approximate date):

Abnormal chest Xray	Diverticulosis/itis	Irritable bowel
Abnormal EKG	Duodenal ulcer	Kidney disease
Abnormal labwork	Dysentery	Melanoma
Allergies	Ear infections	Menopause (female)
Alzheimers	Emotional problems	Migraines
Anemia	Emphysema	Multiple sclerosis
Angina	Endometriosis (female)	Osteoporosis
Anxiety disorder	Epilepsy	Overactive thyroid
Arthritis	Fibroids	Panic attacks
Asthma	Gall bladder disease	Phlebitis
Bleeding disorder	Glaucoma	PMS
Blindness	Goiter	Prostate enlargement (male)
Blood clot	Gonorrhea	Polio
Breast disease	Gout	Raynaud's
Broken bone(s)	Hay fever	Skin cancer
Cancer: Type _____	Heart disease	Syphillis
Carpal tunnel	Heart murmur	Tuberculosis (TB)
Cataracts	Hemorrhoids	Underactive thyroid
COPD	High blood pressure	Other: _____
Depression	Herpes: type _____	Other: _____
Diabetes Type I	High cholesterol	Other: _____
Diabetes Type II	Hypoglycemia	Other: _____
Diarrhea (chronic)	Impotence	Other: _____

Allergies:

<input checked="" type="checkbox"/> DRUG allergies: Are you aware of any medication allergies? Yes No If yes, list the medicines below.							
<input checked="" type="checkbox"/> 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: _____							
<input checked="" type="checkbox"/> FOOD allergies: please circle all that apply.							
Eggs	Dairy	Wheat	Soy	Shellfish	Fruit	Vegetables	Nuts
Other: _____							

Social History:

Issue	Details
Tobacco	Have you ever used tobacco? Never Former Currently
Alcohol	Do you use alcohol?
Narcotics	Using prescription narcotics?
Street Drugs	Using illegal drugs?
Herbal/Supp	Are you using herbal drugs or nutritional supplements?
Dietary	What is your usual diet?
Caffeine	How many cups of coffee/cola/caffeinated drinks per day?
Adv Directives	Do you have a Durable Power or Atty for Health and/or a Living Will?
Marital status	Status:
Children	
Occupation	What is your occupation?
Occupational Exposure	Do you have exposure to dangerous substances at work? If yes, what?
Religion	(Optional answer)
Exercise	What kind of exercise do you do?
Travel	Do you travel outside the US?
Pets	Do you have pets? What kind?
Smoke detectors	Do you have smoke detectors at home?

Assistive devices (please circle all that apply):

Hearing Aid	Contacts	Glasses	Cane	Pacemaker	ICD (internal defibrillator)
Wheelchair	Neck brace	Back brace	Dentures	Walker	Other: _____