



COMMUNITY HEALTH SERVICES
410 Birchard Avenue * Fremont, OH 43420

CHILD PATIENT INFORMATION

Patient Name: _____ Birth Date: _____ Race: _____ Sex: M ___ F ___
(for statistical purposes only)
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Social Security #: _____ Marital Status: _____
Employer Name: _____ Address: _____ Phone: _____

PARENT / GUARDIAN INFORMATION (please circle one)

Mother's/Guardian's Name: _____ Birth Date: _____
Mother's/Guardian's Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Social Security #: _____
Mother's/Guardian's Employer: _____ Phone: _____
Work Address: _____ City: _____ State: _____ Zip: _____
Father's/Guardian's Name: _____ Birth Date: _____
Father's/Guardian's Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Social Security #: _____
Father's/Guardian's Employer: _____ Phone: _____
Work Address: _____ City: _____ State: _____ Zip: _____
Emergency Contact: _____ Phone: _____

PATIENT INSURANCE COVERAGE

Primary Insurance: _____ Group/ID #: _____
Company Address: _____ City: _____ State: _____ Zip: _____
Secondary Insurance: _____ Group/ID #: _____
Company Address: _____ City: _____ State: _____ Zip: _____

DOES PATIENT HAVE MEDICAID OR MEDICARE COVERAGE? Yes ___ No ___ (If yes, please give # below)

Medicaid #: _____ Medicare #: _____

IS PATIENT SELF-PAY? Yes ___ No ___ (A sliding fee scale is available to all qualifying self-pay patients.)

I hereby authorize the release of any medical/dental information necessary for the processing of insurance. I also authorize insurance benefits to be paid directly to Community Health Services. I understand that if my insurance does not pay, I am responsible for payment of services provided.

Signature: _____ Date: _____



COMMUNITY HEALTH SERVICES
410 Birchard Avenue * Fremont, Ohio 43420

PATIENT RIGHTS AND RESPONSIBILITIES STATEMENT

Community Health Services encourages patients and their families to report concerns related to care, treatment, services, and patient safety issues. Community Health Services also ensures that the following rights and responsibilities are preserved for all patients.

PATIENT RIGHTS:

As a patient at Community Health Services you have the right to:

1. Understand and make use of these rights. If an interpreter is needed, the office will attempt to provide the assistance.
2. Equal treatment/care and accommodations that are available, or medically necessary regardless of race, creed, sex, or sources of payment.
3. Respectful care at all times and under all circumstances that allows you to maintain your dignity.
4. Privacy, both personal and informational, within the law.
5. Be assessed for pain.

PATIENT RESPONSIBILITIES:

1. Smoking is NOT allowed on CHS property.
2. You must bring the appropriate insurance card with you to each appointment.
3. A minimum payment is expected at the time of service.
4. When you come in for every appointment, please bring a list of ALL medications with you that you are currently taking. This includes prescriptions, over-the-counter medications, and herbal medication.
5. Due to the small size of exam rooms and waiting room, please limit the number of people accompanying you for your appointment to no more than two. If it is necessary for you to bring small children, please bring another adult to supervise them.
6. All refills on medications will be called to your pharmacy after 5:00 pm the next business day. Please do not call back to see if the refill has been called in.
7. If you cannot afford a medication which has been prescribed for you, let us know.
8. All calls (i.e. appointments, cancellations, refills, medical/dental records, etc.) should be called to the appropriate office phone number. Weekends, holidays, and after-hours, all calls will be transferred automatically to our answering service. In case of emergency when the office is closed, please go to the emergency room.
9. If your child is scheduled for a physical or immunizations you **MUST** bring a current immunization record with you.
10. Allow at least 30 days for completion of insurance forms, disability, transfer of treatment records, etc.
11. **Please give a 24 hour notice when canceling or rescheduling appointments.** Cancellations can be made 24 hours per day, but must be made prior to your appointment time.
12. An established patient who arrives more than 10 minutes late for his/her appointment is considered to be a "No Show" for their appointment, regardless of whether or not the patient is seen that day.
13. An established patient who is a "No Show" for 3 appointments without canceling within a 12 month time frame will be terminated from the practice. Refer to the No Show Policy for reinstatement guidelines.
14. An established patient is someone seen in one of our offices, by one of our providers.
15. If you have not been seen by one of our providers in three years you will be considered a new patient and must complete all required paperwork.

