COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

To Our New Patients:

Welcome to Community Health and Wellness Partners!

Included with this letter, you will find a new patient packet. Please complete this packet and return it to us as soon as possible. **This packet MUST be returned to us before your new patient appointment will be scheduled.** Once we receive the completed packet, we will contact you with your appointment time.

As part of the packet we call your attention to our Missed Appointment Policy, Bill of Rights and Notice of Privacy Practices.

Community Health and Wellness Partners is a Federally Qualified Health Center that accepts most insurances. A reduced payment may be available based on household income (sliding fee scale).

For your convenience, we offer three locations:

BCHC
212 E. Columbus Ave. Suite 1
Bellefontaine, Ohio 43311
Phone: (937)599-1411
Fax: (937)599-4128

ILCHC
8200 St. Rt. 366, Suite 1
Russells Point, Ohio 43348
Phone: (937)599-1411
Fax: (937)599-4128

WLCHC
4879 US Rt. 68 South
West Liberty, Ohio 43357
Phone: (937)599-1411
Fax: (937)599-4128

Again, we ask that you complete and return the new patient forms, so we may better serve you. You may drop off this packet at one of our offices mentioned above, send to us by mail, or return to hospital staff so they can forward to us.
The packet MUST be received before an appointment will be scheduled.

Welcome to Community Health and Wellness Partners!

Sincerely,

Tara Bair, President/CEO

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

THIS PAGE WAS INTENTIONALLY LEFT BLANK

Bellefontaine
212 E. Columbus Ave. Suite 1
Bellefontaine, OH 43311

Indian Lake
8200 St. Rt. 366, Suite 1
Russells Point, OH 43348

West Liberty
4879 US Rt. 68 South
West Liberty, OH 43357

Phone: 937.599.1411 • Fax: 937.599.4128

chwplc.org

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

Patient Information Form (Please Print and Complete All Entries)

Patient Legal Name _____
Last First MI

Preferred Name _____ Date of Birth _____/_____/_____

Social Security # _____-_____-_____ Sex at Birth Female _____Male _____

Address _____
Street City State Zip Code

Home Phone # _____ Cell Phone # _____

Email Address _____

How Should we Contact you? Phone_____ Email _____ Postal Mail _____ Text_____

Emergency Contact: Name _____ Phone # _____ Relationship _____

Responsible party is (Required for patients under the age of 18)
Last Name _____ First Name_____ Relationship_____

How did you about us? Patient____ Newspaper____ Internet_____ Radio____ Flyer_____
Billboard_____ Community Event _____ Other _____
Do you have internet access? Yes _____ No _____

Insurance Information (Please present ALL Insurance Cards and Picture ID)

Primary Insurance _____Policy # _____Group # _____

Policy Holder Name _____ Date of Birth _____/_____/_____

Relationship to Patient _____What is your CO Pay$_____

Information for Statistical Reporting only

Race: White _____ African American _____ American Indian/Alaska Native_____

Native Hawaiian/ Other Pacific_____ Latino/Hispanic _____

More than One Race _____ Other _____Refuse to answer _____

Bellefontaine
212 E. Columbus Ave. Suite 1
Bellefontaine, OH 43311

Indian Lake
8200 St. Rt. 366, Suite 1
Russells Point, OH 43348

West Liberty
4879 US Rt. 68 South
West Liberty, OH 43357

Phone: 937.599.1411 • Fax: 937.599.4128

chwplc.org

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

Preferred Language: English___ Spanish____ French ____German ____Russian ___ Other _____
Sign Language _____

Marital Status: Single_____ Married___ Divorced_____ Legally Separated_____
Widowed_____ Life Partner_____ Other _____

Gender Identity: Male _____ Female _____ Transgender Female _____
Transgender Male _____ Other _____ Refuse to Report _____

Sexual Orientation: Straight or Heterosexual _____ Lesbian, Gay, or Homosexual _____
Bisexual _____ Something Else _____ Don't know _____ Decline to answer _____

