COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

To Our New Patient:

Welcome to Community Health & Wellness Partners (CHWP), where our **mission is to provide whole-person, patient-centered health care to anyone and everyone in our community.**

Established in 2014, CHWP serves the residents of Logan, Champaign, and surrounding counties with primary health care, including in-office procedures, behavioral health, pharmacy, nutrition, chronic care management, substance use treatment, and social services. Services are available at all primary sites and school-based health centers as identified below, and visits can be in-person or via telehealth.

Many of our providers, both physicians and nurse practitioners, are taking new patients. Our staff can assist you in who is accepting new patients and choosing a provider that will help you meet your health care goals. Please review our website below to learn more about our providers and services offered.

To better prepare for your first visit, we ask you to **complete this New Patient Packet in its entirety.** This packet requests necessary information needed that will assist us in providing the quality of health care you deserve. Some of the information may feel invasive or personal. The intent of these questions is to support CHWP's declaration that we do not discriminate on any level in providing health care services. If you have any questions or concerns, please do not hesitate to contact us. We are happy to assist you.

CHWP accepts insured, uninsured, under insured and self-pay patients. A sliding-fee scale is offered to those who qualify. Please complete income information on page 1 fully. If you decide to NOT participate in the sliding-fee scale, please checkmark the income ratio applicable to your household and sign the waiver portion on page 2 of the application indicating you choose not to complete the application at this time.

Please note that 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.** You may drop off this packet at one of our offices mentioned below, send to us by mail, complete online at www.CHWPcares.org/Resources, or return to a hospital staff so they can forward to us.

Thank you for choosing CHWP as your partner in health care! We look forward to meeting you in person soon!

Sincerely,

Tara D. Bair, President/CEO

(Dated: 8/2022)

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

Phone: 937.599.1411 • Fax: 937.599.4128 • chwpcares.org

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Patient Information Form (Please Print and Complete All Entries)

Please check all services that are requesting:

☐ **Primary Medical Care** ☐ **Behavioral Health** ☐ **Substance Use Medication Assistance**

Patient Legal Name_____
Last First MI

Preferred Name_____ Date of Birth_____ _____ _____

Social Security #_____ _____ _____ Sex at Birth _____

Full 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 hear 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?

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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 Migrate 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._____

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Health History

Name: _____ Date of Birth: _____

Pharmacy: _____

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

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

Other: _____

_____

_____

_____

_____

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:

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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 contracptive/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: _____

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Comprehensive Medication Review

Are you getting the most from your medications?

First name: Last name:

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:

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Best Possible Medication History	
Name and Date of Birth Other physicians/specialists (list)	Pharmacies used to fill prescriptions (circle)
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? (circle)	Do you sometimes forget to take your medications? (circle)
Have you ever decreased or quit taking a medication on your own? (circle)	Do you feel hassled by taking your medications? (circle)

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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 _____

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HIPAA

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

_____ **Acknowledgement of receipt of Notice of Privacy Practice regarding protected health information:**
Initials 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

_____ **Assignment of Benefits:**
Initials 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.

_____ **Medical Records Exchange:**
Initials 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.

_____ **Rx-History Consent:**
Initials 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.

_____ **Communication Preferences Regarding PHI**
Initials 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: _____

_____ **May we leave a message on:** ☐Home ☐Cell ☐ Work
Initials **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

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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 _____

Full Address _____ Date of Birth _____

Phone _____

Before approval can be given the following <u>MUST</u> 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 or Patient or Guarantor Date of Signature

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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 or 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:	

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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	$3,053
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*

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STANDARD AUTHORIZATION FORM – REQUEST FOR INFORMATION

(CHWP is requesting to receive patient records)

Fields marked with an asterisk (*) are required to be completed. Failure to provide additional identifying information in Section I may result in the inability to respond to this request. This form is not a patient access request under 45 CFR 164.524. *Records released pursuant to this authorization may include information concerning testing, diagnosis of treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual assault.*

FORM A – AUTHORIZATION FOR RELEASE OF INFORMATION FROM COVERED ENTITIES (OTHER THAN PART 2 PROGRAMS)

Section I

First and Last Name*: Date of Birth*: SSN:

Address:

I hereby authorize the disclosure of health information about the above individual as follows:

Section II

Disclosing Entity* *(Covered Entity such as health plan/insurer or provider)*

Address		**Telephone Number**
City	**State**	**Zip Code**

Recipient (Person or Entity) *
COMMUNITY HEALTH & WELLNESS PARTNERS

Contact Information *(e.g. telephone number, email address, fax number, street address, etc.)*
4879 US Rt. 68 South, West Liberty, OH 43357 P937-599-1411 F937-599-4128

Section III

Reason for Disclosure* ____ Proof of Care ____Transfer of Care ____ Continuity of Care
____ Other:

Health information to be disclosed*

Specify time period, if desired:
Release only information from the period _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*

Section IV

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been take in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.

