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)

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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 Assisted Treatment

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 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: White_____ Black/African American_____ American Indian/Alaska Native _____

Native Hawaiian _____ Other Pacific _____ Guamanian or Chamorro_____ Samoan_____

Asian Indian_____ Chinese_____ Filipino_____ Japanese_____ Korean_____ Vietnamese_____

Other Asian_____ More than one race_____ Other (Please Specify)_____

Refuse to answer_____

Ethnicity: Not Hispanic, Latino/a, or Spanish origin_____ Mexican, Mexican American, Chicano/a_____

Puerto Rican_____ Cuban_____ Another Hispanic, Latino/a, or Spanish origin____

Refuse to answer_____

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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__Guardian____ 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._____

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Health History

Date:_____

Name:_____ Date of Birth:_____

Pharmacy_____

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

	AIDS/HIV
	Alcoholism
	Anemia
	Osteoarthritis of:
	Asthma
	Birth Defects
	Bleeding Disorder: (type if known):
	Cancer of:
	COPD
	Dementia: (type if known):
	Diabetes: Type 1 or Type 2

	Environmental allergies to:
	Epilepsy/Seizures
	Glaucoma
	Heart Disease
	Hyper cholesterol
	Hypertension
	Thyroid: Hyper or Hydro
	Gestational Diabetes
	Kidney Disease
	Liver Disorder
	Migraine
	Stroke

	TIA
	Tuberculosis
	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 all medication, food, andhealth-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? Yes____No____

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? Yes____No _____

Any complications during pregnancy? _____

Last PAP Smear:_____where performed? _____

Last Mammogram:_____where performed? _____

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

I authorize the release of information to my insurance payor and other health care providers in accordance with Health Insurance Portability and Accountability Act (HIPAA) CFR 42 Part 2.

I authorize the release of information to Medicare and authorize Community Health and Wellness Partners 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 am responsible for all health center services offered including but not limited to Primary Care, Behavioral Health, Medication Assisted Treatment, Nutrition Counseling, and Pharmacy Services.

Services may be provided by Telehealth, including Video and Phone. If my services are provided by Telehealth, including Video and Phone, I will be responsible for the charges incurred.

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 when my charges are covered.

I hereby assign, transfer, and set over to Community Health and Wellness Partners 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*

_____ *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 fundraising or marketing efforts. If you do not want to participate in fundraising or marketing efforts, please check off the following box.

Please exclude me from any ☐ Fundraising 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 for 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 the 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 and 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 the boxes and write in the name(s).

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

_____ *Initials*

Communication by e-mail or Text

I hereby authorize Community Health and Wellness Partners ("Provider") and other medical professionals or staff members that the Provider has designated to communicate with me, and the Caregivers identified above, if any, about my medical conditions and treatment using unencrypted text messages, if I have provided a mobile phone number, and/or unencrypted e-mail, if I have provided an e-mail address, including those that may be considered marketing messages (e.g. flu shot reminders, etc.). I acknowledge that text messages are inherently unsecure and may be able to be accessed by third parties.

_____ *Initials*

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

Preferred method for appointment reminder (Check all that apply):

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

Preferred time for reminder 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

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

School-Based Health Centers
West Liberty-Salem Benjamin Logan Indian Lake Riverside

Phone: 937-599-1411 • Fax: 937-599-4128 • CHWPcares.org

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Sliding Fee Opportunity

Must be completed prior to service.

All patients seeking services are assured they will be served regardless of their ability to pay. No one is refused service because of a lack of financial means to pay so long as they complete and are found eligible in the application process.

Please sign to either request or decline the Sliding Fee Opportunity:

REQUEST

I am requesting to apply for discounted services that are available to patients, family members, or others who are experiencing a financial hardship. Discounts are offered based on family income and size. Our services include Family Medicine and Behavioral Health. Information and forms can be obtained by signing below to receive this information.

REQUEST

_____
Patient Printed Name

_____
Patient Signature

_____
Date

DECLINE

I choose not to apply for CHWP's Sliding Fee opportunity at this time. I decline my right to apply for the Sliding Fee Discount. I understand I will be responsible for all charges at the time of service. I am aware that if my financial circumstances change, I am not prohibited in the future from applying for the Sliding Fee Program.

DECLINE

_____
Patient Printed Name

_____
Patient Signature

_____
Date

Please determine the number of people in your household and check your yearly income range. This information is for generalized reporting regarding the health center.

NO FINANCIAL 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+

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Phone: 937-599-1411
Fax: 937-599-4128
Email: documents@chwplc.org

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ Patient Date of Birth:_____

Name of Person completing Form: _____

Relationship to Patient: _____

I, authorize Community Health & Wellness Partners (CHWP) to request, use, and/or disclose Protected Health Information as indicated below.

☐ Exchange Information With ☐ Request Information From ☐ Send Information To

Name of the party requesting or receiving information:
Address:
City/State/Zip:
Phone/Fax:
Email Address:

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I understand that my records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance on it. In order to revoke the Authorization for Release of Information, I will contact the Community Health and Wellness Partners' Health Information Management Department.

This Authorization will remain in effect for one year after I sign and date this form unless I specify an EARLIER expiration date in the space provided. Early Expiration Date:_____

Notice: This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such information by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 C.F. R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

(These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.)

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Amount of Information to be Disclosed:

☐ Information covering all dates of service (past, present, future)
☐ Information covering the following specified date range: _____(mm/dd/yyyy) to _____(mm/dd/yyyy)
☐ Other (specify the date of treatment or admission/discharge): Date:
_____

The purpose/need of this request is:

_____
_____

The following ***INITIALED*** information may be provided by mail, fax, in person, verbally, or by secure email:

_____All of my Physical Health Information contained in the description boxes below:

_____All of my Mental Health Information contained in the description boxes below:

_____All of my Substance Use Information contained in the description boxes below:

INITIAL **beside the information to be shared/requested**

_____ Assessment Information/ Results	_____ Progress Notes/Clinical Notes
_____ Care Plan/Review	_____ Laboratory Results/Drug Screen Results
_____ Treatment Recommendation	_____ Medication History
_____ Transfer/Discharge Summary	_____ Hepatitis C Results
_____ Financial Information	_____ HIV Results or AIDS/ARC Diagnosis Information
_____ Psychiatric Evaluation	_____ CHWP Scheduled Appointment
_____ Treatment Diagnosis	_____ CHWP Attended Appointment
_____ Treatment Progress	_____ Other: _____

_____ _____
Patient Name **Patient Date of Birth**

_____ _____
Signature of the Patient **Date of Patient Signature**

_____ _____
Print Name of the Person Authorized to Sign for the Patient **Describe Authority to Sign for Patient**

_____ _____
Signature of the Person Authorized to Sign for the Patient **Date of Signature**

For administrative use only:

Completed by: _____

Needs Faxed? Yes___ or No___

Preferred Delivery Method Paper__ Fax__ Email __ Other:_____

Date Released: _____