Occupation: Retired ____ Disabled_____ Unemployed___ Student_____
Decline to Answer _____ Employed_____ (list below what you do)
If Employed tell us what you do _____
Transportation Needed? Yes _____ No_____
If yes do you have assisted device? _____
Are you a Veteran? Yes _____ No_____
Are you a Migrate Worker? Yes_____ No_____
Are you Homeless? Yes_____ No _____
If Yes, where are you living? Shelter _____ Transitional_____ Doubling up _____
Street _____ Other _____

What Advanced Directives do you have?
Living Will_____ Durable Power of Attorney _____ POA_____
Decline to Answer _____ None _____
If Yes, please specify who & their relation to you and provide a copy of document to CHWP.
Name _____ Phone#_____ Relationship _____

What are your top 3 goals for your first appointment?
1._____
2._____
3._____

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

Health History

Date: _____

Name: _____ **Date of Birth: _____**

Pharmacy_____ **30 days _____** **90 days _____**

Past Medical History: Have you ever had the following: ☐ Patient denies any past illness

	Condition	Dates
	AIDS	
	Alcohol	
	Alzheimer's	
	Anemia	
	Arthritis	
	Asthma	
	Birth Defects	
	Bleeding Disorder	
	Cancer	
	COPD	
	Depression	
	Diabetes	

	Condition	Dates
	Epilepsy	
	Glaucoma	
	Heart Disease	
	Hyper Cholesterol	
	Hypertension	
	Hyperthyroidism	
	Hypothyroidism	
	Irritable Bowel	
	Kidney Disease	
	Liver Disorder	
	Migraine	
	Pneumonia	

	Condition	Dates
	Stroke	
	Suicidal	
	TIA	
	Tuberculosis	
	Ulcer	
	UTI	
	Other:	

Medications: **Please list ALL medications you are CURRENTLY TAKING** _____ Patient denies any medications

Please bring your medications to EVERY visit

Medication Name	Dosage (mg)	How often per day

Allergies: **Please list all food, medication, and environmental allergies** _____ Patient denies any allergies

Hospitalizations: _____ Patient denies any hospitalizations

Date	Location	Reason for stay	Length of stay

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

Social History:

Household member	Age	Relationship

Occupation: _____

Tobacco Use: ____ None ____ Former ____ Chewing/Smoking How much daily? _____

Alcohol Use: How many drinks? _____ How often? _____

Street Drug Use: ____ None ____ Past Use ____ Current Use

What exercise do you do? _____ How often? _____

Are you currently sexually active? ____ Yes ____ No Number of partners in your lifetime: _____

Family History: Any of the diseases that family members have had.

	Condition
	AIDS
	Alcohol
	Alzheimer's
	Anemia
	Arthritis
	Asthma
	Birth Defects
	Bleeding Disorder
	Cancer
	COPD
	Depression
	Diabetes

	Condition
	Epilepsy
	Glaucoma
	Heart Disease
	Hyper Cholesterol
	Hypertension
	Hyperthyroidism
	Hypothyroidism
	Irritable Bowel
	Kidney Disease
	Liver Disorder
	Migraine
	Pneumonia

	Condition
	Stroke
	Suicidal
	TIA
	Tuberculosis
	Ulcer
	UTI
	Other:

Women Only:

Date of last period: _____ Age at first period: _____

Any problems with your periods? _____

Number of Pregnancies: _____ Number of Children: _____

Any chance you are pregnant now? _____ Yes _____ No

Any problems during pregnancy? _____

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

Comprehensive Medication Review

Are you getting the most from your medications?

What benefits are there from having a Medication Review?

- Address any questions or concerns that you have about your medicine
- Ensure that you are receiving the best medicine therapy possible
- Increase your knowledge and confidence about your medicine
- Reduce your risk of problems from your medicine

Am I a good candidate for a Medication Review?

- ☐ Are you taking several medications or worry that you take too many (including natural products and non-prescription products)?
- ☐ Do any of your medications make you feel unwell?
- ☐ Are your prescriptions unaffordable or have you not taken a prescribed medication because it is too expensive?
- ☐ Do you have trouble understanding or remembering how to take your medicine?
- ☐ Do you ever have trouble using your medicines (swallowing, puffers, eye drops, patches)?
- ☐ Do you worry that your medicines are working against each other?
- ☐ Have you recently been discharged from the hospital?
- ☐ Do you wish you knew more about your medicine?

