



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: _____



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



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CONSENT FOR TREATMENT

I hereby authorize Community Health Services to render medical or dental care, which is considered to be in my best interest by the medical or dental staff and their 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 my provider may deem necessary or advisable in the diagnosis or treatment of myself or child.

Date: _____

Patient Name: _____ DOB: _____
Please Print

Name of Minor: _____ DOB: _____
(If applicable)

Signature: _____
Patient (Parent/Guardian, if minor)

Witness: _____

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

Name: _____ Relationship: _____

- I do not authorize anyone to receive messages for me or to make inquiries concerning my healthcare.

Date: _____ Signed: _____
Patient (Parent, if minor)

Witness: _____



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RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ DOB: _____
(Please Print)

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 stated 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 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: _____



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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