COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

To Our New Patients:

Welcome to Community Health and Wellness Partners of Logan County!

Included with this letter, you will find a new patient packet. Please complete this packet and return it to us as soon as possible. **This packet MUST be returned to us before your new patient appointment will be scheduled.** Once we receive the completed packet, we will contact you with your appointment time.

As part of the packet we call your attention to our Missed Appointment Policy, Bill of Rights and Notice of Privacy Practices.

Community Health and Wellness Partners is a Federally Qualified Health Center that accepts most insurances. A reduced payment may be available based on household income (sliding fee scale).

For your convenience, we offer three locations:

BCHC
212 E. Columbus Ave. Suite 1
Bellefontaine, Ohio 43311
Phone: (937)599-1411
Fax: (937)599-4128

ILCHC
8200 St. Rt. 366, Suite 1
Russells Point, Ohio 43348
Phone: (937)599-1411
Fax: (937)599-4128

WLCHC
4879 US Rt. 68 South
West Liberty, Ohio 43357
Phone: (937)599-1411
Fax: (937)599-4128

Again, we ask that you complete and return the new patient forms, so we may better serve you. You may drop off this packet at one of our offices mentioned above, send to us by mail, or return to hospital staff so they can forward to us.
The packet MUST be received before an appointment will be scheduled.

Welcome to Community Health and Wellness Partners of Logan County!

Sincerely,

Tara Bair

Tara Bair, President/CEO

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

New Patient Form

Date:_____

Name:_____ Date of Birth:_____

☐ **I have reviewed the missed appointment policy.**

Local Pharmacy_____Mail Order Pharmacy_____

Prefer prescriptions for: 30 day 90 day

Medical History: List any medical problems/illnesses that you have had and dates of diagnosis (mm/dd/yy)

_____
_____
_____
_____
_____
_____

When was your last:
Tetanus shot_____ Pneumonia shot_____ Stress test_____

Colonoscopy_____ Pap test_____ Mammogram_____

Surgical History: List all surgeries/procedures you have had and dates of surgery (mm/dd/yy)

_____
_____
_____

Medications: List all medications (prescription and over-the-counter), vitamins, herbals, or supplements. Include medication name, dose, and how often you take it.

_____
_____
_____
_____

Please bring your medications to every visit.

Allergies: Include the drug/substance you are allergic to and the reaction you have had.

_____
_____

(over)

Bellefontaine
212 E. Columbus Ave. Suite 1
Bellefontaine, OH 43311

Indian Lake
8200 St. Rt. 366, Suite 1
Russells Point, OH 43348

West Liberty
4879 US Rt. 68 South
West Liberty, OH 43357

Phone: 937.599.1411 • Fax: 937.599.4128

chwplc.org

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

Social History

Household member	Age	Relationship

Occupation:_____
Tobacco Use: none former chewing smoking
How much daily:_____
Alcohol Use: How many drinks:_____
How often: _____
Street Drug Use: none past use current use
What exercise do you do: _____
How often:_____
Are you currently sexually active: Yes No
Number of partners in your lifetime:_____

Family History: Circle any of the diseases that family members have had:

Alcoholism	Allergies	Anemia
Arthritis	Asthma	Birth Defects
Bleeding Disorder	COPD	Depression
Diabetes	Glaucoma	Heart Attack
High blood pressure	Kidney Disease	Liver Disease
Memory Loss	Mental Illness	Migraine
Seizures	Stroke	Suicide

Types of Cancer:_____

Other:_____

Women Only

Date of last period_____
Age at first period_____
Any problems with your periods:
_____
_____
Number of pregnancies_____
Number of children_____
Any problems during pregnancy:
_____
Any chance you are pregnant now? Yes No
What birth control are you using?
_____

Other What medical issues do you have that have not been addressed?

