

# CHILD PATIENT INFORMATION

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_ Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_  
(for statistical purposes only)  
Employer Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

## PARENT / GUARDIAN INFORMATION (Please Circle One)

Mother's/Guardian's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Mother's/Guardian's Address \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Mother's/Guardian's Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Work Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Father's/Guardian's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_  
Father's/Guardian's Address \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Father's/Guardian's Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Work Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## EMERGENCY CONTACT

Name \_\_\_\_\_ Phone \_\_\_\_\_  
(other than Spouse/Parent/Guardian)

## PATIENT INSURANCE COVERAGE

Primary Insurance \_\_\_\_\_ Group/ID # \_\_\_\_\_  
Primary Insurance \_\_\_\_\_ Group/ID # \_\_\_\_\_

**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 required for all 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**  
**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**

410 Birchard Avenue  
Fremont, OH 43420

**CONSENT – MEDICAL TREATMENT**

I hereby authorize Community Health Services to render medical or surgical care, which is considered to be in my best interest by the medical staff and his/her designees and Community Health Services to employ such operative or technical procedures or test for blood-borne diseases (including but not limited to Hepatitis and AIDS antibodies) as he/she may deem necessary or advisable in the diagnosis or treatment of myself or child.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_ DOB: \_\_\_\_\_  
Patient (Parent, if minor)

Name of Minor: \_\_\_\_\_ DOB: \_\_\_\_\_

Witness: \_\_\_\_\_

**RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

I understand that as part of my healthcare, Community Health Services originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans of future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment as well as providing communication among all the healthcare professionals involved in my care. **(Treatment)**
- A source of information in the application of charges to my account as well as a means by which my insurer can verify that the services billed were actually provided to me. **(Payment)**
- A tool for use in healthcare operations such as assessing the quality of care I have received, the competence of healthcare professionals involved in my care and all other office operations meant to facilitate the efficient rendering of my care. **(Operations)**

For the purposes state above, I \_\_\_\_\_, hereby authorize Community Health Services to release any and all records and written material of any nature whatsoever, pertaining to my care. This includes: office records and test results, hospitalizations and related records, reports, consultations, pathology slides and reports, emergency room records, memoranda and details of any charges for services rendered at any time to myself or child. This consent specifically includes consent for the release of any psychological and/or psychiatric records, records relating to the treatment of sexually transmitted diseases and records relating to any treatment for my HIV or AIDS status.

I acknowledge receipt of Community Health Services' Notice of Privacy Practices and understand I have the opportunity to request clarification of any portion of the notice that is unclear to me. I understand that Community Health Services has the right to change their "Notice" and, prior to implementation, mail a copy of the revised notice to me at the address I have provided.

I understand that I have the right to request restrictions regarding how my Protected Health Information may be used or disclosed to carry out **Treatment, Payment** or **Operations** and that the practice is not required to comply with the restrictions requested. I authorize or restrict the release of information pursuant to the following:

### **NO RESTRICTIONS**

- I request no restrictions.

### **RESTRICTIONS**

- I request the following restrictions to the use or disclosure of my health information:

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- I authorize \_\_\_\_\_, my \_\_\_\_\_ to receive messages for me or to make inquiries concerning my healthcare by use of the following security code: \_\_\_\_\_.

I understand I have the right to revoke this consent in writing, except to the extent that Community Health Services has already taken action in reliance thereon.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_  
Patient (Parent, if minor)

Witness: \_\_\_\_\_



# COMMUNITY HEALTH SERVICES

## DENTAL TREATMENT CONSENT FORM

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

I, \_\_\_\_\_, parent/legal guardian of the above named child give my permission to the individual(s) listed below to bring the above named child to dental appointments and give permission for treatment and procedures, including extractions if needed. This individual may also make medical/dental decisions in my absence.

\_\_\_\_\_  
Signature of Parent/Guardian (Relationship)

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Today's Date

THIS FORM IS VALID FOR ONE YEAR FROM TODAY'S DATE.

Please list the name of any individual that has permission from you:

\_\_\_\_\_  
Name & Relationship

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Name & Relationship

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Name & Relationship

\_\_\_\_\_  
Phone Number

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Name & Relationship

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Phone Number

\_\_\_\_\_  
Name & Relationship

\_\_\_\_\_  
Phone Number