* If any of any of these apply to you, schedule a visit with our pharmacist to review all your medications. This visit may take up to 60 minutes.

Please remember to bring all medications (including over the counter, herbal, vitamins, etc.) to your appointment along with the back of this form filled out. If you turn in this form before your appointment, it will help the pharmacist look into any concerns you may have before your appointment.

Appointment Date & Time:

Location: ☐ West Liberty ☐ Indian Lake ☐ Bellefontaine ☐ WLS Schools

Bellefontaine
212 E. Columbus Ave. Suite 1
Bellefontaine, OH 43311

Indian Lake
8200 St. Rt. 366, Suite 1
Russells Point, OH 43348

West Liberty
4879 US Rt. 68 South
West Liberty, OH 43357

Phone: 937.599.1411 • Fax: 937.599.4128

chwplc.org

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

Best Possible Medication History

Name and Date of Birth Other physicians/specialists (list)	Pharmacies used to fill prescriptions (Click on the gray bar at right and select your pharmacy) Other:
What is your primary concern about your medications today?	
What would you like to achieve from your medication review?	
List any over the counter, herbal, vitamins, etc that you regularly take:	
Do you use a pill box to organize your medications? YES NO	Do you sometimes forget to take your medications? YES NO
Have you ever decreased or quit taking a medication on your own? YES NO	Do you feel hassled by taking your medications? YES NO

Bellefontaine
212 E. Columbus Ave. Suite 1
Bellefontaine, OH 43311

Indian Lake
8200 St. Rt. 366, Suite 1
Russells Point, OH 43348

West Liberty
4879 US Rt. 68 South
West Liberty, OH 43357

Phone: 937.599.1411 • Fax: 937.599.4128

chwplc.org

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

CONSENT TO TREAT

_____ _____

Patient Name (Printed) Patient Date of Birth

I for myself do voluntarily consent to medical care, diagnostic procedures, behavioral health counseling, pharmacy or nutritional counseling services that may be done, requested or directed by or delegated in the judgment of the attending provider. I understand that I may refuse any services at any time.

I authorize release of information to all third-party payors or health and social service agencies.

I authorize release of information to Medicare and authorize Community Health and Wellness Partners of Logan County to bill my charges to Medicare.

I understand that I am still responsible for my bill even though I may have health insurance.

I understand that I will be asked to provide proof of income at least once each year, so my charges can be accurately calculated for the sliding fee schedule.

I understand that I must present a current public aid card, health insurance, or Medicare card at each visit to Community Health and Wellness Partners of Logan County when my charges are covered.

I hereby assign, transfer and set over to Community Health and Wellness Partners of Logan County all of my rights, title and interest to my medical reimbursement benefits under my insurance policies.

Community Health and Wellness Partners is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information.

This notice is in compliance with the guidelines set forth in the Health Insurance Portability and Accountability Act. (HIPAA) of 1996, effective April 14th, 2003.

_____ _____

Signature of Patient, Parent or Guarantor Date

_____ _____

Witness Date

Bellefontaine
212 E. Columbus Ave. Suite 1
Bellefontaine, OH 43311

Indian Lake
8200 St. Rt. 366, Suite 1
Russells Point, OH 43348

West Liberty
4879 US Rt. 68 South
West Liberty, OH 43357

Phone: 937.599.1411 • Fax: 937.599.4128

chwplc.org

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

THIS PAGE WAS INTENTIONALLY LEFT BLANK

Bellefontaine
212 E. Columbus Ave. Suite 1
Bellefontaine, OH 43311

Indian Lake
8200 St. Rt. 366, Suite 1
Russells Point, OH 43348

West Liberty
4879 US Rt. 68 South
West Liberty, OH 43357

Phone: 937.599.1411 • Fax: 937.599.4128

chwplc.org

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

HIPAA

_____ _____

Patient Name: (Please Print) *Date of Birth*

_____ *Initials*

Acknowledgement of receipt of Notice of Privacy Practice regarding protected health Information:

I have received the Practice's Notice of Privacy. Photocopies of this document are to be as valid as the original.

Fundraising & Marketing: Unless you request us not to, we will use your name and address to support our fund-raising or marketing efforts. If you do not want to participate in fund-raising or marketing efforts, please check off the following box.