Review of Systems

Circle all the symptoms you are currently having:

General: headache, lightheadedness, dizziness, fainting, weight gain, weight loss, sleep problems, snoring, anxiety, depressed mood

Eyes: double vision, decreased vision

Ears: problems with hearing, ringing in the ears

Nose and throat: sinus symptoms, allergies, sore throat, hoarseness, difficulty swallowing food sticking

Respiratory: cough, increased sputum, lightness of breathing, chest heaviness, shortness of breath, shortness of breath when laying down

Cardiac: palpitations, skipping or racing heart beats, irregular heart beat, chest pain, chest pressure with exertion

Digestive: nausea, vomiting, indigestion, heartburn, significant weight changes, food intolerance, diarrhea, constipation, rectal bleeding

Urinary: pain with urination, frequent urination, urinary urgency, urination at night

Musculoskeletal: hot or swollen joints, swelling of the legs, muscle aches

Neurologic: numbness, weakness, tingling

Females only: breast lumps, breast discharge, breast tenderness, vaginal discharge, irregular periods, abnormal vaginal bleeding or spotting

Males only: erectile dysfunction, testicular lump

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

CONSENT TO TREAT

_____ _____

Patient Name (Printed) Patient Date of Birth

I for myself do voluntarily consent to medical care, diagnostic procedures, behavioral health counseling, pharmacy or nutritional counseling services that may be done, requested or directed by or delegated in the judgment of the attending provider. I understand that I may refuse any services at any time.

I authorize release of information to all third-party payors or health and social service agencies.

I authorize release of information to Medicare and authorize Community Health and Wellness Partners of Logan County to bill my charges to Medicare.

I understand that I am still responsible for my bill even though I may have health insurance.

I understand that I will be asked to provide proof of income at least once each year, so my charges can be accurately calculated for the sliding fee schedule.

I understand that I must present a current public aid card, health insurance, or Medicare card at each visit to Community Health and Wellness Partners of Logan County when my charges are covered.

I hereby assign, transfer and set over to Community Health and Wellness Partners of Logan County all of my rights, title and interest to my medical reimbursement benefits under my insurance policies.

Community Health and Wellness Partners is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information.

This notice is in compliance with the guidelines set forth in the Health Insurance Portability and Accountability Act. (HIPAA) of 1996, effective April 14th, 2003.

_____ _____

Signature of Patient, Parent or Guarantor Date

_____ _____

Witness Date

Bellefontaine
212 E. Columbus Ave. Suite 1
Bellefontaine, OH 43311

Indian Lake
8200 St. Rt. 366, Suite 1
Russells Point, OH 43348

West Liberty
4879 US Rt. 68 South
West Liberty, OH 43357

Phone: 937.599.1411 • Fax: 937.599.4128

chwplc.org

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

HIPAA

_____ _____

Patient Name: (Please Print) *Date of Birth*

_____ *Initials*

Acknowledgement of receipt of Notice of Privacy Practice regarding protected health Information:

I have received the Practice's Notice of Privacy. Photocopies of this document are to be as valid as the original. **Fundraising & Marketing**: Unless you request us not to, we will use your name and address to support our fund-raising or marketing efforts. If you do not want to participate in fund-raising or marketing efforts, please check off the following box.

Please exclude me from any ☐ Fund-raising Purposes ☐ Marketing Purposes

_____ *Initials*

Assignment of Benefits:

I acknowledge financial responsibility for all facility and physician fees. I understand that the physician billing office will file my insurance claim and I assign direct payment to the physician all payments made under the terms and provisions of my policy. I further understand that any disputes on coverage are between my insurance carrier and myself and I will be responsible for payment for denied services regardless of the outcome of my dispute. I acknowledge financial responsibility for all charges if inaccurate insurance information is given at time of service and the information is not corrected prior to my insurance company's timely filing limit.

