

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
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
Read	Yes	No	Yes No
Write	Yes	No	Yes No
			Patient
			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 _____



COMMUNITY HEALTH SERVICES

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 doctor appointments and give permission for treatment, procedures, immunizations, placing information in the SIIS registry, and well child checks. This individual may also make medical 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

Name & Relationship

Phone Number

Name & Relationship

Phone Number

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-born 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:

- 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: _____