Sharon Community Health Center

Sharon, PA 16146

Please provide the following information in full and provide us with a Photo ID

Patient Information

Full Legal Name: _____ Nickname/Preference_____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Best Number to reach you during the day: [ ] Home [ ] Work [ ] Cell

Email Address: _____ Printer Access [ ] Yes [ ] No

Sex: [ ] Male [ ] Female Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Race: [ ] Caucasian [ ] African American [ ] Asian [ ] American Indian [ ]Alaska Native [ ] Other

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Asian [ ] Other _____

Are you a Veteran: [ ] Yes [ ] No

Date of Birth: _____ Social Security #: _____Preferred Language _____

Emergency Contact Name: _____Phone: _____

Relationship to Patient: [ ] Spouse [ ] Child [ ] Relative [ ] Significant Other [ ] Other _____

Primary Care Physician (PCP) _____ Phone: _____

Insurance Information

Insurance Company: _____ Primary Subscriber Name: _____

Primary Subscriber's Date of Birth: _____ ID #/Group # _____/_____

If the patient is a minor, the following must be completed

Father's Name: _____ Mother's Name: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Date of Birth: _____ Date of Birth: _____

Sharon Community Health Center offers a Sliding Fee Program for patients that are Self Pay and/or have no insurance. Please inquire at the Front Desk for program information and an application.

Pharmacy Records

Sharon Community Health Center requires your permission to access your pharmacy record. This is not only to confirm our medication records are accurate but also to ensure that there are no contradictions between the medications prescribed by the physician.

Pharmacy Name: _____ Phone Number: _____

Patient Signature: _____ Date: _____

SCHC Witness Signature: _____ Date: _____

Medical History

Do you smoke? [ ] Yes [ ] No – If yes how much per day_____

Have you ever smoked? [ ] Yes [ ] No – If yes how much per day _____

Do you drink? [ ] Yes [ ] No – if yes, what type and how much _____/_____

Are you enrolled in a Medical Marijuana Program? [ ] Yes [ ] No – if yes, how long _____

If yes, please provide your Program card for a copy to be placed in your chart.

Current Medications/Supplements/vitamins:

_____

_____

Surgical History: Please include Year:

_____

_____

Allergies, drug/food/environmental/chemical:

_____

_____

Please check all that applies regarding your personal and family history in the chart below. **If a condition applies to a family member, please write in which family member in which it applies to.**

Condition	**You**	**Family**	**Condition**	**You**	**Family**	**Condition**	**You**	**Family**
Acid Reflux/Gerd			Headache/Migraine			Osteoarthritis		
Alcoholism			Heart Attack			Osteoporosis		
Aneurysm			Hepatitis			Rheu. Arthritis		
Anxiety			High Blood Pressure			Seasonal Allergies		
Asthma			High cholesterol			Seizures		
Blood Clots			Kidney Disease			Sleep Apnea		
Cancer			Kidney Stones			STD/HIV		
Depression			Liver Problems			Stroke		
Emphysema/COPD			Lupus			Substance Abuse		
Gout			Obesity			Thyroid Problems		

Complete the chart below as it relates to screening/prevention:

Screening/Prevention Test	**Year**	**Screening/Prevention Test**	**Year**	**Screening/Prevention Test**	**Year**
Cholesterol Check		Physical Exam		For Women: Bone Density Test	
Colonoscopy		Pneumonia Vaccine		For Women: Mammogram	
Diabetes Check		Tetanus Shot		For Women: Pap Test	
Flu Vaccine		For Men: Prostate Exam			

Please complete the following information if you have or have had any symptoms in the past year:

Body System	Symptoms
Dermatology/Skin (Ex: Eczema, Rash, Irregular Moles, Discolored Skin)	
Head, Ears, Nose Throat (Ex: Ear Ringing, Sinus Issues, Mouth Sores)	
Cardiovascular (Ex: Chest Pain, Heart Problems, Fainting)	
Respiratory (Ex: Wheezing, Shortness of Breath, Snoring)	
Gastrointestinal (Ex: Stomach Pain, Nausea, Vomiting, Constipation)	
Genitourinary (Ex: Kidney/Bladder Infections, Pain with Urination)	
Lymphatic/Hematologic (Ex: Easy Bruising, Easy Bleeding, Swollen Glands)	
Musculoskeletal (Ex: Swollen Joints, Muscle Spasms, Muscle Cramps)	
Endocrine (Ex: Thyroid Problems, Diabetes)	
Psychiatric/Neurological (Ex: Headaches, Dizziness, Tremors, Poor Balance)	
Female/Male specific (Ex: Irregular Periods, Pregnancy/ Prostate Problems)	
Other	

OUR OFFICE POLICIES

Our goal is to provide and maintain a good physician-patient relationship. By informing you in advance of some of our policies, it allows for good communication and enables us to achieve our goal. Please read each section carefully. If you have any questions, please do not hesitate to ask a member of our staff.