I, as a patient of COMMUNITY HEALTH SERVICES, agree to the above patient rights and responsibilities.

Patient Name

Date

Signature of Patient or Guardian (if patient is a minor)

Date



COMMUNITY HEALTH SERVICES
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Child Health History (0 - 12 Years)

Name _____ **Today's Date** _____
 Male Female **Date of Birth** _____

Allergies:
 Medications _____
 Environmental _____
Current Medications: _____

Preventative Care:
 Date of Last Physician Visit: _____
 Date of Last Dental Visit: _____
 Name of Dentist: _____

Birth History: Birth Weight ____ lbs. ____ oz. Birth Length ____ inches Vaginal Birth or C-Section
 Place of Birth: _____ Pregnancy History: _____
 Problems at Birth: _____

Medical/Surgical History:
 Illnesses: Strep Throat Infections, Chicken Pox, Measles, Ear Infections, RSV, Croup, Colic, Stomach Problems
 Other _____
Hospitalizations: _____ **Surgeries:** _____

Nutritional History
 Breast Fed: Yes No
 Type of Formula _____
 Taking Supplemental: () Iron () Vitamins
 If older child, type of diet _____

Date of last TB Skin Test _____
 Date of last Chest X-Ray _____

Immunizations						
	Date	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DTaP						
DT						
Hep B						
Hib						
MMR						
IPV						
Varivax						
Prevnar						
Pediarix						

	Age	Medical Conditions	If Deceased Cause/Age
Father			
Mother			
Brothers			
Sisters			

Educational Level:

	Mother	Father	Patient
Read	Yes No	Yes No	Yes No
Write	Yes No	Yes No	Yes No

Barriers to Learning: None Hearing
 Chronic Pain Cognitive/Memory
 Language Emotional Speech
 Dexterity Vision

Primary Language Spoken _____

Cultural/Religious Practice affecting treatment:

Signature _____



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AUTHORIZATION FORM FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION:

PATIENT NAME: LAST FIRST MI MAIDEN OR OTHER

DOB SSN MEDICAL RECORD #

ADDRESS CITY/STATE ZIP CODE

INFORMATION RELEASED FROM:

INFORMATION RELEASED TO:

NAME

NAME

ADDRESS

ADDRESS

CITY/STATE/ZIP

CITY/STATE/ZIP

INFORMATION TO BE RELEASED OR INSPECTED: (Check all applicable categories.)

- Entire Chart/Record, including, but not limited to, all of the following:
Immunizations
Discharge Summary
History & Physical
Operative Reports
Emergency Room Reports
Pharmacy/Prescription
Emergency Transport Reports
X-ray and Other Radiology Reports
Laboratory Reports
HIV Related Information
Nursing Notes
Doctor's Orders and Progress Notes
Copies of Reports Originating From Other Providers
PT, OT, and/or Speech Therapy Notes
Rehab Clinic Reports
Mental Health/Alcohol or Drug Abuse Treatment, HIV, and/or AIDS-related Treatment
Workers' Compensation
Billing and Patient Account Records
Social Services Reports and/or Evaluations
Other:

REASON FOR DISCLOSURE:

This authorization will remain in effect for eight (8) months or until and will be effective for medical records generated up to the date of the signature. I understand that:

- 1. I have a right to revoke this authorization, except to the extent that information has already been released in response to this authorization;
2. I may inspect and receive a copy of the disclosed information upon payment of a reasonable fee.

A FAX copy/photocopy of this authorization shall be considered as valid as the original.

Signature of Patient

Signature of Parent/Guardian/Authorized Person

Date

Date

Reason Patient Unable to Sign: Minor Incompetent Deceased



COMMUNITY HEALTH SERVICES
410 Birchard Avenue * Fremont, Ohio 43420

Dear New Patient:

Welcome to our office! Thanks for choosing one of the area's most respected health care systems to receive your medical/dental care.

Since 1970, our organization has been recognized nationally, as a provider of high quality affordable health care. We have been voluntarily accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) since 2000. The care we provide meets or exceeds standards set for the health care industry.

