Community HEALTH CARE

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: _____ Signing Date: _____
SIGNATURE

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

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.

MedPilot Notice Scan: Billing MMG folder 08-27-2018

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:

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		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: ____/____/____

_____ _____

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:

✓ **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	Nuts

Other: _____

Gyn and OB History **(Females only!)**

Issue	Comments
Periods	How often?
Sexual activity	Are you sexually active?
Pap	Date of last pap smear-
Mammogram	Date of last mammogram-
Bone density	Date of last bone density test-
Abnormal paps	Ever had an abnormal pap? _____ If yes, do you know the issue? _____
STD	Have you ever had a sexually transmitted disease? _____ If yes, what?
Birth control	What kind of birth control do you use?
Total Pregnancies	# of pregnancies
Total Living children	# of children born alive
Stillbirths	# of stillbirths
Miscarriages	# of miscarriages
Abortions	# of abortions
C-sections	# of C-Sections

Past Surgical History: (list all surgeries you have had, plus dates):

DATE	SURGERY
	Have you had a colonoscopy? _____no _____yes If yes, indicate date

Hospitalizations:

When	Why?

Family History:

Family Member	Now alive or deceased	Age	Health issues or cause of death
Father			
Mother			
Paternal GPA			
Paternal GMA			
Maternal GPA			
Maternal GMA			
Uncles			
Aunts			
Siblings			
Children			
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:_____