HIPAA POLICY:

We are concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. Your health care provider and members of the staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. You may restrict the individuals to which your health care information is released. Please complete the information below as to whom you authorize to receive your health information.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

The following information may be disclosed to the above mentioned name(s). (Please check all that apply):

[ ] All Information [ ] Results Only [ ] Appointment Status

Protected Health Information may be disclosed via [ ] Home Voicemail [ ] Mobile Voicemail [ ] Work Voicemail

PER FEDERAL QUIDELINES, WE ARE REQUIRED TO ASK THE FOLLOWING

Sexual Orientation:	**Gender Identity:**	**Sex at Birth:**
[ ] Straight or Heterosexual	[ ] Male	[ ] Male
[ ] Lesbian, gay or homosexual	[ ] Female	[ ] Female
[ ] Bisexual	[ ] Transgender Male/Female to Male	[] Undefined
[ ] Something Else	[ ] Transgender Female/Male to Female	
[ ] Do Not Know	[ ] Gender Queer	
[ ] Choose not to Disclose	[ ] Choose not to Disclose	

CONSENT TO USE AND DISCLOSURE OF INFORMATION FOR TREATMENT, PAYMENT OR OPERATIONS

I hereby consent to the use and disclosure of information in my medical record for treatment, payment and healthcare operations; I understand that this consent is voluntary. I understand that information in my medical record may be used and disclosed to persons other than Sharon Community Health Center to carry out their responsibility with my medical/health treatment, in payment for healthcare services rendered and in activities related to healthcare. Sharon Community Health Center my decline to provide medical/health care services if I do not sign it.

I understand that additional information on Sharon Community Health Center Privacy Practices related to my medical record is available from the SCHC comprehensive Notice of Privacy Practices; a copy of which has been made available to me, and which I have read or do not wish to read prior to signing this consent.

I understand that I may request that Sharon Community Health Center restrict how or whom my medical records are used or disclosed, but that SCHC may refuse the restriction I request. However, if SCHC agrees to the restriction, it is bound to them when disclosing information in my medical record.

I understand that I can revoke this consent at any time by notifying Sharon Community Health Center in writing, but if I do, it won't have any effect on actions SHCH took before they received notification.

Printed Name of Patient: _____ Date: _____

Signature of Patient/Parent or Legal Guardian: _____

I further understand and agree that I am personally responsible for payment of all services rendered to me. I also understand that if I suspend or terminate my care, any fees for professional services rendered will be immediately due and payable. I agree to pay all balances over 90 days from the original due date. I certify that the information I am providing is correct to the best of my knowledge. I will not hold my Provider or any other staff member responsible for errors or omissions that I may have made in the completion of this form.

I hereby authorize Sharon Community Health Center (and/or whomever may be designated) to administer such examination and treatment as they deem necessary.

I understand the above information and guarantee this form was completed to the best of my knowledge.

Signature of Patient: _____ Date: _____

SCHC Witness: _____ Date: _____

PATIENT CONTRACT

We value the time we have set aside to see and treat you. If you are unable to keep your appointment we would appreciate notice as soon as possible. We do require at least a 2 hour notice for cancelling your appointment. Less than that amount of time will result in you being marked as a no show. If you are late for your appointment (10 minutes), you will be rescheduled.

You agree to abide by any/all treatment plans and medication regimen as prescribed by the Provider.

You agree to be courteous and respectful of other patients and staff.

You agree to complete all diagnostic testing, including a Urine Drug Test when prescribed.

It is your responsibility to keep our office updated with your corrected insurance information. You are responsible for any/all co-payments, deductibles, and co-insurance. Payment is required at the time of service. We accept cash, check, or credit card. If we do not participate in your insurance plan, payment in full is expected from you at the time the service is rendered. Self pay must pay in full at the time of service . Please inquire about our Sliding Fee Program. Charges unpaid for more than 90 days may result in cancellation of all services unless other arrangements have been made. Please call if you have a question about your bill. Most problems can be settled quickly and easily and will prevent any misunderstanding. If you are having trouble paying your bill, please discuss it with us. Payment arrangements can be made with the Office Manager.