Most of our physicians are Board Certified in their respective areas and provide care in Pediatrics, Family Medicine, Geriatrics, Podiatry, OB/Gyn and many other disciplines. In addition to excellent care, all of our employees at each of our medical and dental offices are committed to bringing you the highest standards of customer service.

We're also concerned about the high cost of health care. A full-time *Patient Care Coordinator* is available to assist you with enrollment in programs which may help reduce the cost of your visit and medications. Please call 419-333-5309 for additional information. No matter what your financial situation is, we will provide care for you at CHS. Patients who have insurance, Medicaid, Medicare, or who are self-pay are all welcome to see a Provider at CHS.

Again, welcome to our practice. We're glad that you have chosen us as your health care provider and we look forward to providing you and your family with the highest quality health care possible. We truly want to be "*Your Partners for Better Health*".

Please visit at our website www.fremontchs.org.

If I can be of service to you in the future, please feel free to reach me at 419-334-8943 or by emailing me at jlizak@fremontchs.org.

Joseph Liszak, MBA
Chief Executive Officer



COMMUNITY HEALTH SERVICES
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NOTICE OF PRIVACY PRACTICES

This notice, which is effective as of April 14, 2003, describes how personal and medical information about you may be used and disclosed and how you may access information concerning this process.

Please read it carefully.

The health care providers and staff of Community Health Services believe your personal and medical information should remain confidential. In addition, the law now requires us to establish formal office policies that are designated to safeguard your protected health information (**PHI**). This notice constitutes our promise to you that we acknowledge our responsibility and legal obligation to protect your personal and medical information and describes your rights concerning our use of that information.

We will use and disclose your health information for purposes of treatment, payment and/or health care operations.

- 1. Treatment means the provision, coordination or management of health care and any related services rendered to you, by one or more health care providers, including the coordination or management of health care by a health care provider with a third party. This includes consultation between one of our health care providers and a specialist on your behalf, or your referral to a health care provider who specializes in specific treatment that will be of benefit to you. Any information received as a result of that consultation or referral is part of your medical information and will be protected.**
- 2. Payment** is any activity undertaken by a covered health care provider to obtain reimbursement for the provision of services rendered to you. Information provided to your insurance company so that we may be paid for our services is considered information maintained for payment purposes.
- 3. Health Care Operations** include activities of the practice such as our own internal auditing procedures, business management and planning or activities related to legal or accounting services. Organized health care plans, in which we participate, also may have programs to assure quality of care and improvement for the services we render to our patients or to review the qualifications and competence of our healthcare professionals. This may require a random review of patient records.

We are permitted or required to disclose limited health information about you, without your authorization, in the following circumstances:

- **As required by law** – any information limited to the relevant requirements of the law
- **For public health activities** (disease control, vital statistics, public health)
- **Reporting victims** of abuse, neglect or domestic violence
- **Health oversight activities** (audits, civil, criminal or administrative investigations)
- **Judicial and administrative proceedings**, in response to court order
- **To coroners, medical examiners and funeral directors** (identifying disease process or cause of death)
- **For organ or tissue donation**, consistent with applicable laws
- **To avert serious threats to health or safety**

- **Specialized government functions** (regarding military personnel, veterans, national security purposes or inmates)
- **Workers' compensation** to the extent necessary to comply with applicable laws.
- **Marketing**, for purposes of appointment reminders, treatment alternatives or other related benefits and services that may be of interest to you.

Any uses or disclosures other than those noted previously require us to obtain your written authorization, which you may revoke at any time. Any such revocation must be in writing.

You have the following rights with respect to your health information:

1. The right to request restrictions on certain uses of your health information, **however we are not required to agree to your request.**
2. The right to request, **in writing**, the manner or method by which we may contact you to furnish confidential communications about your health information (i.e., fax, voice mail, etc.). (Refer to our Consent to Release Protected Health Information) You are obligated to notify us, **in writing**, of any changes to your request.
3. The right to review your health information (**you are entitled to receive a copy of your health information, except for psychotherapy notes and information compiled in anticipation of or for use in, a civil, criminal or administrative action or proceeding**).
4. In limited circumstances, the right to ask us, **in writing**, to amend your health information, **however we reserve the right to deny your request.** If your request for amendment is denied, we will provide you with information about the basis of our denial.
5. The right to receive an accounting of disclosures of your health information, **except those disclosures related to treatment, payment or health operations. The exception also covers disclosures previously listed in this disclosure that do not require your authorization,**
6. The right to receive a copy of this notice in writing.