_____ *Initials*

Medical Records Exchange:

CHWPLC participates in one or more Health Information Exchanges (HIE). HIEs are electronic networks that securely provide and retrieve access to your health records for a better picture of your health needs. CHWPLC Providers, as well as other healthcare providers, may provide and retrieve access to your health information through an HIE for treatment, payment or other healthcare operations. As a CHWPLC patient, you have the ability to opt out of any HIE at any time by notifying a CHWPLC Associate. This is a voluntary agreement. Unless you advise us differently, your information may be accessed through an HIE by your CHWPLC provider.

_____ *Initials*

Rx-History Consent:

I understand that performing a medication reconciliation in order to prevent adverse drug interactions and overdose is a critical component to my care. By initialing this section, I authorize my provider to query and review my medication fill history including drug, dose, form, strength, prescribing provider, and pharmacy

(Over)

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

_____
Initials

Communication Preferences Regarding PHI

To assist in your care, it may be necessary to release our Protected Health Information to someone other than yourself. To whom may we talk? Please Check boxes and write in name(s).

Yes	No	
☐	☐	Spouse/Significant other: _____
☐	☐	Parent/Step-Parent: _____
☐	☐	Child/Grandchild: _____
☐	☐	Other Person(s): _____
☐	☐	Emergency Contact: _____

_____
Initials

May we leave a message on: ☐Home ☐Cell ☐ Work

Preferred method for appointment remind: Check all that apply

☐ Call to Home ☐ Call to Mobile ☐ Text to Mobile

Preferred time for reminders calls: ☐ Morning ☐ Afternoon ☐ Evening

_____ _____

Patient/Representative Signature Date

(Over)

Bellefontaine
212 E. Columbus Ave. Suite 1
Bellefontaine, OH 43311

Indian Lake
8200 St. Rt. 366, Suite 1
Russells Point, OH 43348

West Liberty
4879 US Rt. 68 South
West Liberty, OH 43357

Phone: 937.599.1411 • Fax: 937.599.4128

chwplc.org

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

NO INSURANCE?

HIGH DEDUCTIBLE OR CO-PAY?

FINANCIAL CONCERNS?

Ask about our SLIDING FEE SCALE!

- Application AND Proof of Income REQUIRED

Each application will be determined eligible by comparing the household income and family size.

General office and behavioral health visits, procedures, preventative exams, vaccines			
Household Size	**Gross Household Monthly Income Less Than**	**Gross Household Monthly Income Between**	**Gross Household Monthly Income Greater Than**
1	$1,012	$1,013-$2,023	$2,024
2	$1,372	$1,373-$2,743	$2,744
3	$1,732	$1,733-$3,463	$3,464
4	$2,092	$2,093-$4,183	$4,184
5	$2,452	$2,453-$4,903	$4,904
6	$2,812	$2,813-$5,623	$5,624
Cost Per Visit/Level	Full Discount*	$35(B), $45(C), $55(D), $65(E)	Do Not Qualify (F)

**Nominal Fee May Apply*

***Final rate to be determined by submitted documentation, CHWPLC staff and current sliding fee scale*

Bellefontaine
212 E. Columbus Ave. Suite 1
Bellefontaine, OH 43311

Indian Lake
8200 St. Rt. 366, Suite 1
Russells Point, OH 43348

West Liberty
4879 US Rt. 68 South
West Liberty, OH 43357

Phone: 937.599.1411 • Fax: 937.599.4128

chwplc.org

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

RELEASE OF INFORMATION

Patient Name: _____

Date of Birth: _____ Social Security #_____

I hereby authorize and request: (Sender of Information)
INCLUDE ADDRESS

_____

_____

_____

To Permit: (Recipient of Information)
INCLUDE ADDRESS

_____

_____

_____

To release/disclose the above named individual's health information. I understand that the information in my record may include information pertaining to HIV/AIDS-related conditions, sexually transmitted diseases, drug/alcohol abuse, and mental health. I understand that by signing this authorization, I am authorizing the release of such information unless otherwise specified. The sender is authorized to deliver such information in person, via US Mail, private delivery service, facsimile or electronic transmission. I understand that information forwarded via these methods may be viewed by someone other than the intended recipient. Furthermore, I hereby release the sender from any liability that may result from the recipient's use, or further dissemination of the information sent. I understand that if the person or entity that receives this information is not a health care provider, or health plan covered by Federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the Federal privacy regulations.

