BUCKEYE FAMILY HEALTHCARE

3477 Commerce Parkway, Suite A, Wooster, Ohio 44691 P: 330-601-0999 F: 330-601-0935

New Patient:

Thank you for choosing Buckeye Healthcare for your healthcare needs.

We welcome you, and would like to take this opportunity to provide information about what you can expect prior to and during your visit.

The appointment time given to you is actually 10 minutes prior to your actual appointment. This allows ample time to complete the check-in process. **Please bring your COMPLETED paperwork, insurance card and photo ID to your first appointment.**
NOTE: If you do not have your New Patient paperwork completed at the time of your appointment, we may have no choice but to reschedule you for a different time/date.

We ask that you bring all medications in their actual bottles (this includes all vitamins and supplements) that are taken daily.

If you have health insurance, please bring your insurance cards so we can make copies of them. This is necessary so that we may properly file your claims with your insurance company.

If you do not have health insurance, we ask that you come prepared to make a minimum payment of **$50.00** toward your first appointment with us. Be sure to ask the receptionist about our self-pay discount options.

Co-payments will be collected before services are rendered. For your convenience, cash, personal checks and credit cards (Visa/MasterCard) are accepted. We also accept CareCredit.

Please note that missed appointments may be subject to a $35.00 fee. Please notify our office 24 hours prior to your appointment if you need to reschedule or cancel your appointment. This courtesy enables other patients to be seen sooner if appointments are available.
NOTE: Failure to call and cancel an appointment or after 3 no call/no show appointments, your physician may have you discharged from the practice.

We take pride in our mission to provide a commonsense approach to medicine and providing quality care to our patients. We look forward to meeting you at your appointment.

~ The Office Staff of Buckeye Family Healthcare ~

Initials _____

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PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ MI _____

STREET ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (____)_____ WORK PHONE (____)_____

SOCIAL SECURITY # _____ MARITAL STATUS M S D W (circle one)

MALE or FEMALE (circle one) DATE OF BIRTH_____

EMERGENCY CONTACT_____ PHONE (____)_____

NEAREST RELATIVE (not living with you) _____ PHONE (____)_____

DRUG ALLERGIES (if any) _____

EMAIL ADDRESS _____

PRIMARY INSURANCE INFORMATION (person who holds policy)

PLEASE DO NOT COMPLETE IF YOU HAVE YOUR INSURANCE CARD WITH YOU !

INS. CO. NAME _____ ID# _____ GROUP # _____

LAST NAME _____ FIRST NAME _____ MI _____

RELATIONSHIP TO PATIENT _____ HOME PHONE (____)_____

STREET ADDRESS _____ WORK PHONE (____)_____

_____ DATE OF BIRTH _____

CITY _____ MALE or FEMALE (circle one)

STATE_____ ZIP_____ SOCIAL SECURITY # _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Buckeye Family Healthcare to furnish insurance carriers concerning my illness and subsequent treatments/procedures, and to allow insurance carriers to supply any required information to Buckeye Family Healthcare. I hereby assign all payments for medical services rendered for my dependents or myself to be paid directly to my physician(s). I fully understand I am solely responsible for any amount not covered by insurance. I understand that co-payments are due at the time of service and I am responsible for full payment of my bills within 30 days of receipt of my monthly statement.

Patient/Responsible Party signature_____ Date _____

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PATIENT REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF PROTECTED HEALTH INFORMATION

As stated in our Notice of Privacy Practices, you may request that we communicate confidential health information to you by alternate means or in alternate locations. The Privacy Rule requires us to accommodate requests if reasonable.

Please indicate your request regarding our communication of Protected Health Information to you by checking the lines you agree with:

_____ You may call my home phone number with confidential information.

_____ Please do not call my home phone number with confidential information.

_____ Please do not call my work phone number with confidential information.

_____ You may leave messages on my home phone answering machine.

_____ Please do not leave messages on my home phone answering machine.

_____ Please do not send confidential communications to my home address.

_____ Please use this address to send confidential communications (if different than home address):

_____

(indicate addressee name and complete mailing address)

Please list anyone you wish to be able to receive your Protected Health Information:

Spouse _____ Other _____

Relative _____ How related _____

Relative _____ How related _____

Power of Attorney _____ How related _____

If you have a Living Will, POA, DNR, etc., it is your responsibility to provide a copy for your file.

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HIPAA AUTHORIZATION

I authorize Buckeye Family Healthcare to use or disclose my protected health information from my health record to specialists, clinics or hospitals. This will be information only pertinent to my current treatment, and will be disclosed only if I need further care by these facilities. This authorization will expire on the day of my death or on the day I terminate my care with Buckeye Family Healthcare, whichever event comes first.