I UNDERSTAND THAT I WILL BE DISCHARGED FROM SHARON COMMUNITY HEALTH CENTER FOR THE FOLLOWING REASONS:

***Usage of illicit drugs.**

***Failure to complete laboratory testing, urine drug screenings, treatment plans or appropriate use of prescribed medications.**

***Failure to notify the staff and/or Provider of your enrollment in a Medical Marijuana Program and knowingly accept prescribed medications from the Provider.**

***Verbal abuse of staff, other patients, or any disruptions of Sharon Community Health Center operations.**

***Failure to keep scheduled appointments.**

***Obtaining prescription medications from other/multiple providers (Dr.shopping).**

I also understand that Sharon Community Health Center will **NOT** replace any medications or prescriptions that are lost or stolen due to my negligence. This contract will be a permanent part of my medical record and I may request a copy for my personal use.

Patient Signature: _____ Date: _____

SHCH Witness: _____ Date: _____

CONSENT TO USE AND DISCLOSURE OF INFORMATION FOR TREATMENT, PAYMENT, OR OPERATIONS

I hereby consent to the use and disclosure of information in my medical record for treatment, payment and health care operation purposes. I understand that this consent is voluntary. I understand that information in my medical record may be used and disclosed to persons other than Sharon Community Health Center to carry out their responsibility in connections with my medical/health treatment, in payment for health care services rendered and in activities related to health care operations.

Initials: _____

I understand that additional information on Sharon Community Health Center privacy practices related to my medical records is available from the SCHC comprehensive Notice of Privacy Practices; a copy of which has been made available to me, and which I have read or do not wish to read prior to signing this consent.

Initials: _____

I understand that changes in Sharon Community Health Center privacy practices will result in modifications to the Notice of Privacy Practices and that up to date notices will be available at the reception desk of Sharon Community Health Center @ 94 W. Connelly Blvd., Sharon, PA 16146

Initials: _____

I understand that I may request Sharon Community Health Center restrict how or to whom my medical records are used or disclosed; but SCHC may refuse the restriction I request. However, if SCHC agrees to the restrictions, it is bound to them when disclosing information in my medical records.

Initials: _____

I understand that I can revoke this consent at any time, by notifying Sharon Community Health Center in writing but if I do, it will not have any effect on actions Sharon Community Health Center took before they received notification.

Initials: _____

I understand that this consent applies to the use and disclosure of information for treatment, payment or operation purposes only and that Sharon Community Health Center may decline to provide medical/health care services to me if I do not sign it.

Initials: _____

Patient Signature: _____ Date: _____

Patient/Guardian Signature(if applicable) _____Date: _____

SHARON COMMUNITY HEALTH CENTER

AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

Patient Name: _____

The use of _____ (list medications) may cause addition and is only one part of the treatment for _____ (diagnosis).

The goals of this medication are:

[ ] to improve my ability to work and function at home

[ ] to help my _____(diagnosis) as much as possible without causing dangerous side effects.

I have been told that:

- If I drink alcohol o use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.
- I may get addicted to this medication.
- If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addition.
- If I need to stop this medication, I must do it slowly or I may get very sick.

I agree to the following:

- **I will not drink alcohol, use marijuana or any other illicit drugs.**
- **I am responsible for my medications. I will not share, sell, or trade my medications. I will not take anyone else's medications.**
- **I will not increase my medication until I speak with my provider or nurse.**
- **My medication may not be replaced if it is lost, stolen, or use up sooner than prescribed.**
- **I will keep appointments set up by my provider (e.g. pain management, substance abuse treatment, primary care, mental health).**
- **I agree to give a blood, urine or saliva sample when asked to test for drug use.**
- **I agree to be present if called within 24 hours for a random pill count or urine drug screen**.

Refills

It is my responsible to track my medications. No early or emergency refills will be made. Refills will be made only during regular office hours. No refills on nights, holidays or weekends. I must call at least three (3) working days ahead to ask for a refill of my medicine. **No Exceptions will be Made!** The nurse will inform me when the refill is done.

Pharmacy

I will only use one (1) pharmacy for my medications. My provider may talk with the pharmacist about my medications. The pharmacy I will utilize is _____.

Other Medications

If another provider gives me a controlled substance medication (e.g. dentist, Emergency Room Provider, hospital), I must bring this medication to my provider in the original bottle, even if there are no pills left.

Privacy

While I am taking the medication, my provider may need to contact other providers or family members to get information about my care and/or use of this medication. I will be asked to sign a release at that time.

Termination of Agreement

If I break any of the rules, or if my provider decides that this medication is hurting me more than helping me, this medication may be stopped by my provider in a safe way. Failure to abide by the above rules will result in discharge of services. I have talked about this agreement with my provider and I understand the above rules.

Provider Responsibilities

As your provider, I agree to perform regular checks to see how well the medication is working.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

[ ] This document has been discussed with and signed by the Provider and patient. A copy of this agreement will be given to the patient and a copy will be placed in the patient's chart.