Please exclude me from any ☐ Fund-raising Purposes ☐ Marketing Purposes

_____ *Initials*

Assignment of Benefits:

I acknowledge financial responsibility for all facility and physician fees. I understand that the physician billing office will file my insurance claim and I assign direct payment to the physician all payments made under the terms and provisions of my policy. I further understand that any disputes on coverage are between my insurance carrier and myself and I will be responsible for payment for denied services regardless of the outcome of my dispute. I acknowledge financial responsibility for all charges if inaccurate insurance information is given at time of service and the information is not corrected prior to my insurance company's timely filing limit.

_____ *Initials*

Medical Records Exchange:

CHWPLC participates in one or more Health Information Exchanges (HIE). HIEs are electronic networks that securely provide and retrieve access to your health records for a better picture of your health needs. CHWPLC Providers, as well as other healthcare providers, may provide and retrieve access to your health information through an HIE for treatment, payment or other healthcare operations. As a CHWPLC patient, you have the ability to opt out of any HIE at any time by notifying a CHWPLC Associate. This is a voluntary agreement. Unless you advise us differently, your information may be accessed through an HIE by your CHWPLC provider.

_____ *Initials*

Rx-History Consent:

I understand that performing a medication reconciliation in order to prevent adverse drug interactions and overdose is a critical component to my care. By initialing this section, I authorize my provider to query and review my medication fill history including drug, dose, form, strength, prescribing provider, and pharmacy

_____ *Initials*

Communication Preferences Regarding PHI

To assist in your care, it may be necessary to release our Protected Health Information to someone other than yourself. To whom may we talk? Please Check boxes and write in name(s).

Yes	No	
☐	☐	Spouse/Significant other: _____
☐	☐	Parent/Step-Parent: _____
☐	☐	Child/Grandchild: _____
☐	☐	Other Person(s): _____
☐	☐	Emergency Contact: _____

_____ *Initials*

May we leave a message on: ☐Home ☐Cell ☐ Work

Preferred method for appointment remind: Check all that apply

☐ Call to Home ☐ Call to Mobile ☐ Text to Mobile

Preferred time for reminders calls: ☐ Morning ☐ Afternoon ☐ Evening

_____ _____

Patient/Representative Signature Date

Bellefontaine
212 E. Columbus Ave. Suite 1
Bellefontaine, OH 43311

Indian Lake
8200 St. Rt. 366, Suite 1
Russells Point, OH 43348

West Liberty
4879 US Rt. 68 South
West Liberty, OH 43357

Phone: 937.599.1411 • Fax: 937.599.4128

chwplc.org

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

THIS PAGE WAS INTENTIONALLY LEFT BLANK

Bellefontaine
212 E. Columbus Ave. Suite 1
Bellefontaine, OH 43311

Indian Lake
8200 St. Rt. 366, Suite 1
Russells Point, OH 43348

West Liberty
4879 US Rt. 68 South
West Liberty, OH 43357

Phone: 937.599.1411 • Fax: 937.599.4128

chwplc.org

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

Initial Application_____ Renewal_____

Sliding Fee Application

Applicant's Name_____ Today's Date_____

Address_____ Date of Birth_____

City_____ State_____ Zip_____ Phone_____

Before approval can be given, the following MUST be received at time of or within 30 days of application.

- Current photo ID along with one proof of income for applicant and other household members over age 19.

Proof of income (Copy of 2 or more checks/paystubs, Recent tax return or W-2, Public Assistance or Social Security letter, Bank Statements, Child Support, Alimony, Unemployment, Medical Assistance or Dept. of Social Services Certification letter. **Include all household income**)

- Must be current within 30 days of application
- If unable to provide documentation of income (Complete Declaration of Income Form)
- Note: Total Gross Income will be calculated to determine approval

List yourself on Line 1, spouse or significant other on Line 2, and all dependents under the age of 19 on Lines 3-6

Household Members	Name(s)	DOB MM/DD/YYY Y	Monthly Gross Income	Student (S)	Employed (E)	Other (O)	Office Use Only Patient/Chart #
1(self)							
2							
	Dependents under age 19						
3							
4							
5							
6							
		Total					

