Center Street Community Health Center
136 West Center Street
Marion OH 43302
Phone: 740-751-6380
Fax: 740-382-8291

Medicaid/Medicare/Commercial Insurance Waiver

For NON-COVERED CHARGES

Advance Beneficiary Notice (ABN)

Patient Name: _____ Patient ID #_____

_____ I have been advised by Center Street Community, Morrow Family, and/or Galion Family Health Center that the healthcare procedure(s) and/or service(s) I would like to have done is considered a non-covered procedure(s) and/or service(s) by Medicaid, Medicare, or Commercial Insurance. I have discussed possible treatment options and elected to proceed with this service.

_____I have been made aware that Center Street Community, Morrow Family, and Galion Family Health Centers do offer a sliding fee based on my household income. I understand that I must provide proof of income to be considered for the sliding fee. I understand that the balance after the sliding fee must be paid in full before the procedure(s) and/or service(s) is performed.

This waiver covers all applicable procedure(s) and/or service(s) may not be covered by my Medicaid, Medicare, or Commercial Insurance on this service date: _____ .

_____ _____

Patient Signature Date

_____ _____

Staff Signature Date

Medical History Child

Parent or guardian: Please fill out the following form to help us provide the best possible care for your child.
(Some questions may apply to a child older or younger than yours.)

PLEASE ANSWER THE QUESTIONS THAT APPLY TO YOUR CHILD.

Do you have an Optometrist (Eye Doctor): ___ YES ___ NO
Do you have a Dentist: ___ YES ___ NO
Do you have a Therapist/Counselor: ___ YES ___NO

Patient Information

Patient (Child) Name: _____ Date of Birth: _____ Age: _____
Mother's Name: _____ Father's Name: _____
If Guardian is not mother/father, give name & relationship to child: _____
Who lives with the child? _____ House or apartment? _____ Year Built: _____

Immunizations

Last date of immunizations: _____ Where: _____
Has the child had any reactions to immunizations in the past? YES NO
If yes, please specify: _____
Do you have a record of your child's shot history? YES NO If yes, please bring a copy to your child's next medical visit.

Past History

Has the child received regular medical care until now? YES NO If yes, who was the doctor? _____
Has the child received regular dental care until now? YES NO If yes, who was the dentist?_____
When was the child's last medical check-up? _____ Last dental check-up? _____
If less than 1 year old, do they sit in a rear-facing car seat? YES NO
If 1-4 years old, do they sit in a forward-facing car seat? YES NO If 5-8 years old, do they sit in a booster seat? YES NO
Does the child have personal habits that are a concern? (Thumb sucking, bed wetting, drug use, tobacco use) YES NO
If yes, please specify: _____
Does the child or your family have any religious beliefs that might affect medical care? YES NO
If yes, please specify: _____

Past Medical History – Has the child ever had the following: _____ Patient denies any past illness

	Condition	Dates		Condition	Dates
	Asthma			Depression	
	Allergies-Hay fever			Diabetes	
	Allergies-Other			Epilepsy/Seizures	
	Allergies-Other			Frequent Ear Infections	
	Birth Defects			Frequent Urinary Tract Infections	
	Bleeding Disorder			Kidney Problems	
	Cancer			Migraines	
	Other Diseases			Other Diseases	

Past Surgical History – Has the child ever had the following: _____ Patient denies any past surgeries
Please list all serious illnesses, operations, and other hospitalizations you have experienced and the dates these occurred

	Condition	Dates		Condition	Dates		Condition	Dates
	Appendix			Gallbladder			Hernia Repair	
	Ear Tubes			Tonsils/Adenoids			Other	

Medications – Please list all medications the child is currently taking _____ Patient denies any medications

Current Medications	Dosage (mg)	How often per day

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

Family History – Has any blood relative had any of the following: (Leave blank if uncertain)
Patient denies family history of: _____ Breast Cancer _____ Colon Cancer _____GYN Cancer

Condition	Relationship to you
Cancer Type:	
Diabetes Type:	
Heart Disease	
High Blood Pressure	
High Cholesterol	
Kidney Problem	

Menstrual History

Age of 1st period: _____ # of days between period: _____ Total days on period: _____ Date of last period: _____
Flow: _____ Light _____ Medium _____ Heavy Does child tend to clot: YES NO
Birth Control: YES NO Name of birth control: _____

Pregnancy History

Total number of pregnancies: ____ Full term pregnancies: ____ Premature Births: ____ Multiple births: ____
Terminated Pregnancies: _____ Miscarriages: _____ Ectopic pregnancies: _____ Living: _____

Social History

Tobacco: ___ Never ___Minimal ___YES (____ packs/day x ____ years) ____ QUIT _____ Years ago (____ packs/day x ____ yrs)
Alcohol: ___ Never ___Minimal ___ Less than 10 a week ____ More than 10 a week ____ QUIT _____ Years ago
Recreational Drugs: ___ Never ___Minimal ___ YES (____ packs/day x ____ years) ____ QUIT ____ Years ago (____ packs/day x ____ yrs)

Printed name of person completing this form: _____Relationship to patient: _____

Signature: _____ Date: _____

Medical Reason for Visit

Patient Name: _____

Preferred Provider: _____

Main Reason(s) for today's visit:

1._____

2._____

Check all that apply:

- ○ Sick visit
- ○ ER/Urgent Care Follow-up Last ER/Urgent Care Visit: _____
- ○ Check-up
- ○ Need shots/Vaccines
- ○ Need Prescription Refills If so, which medications? _____

The American Medical Association supports a national health survey that incorporates a representative sample of the U.S. population of all ages (including adolescents) and includes questions on sexual orientation, gender identity, and sexual behavior for the purposes of research into patient health.

Center Street Community Health Center, Morrow Family Health Center, and Galion Family Health Center are asking that all patients answer the following questions. The information is being collected for demographic purposes only and will ***NOT*** affect your care.

Do you think of yourself as:	**What was your sex at birth?**	**What is your current gender identity?**
○ Lesbian, Gay, or Homosexual ○ Straight or Heterosexual ○ Bisexual ○ Something Else ○ Prefer not to answer	○ Male ○ Female	○ Male ○ Female ○ Transgender Male/Female-to-male ○ Transgender Female/Male-to-Female ○ Other; please specify_____ ○ Chose not to disclose

TRANSFER OF PRIMARY CARE

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

Patient Address: _____ Social Security Number: _____

_____ Phone Number: _____

- I authorize the use or disclosure of the above-named individual's health information as described below.
- The following individual(s) or organization(s) are authorized to make this disclosure:

Name of Individual/Organization: _____

This information for which I am authorizing disclosure will be used for the following purpose:
TRANSFER OF PRIMARY MEDICAL CARE

I hereby request a copy of the information below to be forwarded to:

Center Street Community Health Center
136 West Center Street
Marion, Ohio 43302
Phone: 740-751-6380 Fax: 740-382-8291

Please check **ALL** appropriate boxes for what will be disclosed:

□ ENTIRE RECORD	□ Operative Reports	□ Discharge Summary
□ Immunization Record	□ ER Records	□ Pathology Reports
□ H & P	□ Medication List	□ Consults
□ Progress Notes	□ Discharge Instructions	□ Lab Results
□ Home Care Reports	□ Radiology Reports	□EKG/Cardiology Reports
□ Mental Health Information*	□ Substance Abuse Information*	□STD Related Information*
□HIV/AIDS Related Information*/**	□ Other (please specify) _____	

Signature of Patient/Guardian: _____ Date: _____

*I understand that if my authorization includes Mental Health, Substance Abuse, STD, or HIV/AIDS related information, it may include information concerning physical or mental illness, alcohol and/or drug dependence/abuse, Sexually Transmitted Diseases (STD), Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency (AIDS) test results, and/or HIV/AIDS related conditions.

**I understand that my authorization includes records covered by 42 CFR Part 2, or that concern HIV/AIDS related information. This information has been disclosed to you from records protected by State and/or Federal Confidentiality Rules (ORC 3701.243 and 42 CFR Part 2). These rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature of Practice Representative: _____ Date: _____

A copy of this authorization form has been included with the copy of the medical record(s).

Basic Demographics Patient Information

Demographical Information

Name: (Last) _____ (First) _____ (MI) ____ Date of Birth: _____

Social Security Number: _____ Gender: (Circle One) Male Female

Address: _____ City: _____ State: ____ Zip: _____ County: _____

Phone Numbers: Cell: _____ Can you receive text messages? YES NO Home: _____

Work: _____ Message Phone: _____ Email Address: _____

Preferred way of communication: (Circle One) Cell Phone Home Phone Work Phone Message Phone Email

Do we have permission to contact you and leave messages on your preferred communication method? Yes No

Marital Status: (Circle One)
-Single -Married -Separated -Divorced -Widowed
Race: (Circle One)
-Asian -African Am./Black -Caucasian/White
-Am. Indian/Alaska Native -Native Hawaiian/Other Pac. Islander -Other
Ethnicity: (Circle One)
-Hispanic or Latino -Not Hispanic or Latino
Veteran Status: (Circle One)
-Veteran -Non-Veteran -Unknown

Pharmacy Information

We offer a prescription discount with both Kroger locations in Marion, Wal-Mart in Marion, and Kroger in Mt. Gilead

Pharmacy: _____ Location: _____

Legally Responsible Parent or Guardian Information (If applicable)

Name: (Last) _____ (First) _____ (MI) ____ Date of Birth: _____

Social Security Number: _____ Gender: (Circle One) Male Female

Relationship to patient: _____ Legal custodian: YES NO Residential parent: YES NO

Insurance Information

Insurance Company Name: _____ Policy Holder's Name: _____

Patient's Relationship to Policy Holder: _____ Policy Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____ Policy Holder's Phone Number: _____

Emergency Contacts

Name: _____ Relationship: _____ Contact Number: _____

Name: _____ Relationship: _____ Contact Number: _____

We offer the following services and care at the listed locations:

Marion: Primary Medical, Dental, Counseling, Optical, Chiropractic services

Mount Gilead: Primary Medical, Dental, Counseling

Galion: Primary Medical, Dental, Counseling

Medical Release HIPAA Authorization

Name: (Last)_____ (First)_____ (MI) ____ Date of Birth: _____

Printed Name of Parent or Legal Guardian (If applicable): _____

Health Insurance Portability and Accountability Act (HIPAA) Authorization

I authorize **Center Street Community Health Center (CSCHC), Morrow Family Health Center (MFHC), and Galion Family Health Center** (GFHC) to use and disclose my following **Protected Health Information (PHI)** listed below for the purposes listed elsewhere on the page.

List individuals you would allow us to share medical information with if necessary.

Name of entity or person	Relationship to patient	Telephone Number

Upon supplying proof of identity by showing acceptable form of photo identification, the above listed person(s) may have access to my: medications, prescriptions, documentation in sealed envelope, appointment time, and any life-threatening, emergency information.

This Protected Health Information (PHI) is being given or disclosed for the following purpose(s): Continuity of Care

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at Center Street Community Health Center Corporate office. I understand that revocation is not effective to the extent that my provider has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use or disclosure requested under this authorization may result in direct or indirect remuneration to the provider from a third party.

If the disclosure concerns a patient in an alcohol or drug abuse program, the following notice shall accompany the disclosure: This information has been disclosed to you from our records protected by federal confidentiality rules (442CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I SPECIFICALLY AUTHORIZE THE DISCLOSURE TO & RELEASE FROM THE ABOVE NOTED AGENCIES REGARDING THE INFORMATION BELOW:

___ Mental Health Information- current diagnosis & medication list ___ Substance abuse (including alcohol/drug abuse)

___ STD related information (STD testing) ___ HIV related information (AIDS related testing)

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If you do not agree to these terms, we will be unable to serve as your provider.

Medical Treatment Consent

Name: (Last)_____ (First)_____ (MI) _____ Date of Birth: _____

Printed Name of Parent or Legal Guardian (If applicable): _____

Treatment Consent

I understand that treatment provided to me by any medical, dental, nursing students, LISW, or PsyD staff will be properly supervised by a licensed practitioner. I am giving permission for any exams, tests, or other services that the provider believes are needed. **Center Street Community Health Center (CSCHC), Morrow Family Health Center (MFHC), and Galion Family Health Center (GFHC)** will make sure that all staff that require licensure by the State of Ohio have the proper credentials. I understand and agree that I will participate in the planning of my care, treatment, and/or services. I understand that I may stop care, treatment, and/or services at any time. I also understand that there are no guarantees that treatment will be successful.

CSCHC, MFHC, and GFHC have the right to treat me without consent only in three situations:

1) Emergencies 2) When non-verbal communications show implied consent 3) When legally bound to treat.

Signature: _____ Date: _____

HIE Notice Language

I understand that **Center Street Community Health Center and Morrow Family Health Center, and Galion Family Health Center** participate in one or more Health Information Exchanges. My healthcare providers can use this electronic network to securely provide access to my health records for a better picture of my health needs. They, and other healthcare providers, may allow access to my health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. I understand that I may opt-out at any time by notifying the Health Information Management Services/Medical Records Department OR the office administrator.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If you do not agree to these terms, we will be unable to serve as your provider.

Able to Bring Child/Ward to Appointment Consent

Name: (Last)_____ (First)_____ (MI) ____ Date of Birth: _____

Printed Name of Parent or Legal Guardian (If applicable): _____

I give consent to the following representative(s) to bring my child/ward to his/her visits:

Representative Name	Relationship to patient	Telephone Number

I understand that I should not sign this consent form if there is any information that may be in my child's/ward's healthcare record that I do not want the representative(s) to know.

I understand during my child's/ward's visit that all personal health information within the child's/ward's healthcare record may be discussed with the representative. A follow up visit will be made if my child/ward has a healthcare condition by history or exam that warrants a follow up appointment. The provider may request a parent/guardian be present at the follow-up visit. The provider may choose to not complete a physical form until the healthcare issues are addressed at the follow-up visit with the child/ward and the parent/guardian present if the healthcare condition warrants a follow up appointment. The provider may decide not to perform immunizations, tests, or procedures during the visit if the provider does not feel the representative is able to give enough healthcare history to provide the best care for my child/ward. Pregnancy care and sexually transmitted diseases may be treated during the visit without parental or representative consent as designated by state law. I further understand that confidentiality between the minor and Center Street Community Health Center, Morrow Family Health Center, and Galion Family Health Center professionals will be ensured in specific areas designated by law and will not be discussed with the parent/guardian unless the minor agrees or is determined to be a threat to themselves or another person.

By signing this consent form, I give my consent to the representative(s) listed above to sign for any necessary care for my child/ward upon recommendation of the provider. I further authorize Center Street Community Health Center and all satellite locations to release information regarding my child's/ward's treatment to the third-party payor or others for purposes of billing, program management, and evaluation in accordance with federal and state laws and regulations regarding confidentiality, and my insurance carrier or medical assistance to be billed for services received.

I give permission to all representative(s) listed to bring my child/ward for any services rendered at the following locations:

Center Street Community Health Center:
___ Medical
___ Dental
___ Behavioral Health
___ Optical

Morrow Family Health Center:
___ Medical
___ Dental
___ Behavioral Health

Galion Family Health Center:
___ Medical
___ Dental
___ Behavioral Health

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

We will be unable to serve as your provider if you do not agree to the terms within this consent form.

Basic Demographics Privacy Practices, and Rights and Responsibility

Name: (Last)_____ (First)_____ (MI) _____ Date of Birth: _____

Printed Name of Parent or Legal Guardian (If applicable): _____

Notice of Privacy Practices Acknowledgement

I understand that under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA)**, I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.

*Obtain payment from third-party payers.

*Conduct normal healthcare operations such as quality assessments and physicians' certifications.

I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I received a copy of your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my PHI. I have read the document and understand the information.

Notice of Rights and Responsibilities Acknowledgement

I understand that this organization has the right to change its NOTICE OF RIGHTS AND RESPONSIBILITIES from time to time and that I may contact this organization at any time to obtain a current copy of the NOTICE OF RIGHTS AND RESPONSIBILITIES. I received a copy of your NOTICE OF RIGHTS AND RESPONSIBILITIES containing a more complete description of the guidelines of rights and responsibilities I have while a patient. I have read the document and understand the information.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If you do not agree to these terms, we will be unable to serve as your provider.

Basic Demographics — Self-Declaration of Income

Name: (Last)_____ (First)_____ (MI) _____ Date of Birth: _____

Printed Name of Parent or Legal Guardian (If applicable): _____

Are you eligible for a DISCOUNT?

Lower your healthcare costs with us!

How many people are in your household: _____

(Number of people you are financially responsible for in your home or number of people you claim on your taxes.)

How much is your TOTAL household monthly income?

(Please circle an amount closest to your monthly income)

0	500	1000	1500
2000	2500	3000	3500
4000	4500	5000	Other: _____

If we find you eligible for any discount or assistance program we offer,

verification of all income must be on file before any benefit could begin.

Basic Demographics — Community Survey

How did you hear about us? Please circle all those that apply:

Facebook Billboard Website Radio Newspaper Pamphlet Friend/Relative

Other: (Please Specify) _____

What do you like about us? Please circle all those that apply:

Staff Cleanliness Location Speed Atmosphere Cost

Other: _____

How did you arrive at your appointment today? Please circle one of the following:

Drove own vehicle Friend/Relative Bus/cab Walk

Do you have any suggestions to improve your visit with us?

_____

_____

Thank you for taking the time to complete our survey. Your input is greatly appreciated.