



COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

Students or school staff who plan to visit one of our school-based health centers should complete all of the forms listed below.

School Registration Form (Please Print and Complete All Entries)

Please check the location:

_____ Ben Logan School _____ Indian Lake School _____ West Liberty-Salem

Patient Legal Name _____

Preferred Name _____ Last _____ First _____ MI _____
Date of Birth _____

Social Security # _____ Sex at Birth _____

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)

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:

Ethnicity: Are you Hispanic/Latino?

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

Urbana
605 Miami St., Suite 100
Urbana, OH 43078

School-Based Health Centers

West Liberty-Salem

Benjamin Logan

Indian Lake

Preferred Language: _____

Marital Status: _____

Gender Identity: _____

Sexual Orientation: _____

Occupation: _____

If Employed tell us what you do _____

Transportation Needed? _____

If yes do you have assisted device? _____

Are you a Veteran? _____

Are you a Migrant Worker? _____

Are you Homeless? _____

Yes, where are you living? _____

What Advanced Directives do you have?

Living Will _____ Durable Power of Attorney _____ POA _____ Guardian _____

Decline to Answer _____

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. _____

Health History

Name: _____ Date of Birth: _____

Pharmacy: _____

Past Medical History: Please check any condition you have been **diagnosed** with by a medical professional/provider.

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> TIA
<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Depression
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Osteoarthritis of _____	<input type="checkbox"/> Hypercholesterol	<input type="checkbox"/> ADHD
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Birth defects	Thyroid: Hyper: _____ Hypo: _____	<input type="checkbox"/> Borderline Personality
<input type="checkbox"/> Bleeding disorder:(type if known) _____	<input type="checkbox"/> Gestational diabetes	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Cancer of _____	<input type="checkbox"/> Kidney Disease	Other: _____
<input type="checkbox"/> COPD	<input type="checkbox"/> Liver disorder	_____
<input type="checkbox"/> Dementia:(type if known) _____	<input type="checkbox"/> Migraine	_____
<input type="checkbox"/> Diabetes: Type 1 _____ Type 2 _____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Environmental allergies to: _____	<input type="checkbox"/> Tuberculosis	_____

Medications: Please list all medications, vitamins, supplements that you are currently taking. Please bring medications.

Medication Name:	Dosage (mg)	How often taking per day:

Allergies: Please list medication, food, health related allergies and reactions. If reaction not known write "unknown"

Allergen:	Reaction:

Hospitalizations:

Date:	Location:	Reason for stay:	Length of stay:

Surgical History:

Date:	Type of Surgery:	Hospital/location:

Family History: Please check box if family member diagnosed with that condition. For cancers, please indicate type.

Condition:	Mom	Dad	Dad's Dad	Dad's mom	Mom's Mom	Mom's Dad	Sibling	Child
Alcoholism								
Dementia								
Anemia								
Asthma								
Birth Defects								
Bleeding disorder								
Cancer:								
Diabetes								
Heart Disease								
high cholesterol								
Stroke								
Heart Attack								
Migraine								
Epilepsy								
Glaucoma								
thyroid issues								
Suicide								
Tuberculosis								

Social History:

Have you been sexually active in the last 12 months? _____

Men, Women, or both: _____

Have you ever had a sexually transmitted disease? Type: _____

Type of contraceptive/protection used: _____

Female History:

Date of Last Period: _____

Age at first period: _____

Number of pregnancies: _____

Number of children: _____

Any chance you are pregnant now?

Complications during pregnancy? _____

Last PAP Smear: _____ where performed: _____

Last Mammogram: _____ where performed: _____



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

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:

CHWP 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. CHWP 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 CHWP patient, you have the ability to opt out of any HIE at any time by notifying a CHWP Associate. This is a voluntary agreement. Unless you advise us differently, your information may be accessed through an HIE by your CHWP 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	
<input type="checkbox"/>	<input type="checkbox"/>	Spouse/Significant other: _____
<input type="checkbox"/>	<input type="checkbox"/>	Parent/Step-Parent: _____
<input type="checkbox"/>	<input type="checkbox"/>	Child/Grandchild: _____
<input type="checkbox"/>	<input type="checkbox"/>	Other Person(s): _____
<input type="checkbox"/>	<input type="checkbox"/>	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



COMMUNITY HEALTH
& WELLNESS PARTNERS
Care... To Live Life Fully

Initial Application or Renewal:

Sliding Fee Application

A Sliding Fee Scale is available. Discounts are based on income and family size.
If you do not wish to be considered for a discount, please skip to the WAIVER section.

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/YYYY	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

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

Patient's Signature

CHWP Witness

Because we are partially funded by a federal grant, we are asked to collect income information. Please determine the number of persons in your household and check your annual (yearly) income range. This information is for generalized reporting regarding the health center, **NO PERSONAL INFORMATION IS SHARED.**

NUMBER OF PEOPLE IN YOUR HOUSEHOLD: _____

Range 1	Range 2	Range 3	Range 4	Range 5	Range 6
() \$0 to \$15,000	() \$15,001 to \$30,000	() \$30,001 to \$45,000	() \$45,001 to \$60,000	() \$60,001 to \$75,000	() \$75,001+

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 CHWP OFFICE USE ONLY

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

**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	\$1,133	\$1,134-\$2,266	\$2,267
2	\$1,526	\$1,527-\$3,052	\$2,905
3	\$1,919	\$1,920-\$3,838	\$3,839
4	\$2,313	\$2,314-\$4,626	\$4,627
5	\$2,706	\$2,707-\$5,412	\$5,413
6	\$3,099	\$3,100-\$6,198	\$6,199
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, CHWP staff and current sliding fee scale*