Certification: I certify that the household size and income information shown above is correct. **I understand that documentation supporting my household financial position is required before my discount can be approved and that I must provide this information within 30 days or prior to my next visit if sooner.**

I understand that I must update this information if my situation changes and that a new Sliding Fee Application must be completed at least every twelve (12) months. I have received information explaining the program and I understand and agree to abide by the terms. I understand that if I am eligible for the sliding fee discount**; I will be responsible to pay at least a minimum nominal fee for healthcare services**. If an unpaid balance exists on my account after applying my sliding fee discount, I agree to make payment arrangements and honor the terms. I understand that if I am unable to make a payment in any given month, I must contact the Billing Office prior to the due date to discuss my need to modify my payment arrangement.

_____ _____ _____

Patient Name (print) Signature of Patient or Guarantor Date of Signature

Bellefontaine
212 E. Columbus Ave. Suite 1
Bellefontaine, OH 43311

Indian Lake
8200 St. Rt. 366, Suite 1
Russells Point, OH 43348

West Liberty
4879 US Rt. 68 South
West Liberty, OH 43357

Phone: 937.599.1411 • Fax: 937.599.4128

chwplc.org

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

Documentation of No Income: If you report $0 income, please explain below how you are surviving without income:

_____

_____

_____

_____ _____

Patient's Signature CHWP Witness

WAIVER of Sliding Fee Scale Discount

DO NOT sign below if you wish to be considered for a discount. Signing below will **void** your Sliding Fee Application. Even if you have insurance, you may still qualify for an additional discount if you provide your household income information and provide applicable documentation as stated on the application.

I choose not to complete the Sliding Scale Application at this time. I am waiving my right to any discount to which I may otherwise be entitled. I understand that I will be responsible for full payment of all charges at the time of service.

_____ _____ _____

Patient Name (print) Signature of Patient or Guarantor Date of Signature

FOR CHWPLC OFFICE USE ONLY

Application Reviewed By:	**Date:**
Documentation Received By:	**Date:**
Sliding Fee Approval Level (A-E):	**Date:**
Signature:	

Bellefontaine
212 E. Columbus Ave. Suite 1
Bellefontaine, OH 43311

Indian Lake
8200 St. Rt. 366, Suite 1
Russells Point, OH 43348

West Liberty
4879 US Rt. 68 South
West Liberty, OH 43357

Phone: 937.599.1411 • Fax: 937.599.4128

chwplc.org

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

To see if you qualify, review the following information…
Find your household size and monthly income on the chart

Step 1. Circle Household Size
Step 2. Circle MONTHLY Gross Income Range (on same line) for household size you selected
Step 3. If your circle is in the middle two columns you qualify for a sliding fee discount **

General office and behavioral health visits, procedures, preventative exams, vaccines			
Household Size	**Gross Household Monthly Income Less Than**	**Gross Household Monthly Income Between**	**Gross Household Monthly Income Greater Than**
1	$1,063	$1,064-$2,127	$2,128
2	$1,437	$1,438-$2,873	$2,874
3	$1,810	$1,811-$3,620	$3,621
4	$2,183	$2,184-$4,367	$4,368
5	$2,557	$2,558-$5,113	$5,114
6	$2,930	$2,931-$5,860	$5,861
Cost Per Visit/Level	Full Discount*	$35(B), $45(C), $55(D), $65E	Do Not Qualify (F)

**Nominal Fee May Apply*

***Final rate to be determined by submitted documentation, CHWPLC staff and current sliding fee scale*

Bellefontaine
212 E. Columbus Ave. Suite 1
Bellefontaine, OH 43311

Indian Lake
8200 St. Rt. 366, Suite 1
Russells Point, OH 43348

West Liberty
4879 US Rt. 68 South
West Liberty, OH 43357

Phone: 937.599.1411 • Fax: 937.599.4128

chwplc.org

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

THIS PAGE WAS INTENTIONALLY LEFT BLANK

Bellefontaine
212 E. Columbus Ave. Suite 1
Bellefontaine, OH 43311

Indian Lake
8200 St. Rt. 366, Suite 1
Russells Point, OH 43348

West Liberty
4879 US Rt. 68 South
West Liberty, OH 43357

Phone: 937.599.1411 • Fax: 937.599.4128

chwplc.org