We have the following obligations:

1. We are required by law to maintain the privacy of your Protected Health Information, to provide you with a notice of our legal duties and Notice of Privacy Practices and obtain a written acknowledgement that it has been provided to you.
2. We are required to abide by the terms of the notice, including privacy agreements with Trading Partners and/or Business Associates with whom we contract or do business and by maintaining physical, electronic and work practice controls that comply with suggested federal regulations to guard your PHI.
3. We are required to advise you of any changes we make in the terms of our Notice of Privacy Practices, post the amended Notice and make a copy available to you upon request.

Complaints: If you feel we have violated your privacy rights, or have questions concerning our Notice of Privacy Practices, you may contact or file a written complaint to **Privacy Officer**, at the following address: **Community Health Services, 410 Birchard Avenue, Fremont, Ohio 43420** or with the federal agency in charge of enforcing patients' privacy rights. That address is: **Office for Civil Rights, U>S> Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHS Building, Washington, D.C. 20201**



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NO SHOW POLICY

Patients who no-show for their scheduled appointment 3 times within a one year period will be suspended from our practice until they attend a no-show class which is offered bi-monthly.

You may call 24 hours a day to cancel your appointment. If you call to cancel a medical appointment after office hours the answering service will take a message. If you call to cancel a dental appointment after office hours please leave a message on the answering machine.

Appointments may also be cancelled on our website fremontchs.org. Click on the cancel appointment option on the left side of the screen, fill out the form with the necessary information, and click on submit. We will handle it from there.

We look forward to providing you and your family with the highest quality medical and dental care.

Thank you for choosing Community Health Services.



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EMERGENCY ROOM GUIDE

Dear Patient:

Community Health Services would like to ensure that our patients receive the highest quality of care in the most appropriate setting.

If a patient experiences ANY of the following symptoms, they should go to the emergency room immediately.

**Chest Pain
Shortness of Breath
Rectal Bleeding
Vomiting Blood
Numbness and Tingling in
hands, feet, face, or unable
to move hands, feet, arms,
legs**

**Severe Cut
Injuries
Severe Abdominal Pain
Extreme Drowsiness, Tiredness,
or Emotional Changes
Seizure
Bleeding while Pregnant**

During office hours patients with non-emergency medical problems should be seen at the office of their physician.

Community Health Services
410 Birchard Avenue
Fremont, OH 43420
(419) 334-3869

Fremont Family Practice
1220 East State Street
Fremont, OH 43420
(419) 355-8186

Birchard Medical Center
418 Birchard Avenue
Fremont, OH 43420
(419) 334-4428

West Side Pediatrics
2276 West State Street
Fremont, OH 43420
(419) 334-9137

CHS - Willard
3903 Kok Road
Willard, OH 44890
(419) 933-7408

CHS – Napoleon
407 Independence Drive
Napoleon, OH 43545
(419) 599-9035

Thank you for helping us to ensure that you obtain your health care in the most appropriate setting.

John Imm, MD
Medical Director

P.S. Please remember to keep any appointments you have with your doctor and bring your medications to all appointments.



NO WRONG DOOR INFORMATION SHEET

SANDUSKY COUNTY

"Bringing people and services together"