Expiration Date or Event _____ *(mm/dd/yyyy)*

* I understand that I may not be denied treatment, payment, and enrollment in the health plan, or eligibility for benefits for refusing to authorize disclosure unless such denial is permitted under state and federal law.
* I understand that information disclosed by this authorization, except as prohibited by 42 CFR Part 2 or other applicable law, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Park 164).

Signature of individual*	**Date*** *(mm/dd/yyyy)*
Signature of Personal Representative (If applicable) * *(identify relationship to individual below)*	**Date*** *(mm/dd/yyyy)*

Relationship to Personal Representative to Individual *(Personal representative shall submit proof of authority to the disclosing entity)*
[ ]Parent [ ]Legal Guardian [ ]Healthcare Power of Attorney [ ]Executor/Administrator [ ]Other [ ]N/A

For administrative use only:

*Completed by:	*Needs completed?	*Delivery method:	*Date Released
	[ ]YES [ ]NO	Paper Fax Portal Other:	

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FORM B – CONSENT FOR RELEASE OF PART 2 PROGRAM (SUBSTANCE USE DISORDER PROVIDER) INFORMATION

A Part 2 Program is a federally assisted: (i) individual or entity other than a general medical facility who holds itself out as providing, and provides, substance use disorder (SUD) diagnosis, treatment, or referral for treatment; (ii) an identified unit within a general medical facility that holds itself out as proving, and provides, SUD diagnosis, treatment, or referral for treatment; or, (iii) medical personnel or staff in a general medical facility whose primary function is provision of SUD diagnosis, treatment, or referral for treatment, and who are identified as such providers.

Section I

First and Last Name*: **Date of Birth*:** **SSN:**
Address:

I hereby authorize the disclosure of health information about the above individual as follows.

Section II

Disclosing Entity* *(Name of Holder of Part 2 Program Information)*		**Telephone Number**	
Address	**City**	**State**	**Zip Code**

The information is to be provided to the following*:

[ ] Named Individual:
[ ] Named Third Party Payer:
[ ] Named Treatment Provider Entity:
[ ] Named Non-Treatment Provider (such as an intermediary or research entity)*
* If non-treatment provider is selected, complete a, b, and/or c below.

a. Named Individual Participant(s):
b. Named Treatment Provider Entity Participant(s):
c. Description of Group or Class of Treatment Provider Entity Participant(s):

Contact Information *(e.g. telephone number, email address, fax number, street address, etc.)* Phone: 937-599-1411
Community Health & Wellness Partners, 4879 US Rt. 68 South, West Liberty, OH 43357 Fax: 937-599-4128

Section III

Reason for Disclosure*	**Health Information to be disclosed*:**

Specify time period, if desired:
Release only information from the period *(mm/dd/yyyy)* to *(mm/dd/yyyy)*

Section IV

This authorization will remain in effect until revoked or shall expire on date or event specified below. I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this authorization will expire in one year.

Expiration Date or Event *(mm/dd/yyyy)*

* Substance use disorder records of Part 2 programs disclosed pursuant to this Consent are protected by federal regulations and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations. Any information disclosed pursuant to the Consent other than substance use disorder records or records protected under another state law may be subject to re-disclosure by the recipient.
* I might be denied services if I refuse to authorize disclosure of information for purposes of assessment, treatment, or payment relating to substance use disorder if refusal is permitted by state law. My refusal to authorize disclosure of information for other purposes will not affect my ability to obtain treatment or services.
* If I have authorized disclosure to a generally described group or class or participants in an entity which is not my treatment provider, upon my written request, I must be provided a list of entities to which my information has been disclosed pursuant to that general designation.

Signature of Individual*	**Date*** *(mm/dd/yyyy)*
Signature of Personal Representative (if applicable)* *(identify relationship to individual below)*	**Date*** *(mm/dd/yyyy)*

Relationship of Personal Representative to Individual *(Personal representative shall submit proof of authority to the disclosing entity)*
[ ] Parent [ ] Legal Guardian [ ] Healthcare Power of Attorney [ ] Executor/Administrator [ ] Other [ ] N/A

For administrative use only:

*Completed by:	*Needs completed? YES NO	*Delivery method: Paper Fax Portal Other:	*Date Released