Print name _____ Date _____

Signature _____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, born ____ / ____ / _____, authorize Buckeye Family Healthcare to ____ disclose to, or ____ request from the following person/entity the protected health information described below in accordance with this authorization:

_____ by ____ Mail
Name of previous physician
____ Fax to 330-601-0935

_____ ____ Will pick up on: _____ (date)
Street address
____ Other: _____

_____ _____
City, State, ZIP

.....

PROTECTED HEALTH INFORMATION TO BE DISCLOSED

____ 1. I authorize ALL information in my medical record form to be disclosed according to the terms of this authorization.
____ 2. In addition, please release X-rays of (body part): _____
____ 3. In addition, I authorize the following protected health information to be disclosed according to the terms of this Authorization.

INITIAL ONE OF THE FOLLOWING:

____ I consent to the disclosure of any information pertaining to alcohol abuse, drug abuse, psychiatric condition, any condition related to sexually transmitted disease and/or HIV and AIDS.
____ I DO NOT consent to the disclosure of any information pertaining to alcohol abuse, drug abuse, psychiatric condition, any condition related to sexually transmitted disease and/or HIV and AIDS.

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1. This authorization shall be in full force and effect for sixty (60) days from the date of the signing, at which time this authorization will expire.
2. My permission is extended only for the purposes as stated on this authorization, and I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Buckeye Family Healthcare. I understand that a revocation is not effective to the extent that Buckeye Family Healthcare has relied on the use or disclosure of the presented health information.
3. I understand that I will be responsible for any charges incurred for the copying and/or faxing of my medical record as permitted by law. _____ **(initial)**
4. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
5. Buckeye Family Healthcare will not condition my treatment on whether I provide authorization for the requested use or disclosure.
6. I understand that I have the right to refuse to sign this authorization. I further understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted by law.

_____ _____
Signature of patient or guardian Date

_____ _____
Street address Home phone number

_____ _____
City, State, ZIP Work phone number

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PATIENT PAYMENT POLICY

Buckeye Family Healthcare strives to ensure a clear understanding of your financial responsibility with respect to the medical services we provide. These policies apply to all procedures and departments.

CO-PAYS: We require payment of co-pays at the time of service and reserve the right to refuse treatment.

NO INSURANCE: If you have no health insurance, we offer a price break on all services. The price break is based on the Medicare allowable rate. Payment is due at the time of service unless you have made payment arrangements with our billing office.

PAYMENTS: We accept cash, Visa, MasterCard and the CareCredit card. We also accept payments by check and debit cards. Buckeye Family Healthcare will send patient accounts to collections for balances not paid after receipt of four (4) statements unless you have made payment arrangements with our billing office. We reserve the right to require payment for services to be made at or before the time of service.

OUTSTANDING BALANCES: We may refuse to see patients with balances greater than $250, and who are not making regular payments on the balance. If your account is placed into collections, a collection fee will be added to your account, along with any attorney fees and/or court costs that may be necessary for recovery of the outstanding balance. In the event of a return/NSF check, there will be a $20 NSF charge added to the balance due.

CLAIM FILING: We file your claims with your insurance company as a courtesy. Please keep in mind that payment remains your responsibility. We bill insurance in accordance with all federal, state and other contractual requirements in cases where we have an agreement or we are a participating provider. We expect payment in full from you if your insurance company delays processing of your claim for over 90 days. You agree to pay any portion of the charges not covered by insurance. If your insurance company sends payments directly to you, send or drop-off the payment to Buckeye Family Healthcare and it will be applied to your account.

I have read, understand, and agree with Buckeye Family Healthcare's payment policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility. I acknowledge that these policies do not obligate Buckeye Family Healthcare to extend credit.

I authorize my insurance benefits to be paid directly to Buckeye Family Healthcare.

I authorize Buckeye Family Healthcare to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Patient name (print) _____

Patient signature _____ Date _____

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Patient name _____ Date of birth _____

MEDICAL RECORDS REQUEST FEE

Buckeye Family Healthcare will provide your records to you once you have completed the Patient Authorization for Use/Disclosure of Protected Health Information (PHI) form. The form is attached. Please be sure to sign the form. Unsigned requests cannot be processed.

Your request will be processed and fulfilled within thirty (30) working days. We will either mail or fax the records according to the information you provide on the authorization form. Listed below are charges for copying medical records:

Pages 1-20	$15.00
Pages 21-50	$25.00
Pages 51+	$40.00

FORM AND LETTER FEES

This is to notify you that Buckeye Family Healthcare, the office of Scott A. Hannan, MD, Mark A. Stutzman, DO, and Lisa A. Malys, DO, will apply a fee of $20.00 to your account for patient, companies, family members, insurance carriers or other person(s) requesting from and/or letters to be completed.

Forms include, but are not limited to, FMLA, disability, motor vehicle division, continuation of pay, payment of car loans, payment of mortgages, industrial information, etc. Letters include, but are not limited to, attorneys, insurance companies, employers, schools, airlines, travel agencies, gyms, etc.

