

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

