BUCKEYE FAMILY HEALTHCARE
3477 Commerce Parkway Suite A, Wooster, OH 44691
Ph: 330-601-0999 Fax: 330-601-0995

Dear New Patient,

Thank you for choosing Buckeye Family Healthcare. Our goal is to provide the highest quality care for all of our patients.

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

Your new patient paperwork needs to be completed before you can be seen in the office.

The appointment time given to you is actually 10 minutes prior to the start of your appointment. This allows ample time to complete the check-in process. Please bring your insurance card, photo ID and co-payment if applicable to your first appointment. 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 discounts.

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

We ask that you bring all medication in the prescription bottles (this includes all vitamins and supplements) that are taken daily.

Please note that missed appointments are subject to a $35.00 no show fee. Please notify our office 24 hours prior to your appointment if you need to reschedule or cancel your appointment.

We look forward to meeting you at your appointment!

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PATIENT PAYMENT POLICY

BILLING: Our billing company, National Revenue Consulting (NRC) is located off site. NRC will file all claims with your insurance company. The payment balance remains the patient's responsibility. If your insurance changes, it is your responsibility to contact our office or our billing company. We bill insurance in accordance with all federal, state and other contractual requirements. 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.

CO-PAYMENT: All co-pays and past due balances are expected at the time of service, unless a prior agreement has been made with our billing department. If you have any questions about coverage you can contact them directly at 330-946-5807.

OUTSTANDING BALANCE/COLLECTIONS: We may refuse to see any patient with an account balance 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 $35 NSF charge added to the balance due.

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 copayments and deductibles, are my responsibility. I acknowledge that these policies do not obligate Buckeye Family Healthcare to extend credit.

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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MEDICATION REFILL POLICY: If you are on a medication that requires refills for a chronic disease (for example, high blood pressure or diabetes), you will be given refills during your office visit. We ask that you allow 24 - 48 hours for refills to be completed. Please call your pharmacy first before calling into the office. If there is a problem refilling your prescription, a nursing staff member will contact you. To receive refills for chronic medications, you must be seen at least once per 365 days.

New medications (including antibiotics) will NOT be called in over the phone. This is an interruption to our physicians while they are caring for scheduled patients. Please schedule an appointment for further evaluation by your physician for new medications.

MEDICAL RECORDS REQUEST POLICY: Buckeye Family Healthcare will provide records to you once you have completed the Patient Authorization/ Disclosure of Protected Health Information (PHI) form. Your will be processed and fulfilled within 30 business days. We can mail or fax the records according to the information you provide. Your first copy is free. A fee will apply to any additional record requests. Charges for additional copies: Pages 1-20 $15.00. Page 21- 50 $25.00 and Pages 51+ $40.00.

MEDICAL FORMS: Buckeye Family Healthcare will apply afee of $20.00 to your account for any letters or requests for the physician to complete outside a scheduled office visit. Forms include, but are not limited to: FMLA, disability, motor vehicle division, letters to travel agencies, geyms, employers, attorneys, etc. We ask that you allow 3 business days for completion. If you need them the same day, an additional fee will be collected, and the total will be $35.00. All fees must be paid in advance, no exception for same day service.

HIPAA COMPLIANCE/PATIENT PRIVACY POLICY: To comply with federal laws such as HIPAA, this office MUST have signed authorization form for each patient or responsible party stating to whom we are authorized to release Protected Health Information (PHI) each calendar year. There is a form located in your new patient packet and can be obtained from the receptionist.

AFTER HOURS POLICY: In case of a MEDICAL EMERGENCY, you can reach your physician after hours by contacting Wooster Community Hospital Physician's Registry at 330-263-8500. Please call the office during normal business hours for routine questions, refills or other concerns.

LAB SERVICES: We are pleased to announce the opening of our new moderate complexity lab, we run the majority of our tests in house, but high complexity tests are sent to LabCorp.

