Patient Information

Patient Name: _____

Mailing Address: _____

Primary Phone: _____

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 your child been to any specialists, been hospitalized, or been to the ER since your last visit here? ____no _____yes

Is your child a 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.

_____

✓ 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 a copy of Community Health Care's HIPAA "Notice of Privacy Practices".

Signed: _____ Signing Date: _____
SIGNATURE

Print Name:_____ Date of Birth: _____

CIRCLE OF CARE

What specialists does your child see?

☐ **None**

Specialist Name	Kind of specialty

☐ **Does the child have a caregiver?** ___no ___yes

if yes, list who takes care of child: _____

☐ **Does the child a Legal Guardian?** ___no ___yes

If yes, list who is your guardian:_____

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 ____/____/____
☐ I decline the opportunity to have my previous records transferred here.

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

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_____ Last Name_____ DOB _____

_____ _____

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

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

Rita Kazlauskas, M.D.

Diane S. Belardo, M.D.

Erin Weber, M.D.

Darcy Drevon, APRN

Ashley Korsa, APRN

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 STRONGLY believe 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.

Availability

Office Hours:

Monday:	8:30am-7pm
Tuesday:	8:30-7pm
Wednesday:	8:30am-5pm
Thursday:	8:30am-5pm
Friday:	8:30am-5pm
Saturday:	Seasonal Hours

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

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 will 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 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.

Services We Provide at COMMUNITY HEALTH CARE PEDIATRICS

General Evaluation Services

- Routine physical examinations
- Illness evaluation and treatment
- Sport, camp, and school physicals
- Newborn Care
- Well-child exam
- Routine Immunizations
- Sick-child evaluation and treatment
- Bedwetting evaluation and treatment
- Attention Deficit evaluation
- Lactation Counseling

La**boratory Services**

- In house testing, including Urinalysis, Urine Pregnancy Testing, Strep testing, Flu testing

Patient Education, Preventive Care, and Counseling

- Diagnosis-specific written materials
- Medication and injection training
- One-on-one instruction
- Well-child educational materials for parents
- Diabetes and dietary education
- Cancer Screening
- Lifestyle and dietary counseling
- Health maintenance and disease awareness
- Depression screening and management

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

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 a trusted specialist 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.

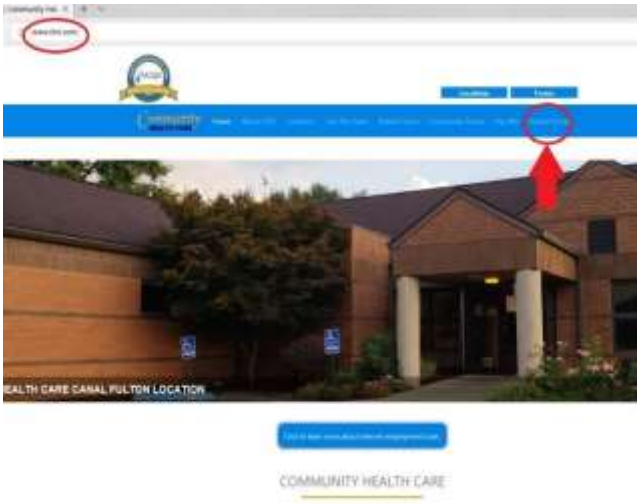
PRINCIPLES OF PCMH:

- **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.

WELCOME TO OUR "HOME"!

Community Health Care Pediatrics

YOU'VE BEEN INVITED



Our Website

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.

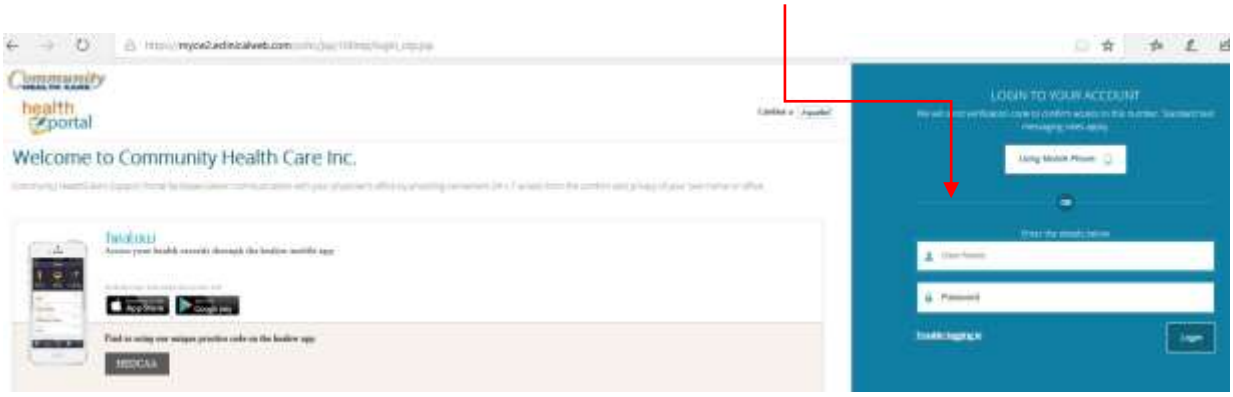
You will be able to:

- 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.

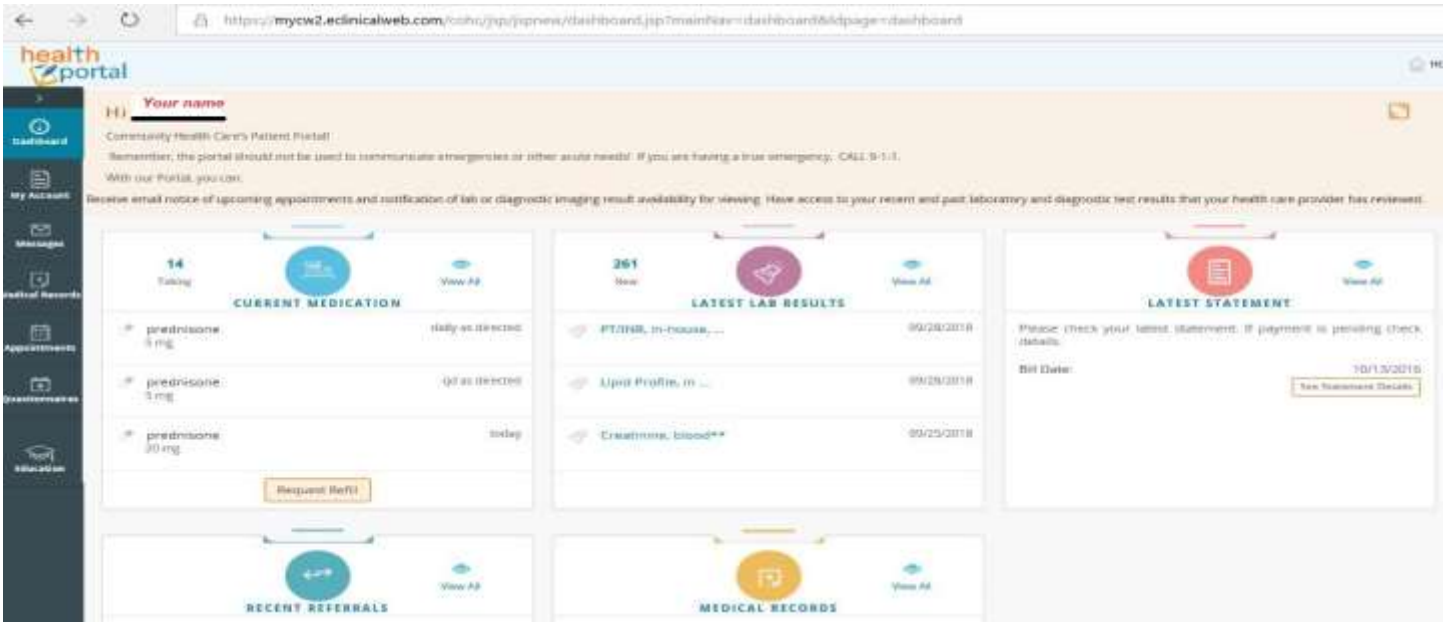
    a. **LAB/DIAGNOSTIC IMAGING**: Any lab work you might be looking for is listed in LABS/DIAGNOSTING IMAGING, also along the left margin. Click on the NAME of the lab test to see your results and any comments from the provider.

    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!