ABUSE - CHILDREN/ELDERLY

SCDJF, Children Services Unit..... 419.334.8708

ADOPTION SERVICES

Catholic Charities 419.334.5061

SCDJF, Children Services Unit..... 419.334.8708

AFTER SCHOOL/SUMMER PROGRAM

New Directions After School Program 419.334.8911

ALCOHOL/SUBSTANCE ABUSE SERVICES

Al-Anon Meetings/Information 419.334.2720

Alcoholics Anonymous 419.380.9862

Firelands Hotline..... 800.334.3562

Firelands Counseling and Recovery..... 419.332.5524

Lutheran Social Services..... 419.334.3431

TASC 419.334.4644

BUDGETING/MONEY MANAGEMENT

Consumer Credit Counseling..... 800.355.2227

OSU Extension 419.334.6340

CHILDREN'S SERVICES

SCDJF, Children Services Unit..... 419.334.8708

CHILD SUPPORT

SCDJF, Child Support Unit 419.334.2909

CLOTHING ASSISTANCE

Goodwill Industries 419.334.8722

Pass It On..... 419.483.3071

SC Share and Care Center 419.334.2832

COUNSELING SERVICES

Center for Mental Health and Well-Being 419.334.6619

Firelands Counseling and Recovery..... 419.332.5524

Lutheran Social Services..... 419.334.3431

Valley Gate Recovery Center 419.355.8472

CRIME VICTIM ASSISTANCE

Prosecuting Attorney Victim Assistance..... 419.334.6418

DAYCARE/PRESCHOOL

ABC Academy of Fremont 419.332.2240

Child Care Resource Center 800.526.5268 x 59

Early Learning Center 419.559.2250

Fremont READS Even Start 419.332.8534

Rainbow Station Preschool and Daycare..... 419.334.7173

Sacred Heart SHARE Center..... 419.332.7190

SC YMCA..... 419.332.9622

St. Ann Little Blessings Child Care Center ... 419.332.6598

St. John's Christian Preschool 419.483.7072

St. Paul's Christian Daycare..... 419.483.3969

Temple Tot Nursery School..... 419.332.5272

Wee Care Preschool and Daycare..... 419.332.9971

WSOS Early Childhood Program/Headstart.. 419.334.8911

DENTAL

Community Health Services 419.334.8855

DISABILITY SERVICES

Easter Seals..... 419.332.3061

NAMI..... 419.334.8021

SC Board of MRDD..... 419.332.9296

DISASTER RESPONSE

American Red Cross 419.332.5574

DOMESTIC VIOLENCE

First Step..... 800.466.6228

EARLY CHILDHOOD DEVELOPMENT

Help Me Grow - Sandusky County..... 419.334.6314

WSOS Early Childhood Program/Headstart.. 419.334.8911

EDUCATIONAL SERVICES

North Central OH Educational Service Ctr.... 419.332.8214

Terra Community College..... 419.334.8400

EMPLOYMENT/JOB SERVICES

Job Stores/One Stop..... 419.332.2169

SC Dept. of Job and Family Services..... 419.334.3891

FINANCIAL ASSISTANCE

Bellevue Salvation Army 419.484.2769

Clyde Salvation Army..... 419.547.9555

Fremont/Clyde Clergy Emergency Funds 419.334.2720

Gibsonburg Clergy Association..... 419.637.7007

SC Dept. of Job and Family Services..... 419.334.3891

SC Share and Care/Salvation Army..... 419.334.2832

Social Security 419.334.9771

WSOS..... 419.334.8911



NO WRONG DOOR

BRINGING PEOPLE AND SERVICES TOGETHER

FOOD

Bellevue Fish and Loaves.....	419.484.2814
Clyde Food Pantry (The Back Door).....	419.547.6232
Fremont Soup Kitchen.....	419.332.1558
Gibsonburg Food Pantry	no contact phone
SC Dept. of Job and Family Services.....	419.334.3891
SC Food Pantry	419.334.8158
WSOS Senior Programs.....	419.334.8911

GRIEF/BEREAVEMENT

Compassionate Friends.....	419.547.7039
Hospice of Memorial Hospital	419.547.6419

HOMELESS SHELTER

Cross Roads (Erie County).....	419.626.6505
Liberty Center of Sandusky County.....	419.332.8777

HOUSING SERVICES

Sandusky Metro Housing Authority.....	419.334.4426
WSOS.....	419.334.8911

IMMUNIZATION

Community Health Services.....	419.334.3869
SC Health Department.....	419.334.6377

INFORMATION AND REFERRAL

First Call For Help.....	419.334.2720/800.593.9444
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LEGAL SERVICES

Legal Aid of Western Ohio.....	800.837.8908
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LITERACY/GED

Adult Basic and Literacy Education. ...	419.334.6901 x 420
Fremont READS Even Start	419.332.8534
Project READ Adult Literacy.....	419.334.6901 x 418
Vanguard Career Center	419.332.2626