2. In particular, without intending to limit the above authorization in any way, I am requesting the following information To be released: (include dates as appropriate)

_____

3. The purpose of the authorized use or disclosure of the information is as follows:

_____Permanently Transferring Records to Another Health Provider

_____Pending Legal Action

_____For Referral Only

_____Other _____

This consent will expire sixty (60) days after the date below unless otherwise specified. I understand I may revoke this authorization in writing at any time, except to the extent already taken by the sender in reliance on this authorization, by sending a written revocation to: Office Manager, Community Health & Wellness Partners of Logan County, 4879 US 68 S., West Liberty, Ohio 43357. I understand this revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Community Health & Wellness Partners of Logan County discloses it to another party.

I understand I am not required to sign this authorization and Community Health & Wellness Partners of Logan County will not condition the provision of treatment, or other benefits to me on the signing of this authorization.

Dated:_____ _____

Signature of Patient (18 years or older)

_____ _____

Signature of Witness Signature of Parent/Legal Guardian

Community Health & Wellness Partners of Logan County will attempt to process the above request within 14 days of receiving the request.

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

Patient Information Form (Please Print and Complete All Entries)

Patient Legal Name: _____
Last First MI

Preferred Name: _____

Address: _____
Street City State Zip

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____ Sex at Birth: Female Male

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Work Phone: ____-_____-_____

Email Address: _____ _____We will use e-mail address to web-enable your portal

Employer Name: _____Are you covered under your employer's insurance? Yes No

Emergency Contact:_____
Contact Name Phone Number Relationship to You

Family Income

Because we are partially funded by a federal grant, we are asked to collect income information. Please determine the number of persons in your household and check your annual (yearly) income range. This information is for generalized reporting regarding the health center, **NO PERSONAL INFORMATION IS SHARED.**

NUMBER OF PEOPLE IN YOUR HOUSEHOLD: _____

Range 1	Range 2	Range 3	Range 4	Range 5	Range 6
( ) $0 to $20,000	( ) $20,001 to $40,000	( ) $40,001 to $60,000	( ) $60,001 to $80,000	( ) $80,001 to $100,000	( ) $100,001+

Information for Statistical Reporting Only (Please Circle)

Marital Status: Married Single Divorced Legally Separated Life Partner Widowed Other

Sexual Orientation: Straight Lesbian/Gay Bisexual Something else Don't Know Refuse to Report

Gender Identity: Female Male Transgender Male Transgender Female Other Refuse to Report

Race: White Black/African American American Indian/Native American Asian

More than One Race Native Hawaiian/Pacific Islander Other: _____

Preferred Language: English Spanish French German Russian Other: _____

Transportation Need?	Yes	No	Migrant/Seasonal?	Yes	No
Language Barrier?	Yes	No	Are you Hispanic or Latino?	Yes	No
Are you Homeless?	Yes	No	Are you a Veteran?	Yes	No
Advanced Directives?	Yes	No	Do you have a POA?	Yes	No

I understand that it is my responsibility to provide complete and accurate information on this form. I understand that failure to provide accurate information may result in my responsibility to pay full charges for services rendered.

_____ _____ _____/_____/_____
Responsible Party, (*if patient under age 18*) Signature of Patient/Responsible Party Date

Bellefontaine
212 E. Columbus Ave. Suite 1
Bellefontaine, OH 43311

Indian Lake
8200 St. Rt. 366, Suite 1
Russells Point, OH 43348

West Liberty
4879 US Rt. 68 South
West Liberty, OH 43357

Phone: 937.599.1411 • Fax: 937.599.4128

chwplc.org