



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 _____



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 to any CHS personnel or by calling The Joint Commission at 1-800-994-6610. Community Health Services also ensures that the following rights and responsibilities are preserved for all patients.

PATIENT RIGHTS:

1. Understand and make use of your rights.
2. If an interpreter is needed, the office will attempt to provide the assistance.
3. Respectful and equal treatment, care and accommodations are available regardless of race, creed, sex, or sources of payment.
4. Privacy 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. 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.
5. Please bring a list of ALL medications with you at every appointment. This includes prescriptions, over-the-counter medications, and herbal medication.
6. Provide Community Health Services' providers with full medical disclosure.
7. It is the patient's responsibility to carry out the recommended treatment plan.
8. If your child is scheduled for a physical or immunizations a current immunization record **MUST** be brought with you.
9. Allow at least 30 days for completion of insurance forms, disability, transfer of treatment records, etc.
10. All refills on medications will be directed to your pharmacy after 5:00 pm the next business day.
11. 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.
12. 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.
13. Our website www.fremontchs.org may also be used for cancellations, refills, and payments.
14. 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.
15. 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. **All new patients who no show their first appointment will be terminated from the practice.**
16. An established patient is someone seen in one of our offices, by one of our providers.
17. If you have not been seen by one of our providers in three years you will be considered a new patient.

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

Patient Name (please print)

Date

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

Date