MEDICAL/HOSPITAL/HEALTH DEPARTMENT

The Bellevue Hospital.....	419.483.4040
Community Health Services.....	419.334.3869
Memorial Hospital.....	419.332.7321
SC Health Department.....	419.334.6377
St. Francis Health Care Centre	419.639.2626

MIGRANT SERVICES

Rural Opportunities, Inc.	419.334.2689
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PREGNANCY

Heartbeat.....	419.334.9079
WIC/SC Health Department.....	419.334.6363

PRESCRIPTION

Bellevue Salvation Army.....	419.484.2769
Fremont/Clyde Clergy Emergency Funds.....	419.334.2720
Gibsonburg Clergy Association.....	419.637.7007
SC Share and Care/Salvation Army.....	419.334.2832

SENIOR CITIZEN SERVICES

WSOS Senior Programs.....	419.334.8911
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SHORT-TERM ADULT DAYCARE OR RESPITE CARE

Arbors at Clyde.....	419.547.9595
Bellevue Care Center	419.483.6225
Bethesda Care Center	419.334.9521
Countryside Continuing Care Center.....	419.334.2602
Elmwood of Fremont	419.332.6533
Gardens At Clyde.....	419.547.7746
Orchard Grove Assisted Living.....	419.484.1111
Parkview Care Center.....	419.332.2589
Valley View Healthcare Center	419.332.0357
Windsor Lane Health Care	419.637.2105

TRANSPORTATION

TRIPS.....	419.332.8091
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UTILITY ASSISTANCE

Bellevue Salvation Army.....	419.484.2769
Clyde Salvation Army.....	419.547.9555
Fremont/Clyde Emergency Funds.....	419.334.2720
Gibsonburg Clergy Association.....	419.637.7007
SC Share and Care/Salvation Army.....	419.334.2832
WSOS.....	419.334.8911

VETERANS SERVICE

Veterans Service Office and Commission.....	419.334.4421
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No Wrong Door Agencies

United Way First Call For Help	419.334.2720
SC Family and Children First Council.....	419.332.9296 x 118
City of Fremont.....	419.334.5900
Community Health Services.....	419.334.3869
Firelands Counseling and Recovery Services..	419.332.5524
Fremont City Schools	419.332.6454
Help Me Grow.....	419.334.6314
Liberty Center of Sandusky County, Inc.....	419.332.8777
Mental Health and Recovery Services Board.	419.448.0640
Ohio Department of Youth Services.....	419.245.3040
Ohio State University Extension, SC.....	419.334.6340
SC Board of MRDD.....	419.332.9296
SC Commissioners.....	419.334.6100
SC Department of Job and Family Services..	419.334.3891
SC Educational Service Center	419.332.8214
SC Health Department.....	419.334.6377
SC Juvenile Court	419.334.6200
SC Probate Court	419.334.6211
Terra Community College.....	419.334.8400
United Way of Sandusky County.....	419.334.8938
WSOS Community Action Commission, Inc.....	419.334.8911

**FIRST CALL
FOR HELP**



A Service of United Way

Edited 2008





COMMUNITY HEALTH SERVICES
410 Birchard Avenue * Fremont, Ohio 43420

ASSISTANCE PROGRAMS FOR TRANSPORTATION

DANNY'S TAXI	419-332-8284
FIRST CHOICE CAB CO.	419-307-1352
HART'S AMBULETTE	419-332-3911
NORTH CENTRAL EMS	419-334-4553
TRIPS	419-332-8091
VETERANS SERVICE OFFICE	419-334-4421



COMMUNITY HEALTH SERVICES
410 Birchard Avenue * Fremont, Ohio 43420

Departments

BILLING OFFICE		
Medical Billing	419-333-5305	
Dental Billing	419-333-5304	
MEDICAL RECORDS DEPARTMENT		419-333-5311
PATIENT CARE COORDINATOR		419-333-5309

Individual Offices

CHS MEDICAL.....	419-334-3869
CHS DENTAL	419-334-8855
FREMONT FAMILY PRACTICE	419-355-8186
BIRCHARD MEDICAL CENTER.....	419-334-4428
WEST SIDE PEDIATRICS & ASSOC.....	419-334-9137
CHS – WILLARD OFFICE	419-933-7408
CHS – NAPOLEON OFFICE	419-599-9033

OUR WEBSITE ADDRESS: www.fremontchs.org