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PATIENT DEMOGRAPHICS

First Name: _____ Last Name: _____

Date of Birth: _____ Social Security: _____

Gender: _____ Ethnicity: _____

Primary Phone Number:
_____

Secondary Phone Number:
_____

Contact Method: EMR Portal _____ Email _____ Text_____ Phone _____

Email Address:
_____

Address:
_____

City: _____ State: _____ Zip Code: _____

Emergency Contact Name:_____ Phone number: _____

Primary Insurance:
_____

Plan Name:
_____

Member ID Number: _____Group Number: _____

Policy Holder's Name: _____ DOB: _____

Policy Holder's Relationship: _____

Local
Pharmacy:_____

Mail Order Pharmacy: _____

BUCKEYE FAMILY HEALTHCARE
Mark Stutzman, DO, Lisa Malys, DO, Hannah Miedel, MD, Rachel Edgar, CNP
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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:

_____
Name of physician

_____
Street Address

_____
City, State, Zip

_____ Mail
_____ Fax
_____ Pick up
_____ Other :

PROTECTED HEALTH INFORMATION TO BE DISCLOSED

_____ 1. I authorize ALL information in my medical record 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 of the follow:

_____ I consent to the disclosure of my information pertaining to alcohol abuse, drug abuse, psychiatric condition, any condition related to sexually transmitted diseases and/or HIV and AIDS.

_____ I DO NOT consent to the disclosure of my information pertaining to alcohol abuse, drug abuse, psychiatric condition, any condition related to sexually transmitted diseases 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 signature, 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.
4. 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.

Print Name _____ DOB_____

Signature _____ Date_____

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HIPAA RELEASE FORM

Patient request to receive confidential communication of protected health information

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

_____ I authorize the release of my Protected Health Information including, diagnosis, imaging, lab results, records; examination rendered to me and claim information to myself and the following people.

Please provide phone numbers and emergency contact

_____ Spouse _____

_____ Sibling(s) _____

_____ Child(ren) _____

_____ Healthcare POA _____

_____ Other _____

_____ Medical Information is **NOT** to be released to anyone.

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

This Release of Information will remain in effect until terminated by me in writing.
Initial _____

Messages: _____ No Messages _____ Yes- leave detailed message _____ Return call only

I authorize Buckeye Family Healthcare to use or disclose my protected health information and 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 facilities. This authorization will expire on the day or my death or on the day I terminate my care with Buckeye Family Healthcare, whichever event comes first.

Print Name _____ **DOB**_____

Signature _____ **Date**_____

BUCKEYE FAMILY HEALTHCARE
Health Questionnaire

NAME:
_____

DOB: _____

Past Medical History

- ☐ Adrenal Disorder
- ☐ AIDS/HIV
- ☐ Alcohol Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Aneurysm (Type:_____)
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Back Pain
- ☐ Bladder/UTI
- ☐ Blood Clots
- ☐ Bleeding Disorder
- ☐ Breast Lump or Cyst
- ☐ Breast Cancer
- ☐ Cancer (Type:_____)
- ☐ Cataracts
- ☐ Carotid Blockages
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Bronchitis
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Emotional Problems (anxiety/depression)
- ☐ Emphysema (COPD)
- ☐ Enlarged Prostate
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gastrointestinal problems
- ☐ Goiter
- ☐ Gout
- ☐ Headaches/migraine
- ☐ Heart Disease
- ☐ Hepatitis A/B/C
- ☐ High or low calcium
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives
- ☐ Hypoglycemia
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Failure
- ☐ Liver Disease
- ☐ Lupus
- ☐ Heart Murmur
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Parathyroid
- ☐ Pituitary Disorder
- ☐ Pneumonia
- ☐ Polycystic Ovarian Syndrome
- ☐ Reflux (GERD)
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Skin Cancer
- ☐ Stroke
- ☐ Thyroid Cancer
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Vascular Disease
- ☐ Vision Problems
- ☐ Vitamin Deficiency
- ☐ Valve Problems (heart)

Other Medical Problems:

_____

_____

_____

_____

_____

_____

_____

_____

Surgeries

Please include approximate dates

_____
_____
_____
_____
_____
_____

Habits

Tobacco Use:
Non-Smoker _____ Current Smoker _____ Former Smoker _____

Illicit Drug:
Yes _____ No_____ History of illicit drug use _____

Sun Exposure:
Minimal _____ Moderate _____ Excessive _____

Seat Belt Use:
All the time _____ Most of the time_____ Never _____

Specific Diet: _____

Routine Exercise: _____

OB History

Total Number of pregnancies: _____

Vaginal Deliveries: _____

Living Children: _____

C-Section: _____

Birth Control Method: _____

Age at first period: _____

Age at menopause: _____

Allergies

Agent	**Reaction**	**Severity**

Medications

Please include all prescription and over the counter medications

Medication Name	**Dosage**	**Frequency per Day**