To comply with federal laws such as HIPAA, as well as Ohio state and federal statutes, this office must have a signed authorization form from the patient/responsible party stating to whom we are authorized to release information. Attached is the form. Please be sure to sign the form. Unsigned requests cannot be processed.

Patient signature _____ Date _____

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PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT RIGHTS

- ☐ Patients have the right to create Advance Directive which will let providers and others know the person's wishes regarding medical treatment.
- ☐ Patients have the right to assert complaints and grievances about the providers and their health care provided.
- ☐ Patients have the right to be informed about the role of medical students/supervised practitioners and the right to refuse such care.

PATIENT RESPONSIBILITIES

- ☐ To be informed about their insurance plan, including the benefits that are available.
- ☐ To become knowledgeable of the system to access medical care.
- ☐ To keep all scheduled appointments and to notify the provider when unable to keep a scheduled appointment.
- ☐ To be on time for all scheduled appointments.
- ☐ To follow all medically appropriate physician orders and prescriptions.
- ☐ To treat personnel with courtesy and respect.
- ☐ To provide complete health status information for accurate diagnosis and appropriate treatment.
- ☐ To always call your preferred care provider (PCP) before receiving urgent care and, when possible, emergency care.
- ☐ To notify your PCP when you receive emergency care within twenty-four (24) hours or as soon as possible.

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Patient name _____ Date of birth _____

Preferred pharmacy _____

MEDICAL HISTORY

Please mark if you now have, or ever had, any of the medical problems listed below:

- ☐ Adrenal disorder
- ☐ AIDS/HIV
- ☐ Alcohol abuse
- ☐ Allergies (seasonal/hay fever)
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Back problems
- ☐ Bone fractures
- ☐ Bladder/UTI
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Blood transfusion
- ☐ Breast cancer
- ☐ Breast lump or cyst
- ☐ Cancer
- ☐ Carpal tunnel syndrome
- ☐ Cataracts
- ☐ Chronic bronchitis
- ☐ Diabetes
- ☐ Drug abuse
- ☐ Emotional problems (anxiety/depression)
- ☐ Emphysema (COPD)
- ☐ Gallstones
- ☐ Gastrointestinal problems
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Headaches/migraines
- ☐ Hearing problems
- ☐ Heart disease
- ☐ Heart failure
- ☐ Hepatitis A / B / C
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ High or low calcium
- ☐ High triglycerides
- ☐ Hives
- ☐ Hormone deficiency
- ☐ Hypoglycemia
- ☐ Infections - recurrent
- ☐ Irritable bowel syndrome
- ☐ Kidney disease
- ☐ Kidney failure
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Lupus
- ☐ Murmur (heart)
- ☐ Neuropathy (nerve damage)
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Parathyroid
- ☐ Pituitary disorder
- ☐ Pneumonia
- ☐ Polycystic ovary
- ☐ Reflux (GERD)
- ☐ Rheumatoid arthritis
- ☐ Seizures
- ☐ Skin cancer
- ☐ Stroke
- ☐ Thyroid cancer
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Valve problems (heart)
- ☐ Vascular disease
- ☐ Vision problems
- ☐ Vitamin deficiency

Other medical problems or details for above: _____

_____

_____

_____

_____

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HOSPITALIZATIONS AND SURGERIES

Please include approximate dates:

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY

Tobacco ☐ current smoker ☐ former smoker ☐ never smoked

Alcohol ☐ yes ☐ no Type/amount _____

Illegal drugs ☐ yes ☐ no

Exercise ☐ yes ☐ no Type _____ Frequency_____

FAMILY HISTORY

Please indicate which family members (e.g. grandfather, mother, brother, etc.) have/had the following:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anesthesia - complications
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disorders (e.g. Lupus, RA)
- ☐ Birth defects
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Blood transfusions
- ☐ Bowel disease
- ☐ Breast cancer
- ☐ Cervical cancer
- ☐ Colon cancer
- ☐ Cancer - other
- ☐ Depression
- ☐ Heart attacks (indicate age at time)
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hormone problems
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Melanoma
- ☐ Mental disorders
- ☐ Osteoporosis
- ☐ Ovarian cancer
- ☐ Parkinson's disease
- ☐ Psychiatric care
- ☐ Respiratory disease
- ☐ Seizures/epilepsy
- ☐ Severe allergies
- ☐ Skin cancer
- ☐ STD
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid disease
- ☐ Ulcer disease
- ☐ Uterine cancer

Other conditions or details for above: _____

_____

_____

_____

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ALLERGIES

Agent	Reaction	Severity (mild, moderate, severe)

CURRENT MEDICATIONS

Please include prescriptions, over-the-counter medicine, and vitamin/supplements:
