Coordinated Health

Appointment Checklist (please bring the following to your appointment):

1. Completed patient information forms (included in this packet)
2. Insurance Card(s)
3. Driver's License or valid photo ID
4. Claim Information (if auto or worker's compensation injury)
5. Copay/Deductible Payment
6. Primary Care Referral (if applicable)
7. Any applicable imaging studies done in the past year (includes X-rays, MRI's, CT scans, and EMG's)

Patient Guidelines:

Thank you for choosing us as your healthcare provider. It is our mission to provide you with an exceptional patient experience and return you to your activities as quickly and safely as possible. Please help us in our mission to provide high quality, integrated care by adhering to the following policies while in our facility:

1. **Check-in** – Check in at the front desk prior to each appointment. Your copay will be collected prior to your appointment and will make a copy of your insurance card.

2. **Check-out** – All patients must check out after each appointment regardless of if a follow-up appointment is necessary.

3. **Copays** – Your copay is due at the time of your appointment. If you do not have your copay, your appointment will be rescheduled. If you insurance changes during the course of your treatment let us know right away so you do not get billed for any unpaid balances.

4. **Referrals** – If your insurance requires a referral, it is your responsibility to bring it with you. You will be responsible for payment of your office visit if you do not have it.

5. **Appointment Times** – If you are 10-15 minutes late for your appointment time, you may be asked to reschedule your appointment. If you know in advance you will be running late, please call and let us know. Being early is helpful, but it does not mean you will be taken back early.

6. **Monitor Children** – If you do bring children to your appointment, we ask that you supervise them and do not leave them alone in the waiting room.

7. **Cell Phones** – Refrain from using your cell phone during your appointment when you are with physician, clinician or other member of our staff.

8. **Form Fee** – There is a $15 fee for all disability or FMLA forms that need to be completed by a doctor. Allow 5-7 business days for your form to be completed. You will be contacted when they are ready.

Medical Examination Report
FOR COMMERCIAL DRIVER FITNESS DETERMINATION

649-F (6045)

1. DRIVER'S INFORMATION

Driver completes this section

Driver's Name (Last, First, Middle)	Social Security No.	Birthdate M / D / Y	Age	Sex ☐ M ☐ F	New Certification ☐ Recertification ☐ Follow-up ☐	Date of Exam

Address	City, State, Zip Code	Work Tel: ( ) Home Tel: ( )	Driver License No.	License Class ☐ A ☐ C ☐ B ☐ D ☐ Other	State of Issue

2. HEALTH HISTORY

Driver completes this section, but medical examiner is encouraged to discuss with driver.

Yes No

- ☐ ☐ Any illness or injury in the last 5 years?
- ☐ ☐ Head/Brain injuries, disorders or illnesses
- ☐ ☐ Seizures, epilepsy
  - ☐ medication_______________________________
- ☐ ☐ Eye disorders or impaired vision (except corrective lenses)
- ☐ ☐ Ear disorders, loss of hearing or balance
- ☐ ☐ Heart disease or heart attack; other cardiovascular condition
  - ☐ medication_______________________________
- ☐ ☐ Heart surgery (valve replacement/bypass, angioplasty, pacemaker)
- ☐ ☐ High blood pressure ☐ medication___________________
- ☐ ☐ Muscular disease
- ☐ ☐ Shortness of breath

Yes No

- ☐ ☐ Lung disease, emphysema, asthma, chronic bronchitis
- ☐ ☐ Kidney disease, dialysis
- ☐ ☐ Liver disease
- ☐ ☐ Digestive problems
- ☐ ☐ Diabetes or elevated blood sugar controlled by:
  - ☐ diet
  - ☐ pills
  - ☐ insulin
- ☐ ☐ Nervous or psychiatric disorders, e.g., severe depression
- ☐ ☐ medication_____________________
- ☐ ☐ Loss of, or altered consciousness

Yes No

- ☐ ☐ Fainting, dizziness
- ☐ ☐ Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
- ☐ ☐ Stroke or paralysis
- ☐ ☐ Missing or impaired hand, arm, foot, leg, finger, toe
- ☐ ☐ Spinal injury or disease
- ☐ ☐ Chronic low back pain
- ☐ ☐ Regular, frequent alcohol use
- ☐ ☐ Narcotic or habit forming drug use

For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

____

____

____

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate.

Driver's Signature_______________________________________ Date_______________

Medical Examiner's Comments on Health History (The medical examiner must review and discuss with the driver any "yes" answers and potential hazards of medications, including over-the-counter medications, while driving. This discussion must be documented below.)

____

____

____

____

TESTING (Medical Examiner completes Section 3 through 7) Name: Last, First, Middle,

3. VISION

Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70 degrees peripheral in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

INSTRUCTIONS: When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording distance vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious. ***Monocular drivers are not qualified.***

Numerical readings must be provided.

ACUITY	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION
Right Eye	20/	20/	Right Eye °
Left Eye	20/	20/	Left Eye °
Both Eyes	20/	20/	

Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green, and amber colors? ☐ Yes ☐ No

Applicant meets visual acuity requirement only when wearing:
☐ Corrective Lenses

Monocular Vision: ☐ Yes ☐ No

Complete next line only if vision testing is done by an opthalmologist or optometrist

Date of Examination | Name of Ophthalmologist or Optometrist (print) | Tel. No. | License No./ State of Issue | Signature

4. HEARING

Standard: a) Must first perceive forced whispered voice ≥ 5 ft., with or without hearing aid, or b) average hearing loss in better ear ≤ 40 dB

☐ Check if hearing aid used for tests. ☐ Check if hearing aid required to meet standard.

INSTRUCTIONS: To convert audiometric test results from ISO to ANSI, -14 dB from ISO for 500Hz, -10dB for 1,000 Hz, -8.5 dB for 2000 Hz. To average, add the readings for 3 frequencies tested and divide by 3.

Numerical readings must be recorded.

a) Record distance from individual at which forced whispered voice can first be heard.	Right ear \ Feet	Left Ear \ Feet

b) If audiometer is used, record hearing loss in decibels. (acc. to ANSI Z24.5-1951)	Right Ear			Left Ear		
	500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
	Average:			Average:		

5. BLOOD PRESSURE/ PULSE RATE

Numerical readings must be recorded. Medical Examiner should take at least two readings to confirm BP.

Blood Pressure	Systolic	Diastolic

Driver qualified if ≤140/90.

Pulse Rate: ☐ Regular ☐ Irregular

Reading	Category	Expiration Date	Recertification
140-159/90-99	Stage 1	1 year	1 year if ≤140/90. One-time certificate for 3 months if 141-159/91-99.
160-179/100-109	Stage 2	One-time certificate for 3 months.	1 year from date of exam if ≤140/90
≥180/110	Stage 3	6 months from date of exam if ≤140/90	6 months if ≤ 140/90

6. LABORATORY AND OTHER TEST FINDINGS

Numerical readings must be recorded.

URINE SPECIMEN	SP. GR.	PROTEIN	BLOOD	SUGAR

Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Other Testing (Describe and record)

7. PHYSICAL EXAMINATION

Height:__________ (in.) Weight:________ (lbs.)   Name: Last,   First,   Middle,

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen or is readily amenable to treatment. Even if a condition does not disqualify a driver, the medical examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible particularly if the condition, if neglected, could result in more serious illness that might affect driving.

Check YES if there are any abnormalities. Check NO if the body system is normal. Discuss any YES answers in detail in the space below, and indicate whether it would affect the driver's ability to operate a commercial motor vehicle safely. Enter applicable item number before each comment. If organic disease is present, note that it has been compensated for. See *Instructions to the Medical Examiner* for guidance.

BODY SYSTEM	CHECK FOR:	YES*	NO
1. General Appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse.		
2. Eyes	Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos. Ask about retinopathy, cataracts, aphakia, glaucoma, macular degeneration and refer to a specialist if appropriate.		
3. Ears	Scarring of tympanic membrane, occlusion of external canal, perforated eardrums.		
4. Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing.		
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker, implantable defibrillator.		
6. Lungs and chest, not including breast examination	Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rales, impaired respiratory function, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/ or xray of chest.		
7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness.		
8. Vascular System	Abnormal pulse and amplitude, cartoid or arterial bruits, varicose veins.		
9. Genito-urinary System	Hernias.		
10. Extremities- Limb impaired. Driver may be subject to SPE certificate if otherwise qualified.	Loss or impairment of leg, foot, toe, arm, hand, finger, Perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficicent grasp and prehension in upper limb to maintain steering wheel grip. Insufficient mobility and strength in lower limb to operate pedals properly.		
11. Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness.		
12. Neurological	Impaired equilibrium, coordination or speech pattern; asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinki's reflexes, ataxia.		

***COMMENTS:** ____

____

____

____

____

Note certification status here. See Instructions to the Medical Examiner for guidance.

- ☐ Meets standards in 49 CFR 391.41; qualifies for 2 year certificate
- ☐ Does not meet standards
- ☐ Meets standards, but periodic monitoring required due to ____________________.

  Driver qualified only for: ☐3 months ☐6 months ☐1 year ☐ Other

Temporarily disqualified due to (condition or medication):____________________

Return to medical examiner's office for follow up on ____________________

- ☐ Wearing corrective lense
- ☐ Wearing hearing aid
- ☐ Accompanied by a ____________ waiver/ exemption. Driver must present exemption at time of certification.
- ☐ Skill Performance Evaluation (SPE) Certificate
- ☐ Driving within an exempt intracity zone (See 49 CFR 391.62)
- ☐ Qualified by operation of 49 CFR 391.64

Medical Examiner's signature ____________________

Medical Examiner's name ____________________

Address ____________________

Telephone Number ____________________

If meets standards, complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h). (Driver must carry certificate when operating a commercial vehicle.)

Coordinated Health

REVIEW OF SYSTEMS

Patient Name ____ Today's Date _________________

Please answer the following questions to the best of your ability.

		IN THE PAST 6 MONTHS: HAVE YOU HAD?		ARE YOU BEING TREATED BY A DR. FOR?	
	General:				
1.	Any recent unexplained changes in weight?	_____ NO	_____ YES	_____ NO	_____ YES
2.	Any unexplained fevers?	_____ NO	_____ YES	_____ NO	_____ YES
3.	Night sweats?	_____ NO	_____ YES	_____ NO	_____ YES
4.	Any weakness or fatigue?	_____ NO	_____ YES	_____ NO	_____ YES
5.	Loss of appetite?	_____ NO	_____ YES	_____ NO	_____ YES
6.	Any immune deficiencies?	_____ NO	_____ YES	_____ NO	_____ YES
	Musculo-skeletal:				
7.	Any joint pain?	_____ NO	_____ YES	_____ NO	_____ YES
8.	Joint swelling?	_____ NO	_____ YES	_____ NO	_____ YES
9.	Muscle pain?	_____ NO	_____ YES	_____ NO	_____ YES
10.	Muscle cramps?	_____ NO	_____ YES	_____ NO	_____ YES
11.	History of back pain?	_____ NO	_____ YES	_____ NO	_____ YES
	Skin:				
12.	Any rashes?	_____ NO	_____ YES	_____ NO	_____ YES
13.	Changes in skin?	_____ NO	_____ YES	_____ NO	_____ YES
14.	Changes in nails?	_____ NO	_____ YES	_____ NO	_____ YES
15.	Changes in hair (e.g. - dryness)?	_____ NO	_____ YES	_____ NO	_____ YES
	Head:				
16.	Frequent headaches?	_____ NO	_____ YES	_____ NO	_____ YES
	Eyes:				
17.	Any eye pain? (discomfort)	_____ NO	_____ YES	_____ NO	_____ YES
18.	Any double vision?	_____ NO	_____ YES	_____ NO	_____ YES
19.	Any blurred vision?	_____ NO	_____ YES	_____ NO	_____ YES
	Ears, Nose & Throat:				
20.	Any ringing in the ears?	_____ NO	_____ YES	_____ NO	_____ YES
21.	Any ear pain?	_____ NO	_____ YES	_____ NO	_____ YES
22.	Any nasal discharge?	_____ NO	_____ YES	_____ NO	_____ YES
23.	Any nasal bleeding?	_____ NO	_____ YES	_____ NO	_____ YES
24.	Any sinus pain?	_____ NO	_____ YES	_____ NO	_____ YES
25.	Any soreness?	_____ NO	_____ YES	_____ NO	_____ YES
26.	Any hoarseness?	_____ NO	_____ YES	_____ NO	_____ YES
27.	Any difficulty swallowing?	_____ NO	_____ YES	_____ NO	_____ YES
	Respiratory:				
28.	Any chest pain?	_____ NO	_____ YES	_____ NO	_____ YES
29.	Wheezing?	_____ NO	_____ YES	_____ NO	_____ YES
30.	Coughing?	_____ NO	_____ YES	_____ NO	_____ YES
31.	Do you or have you had tuberculosis?	_____ NO	_____ YES	_____ NO	_____ YES
32.	Are you a smoker?	_____ NO	_____ YES	_____ NO	_____ YES

OVER →

	IN THE PAST 6 MONTHS: HAVE YOU HAD?	ARE YOU BEING TREATED BY A DR. FOR?
Neurological:		
33. Have you had any fainting or blackouts?	_____ NO _____ YES	_____ NO _____ YES
34. History of seizures?	_____ NO _____ YES	_____ NO _____ YES
35. Any memory loss?	_____ NO _____ YES	_____ NO _____ YES
36. Numbness?	_____ NO _____ YES	_____ NO _____ YES
37A. Tingling?	_____ NO _____ YES	_____ NO _____ YES
37B. Loss of bowel control?	_____ NO _____ YES	_____ NO _____ YES
37C. Loss of bladder control?	_____ NO _____ YES	_____ NO _____ YES
Cardiovascular:		
38. History of heart problems?	_____ NO _____ YES	_____ NO _____ YES
39. High blood pressure?	_____ NO _____ YES	_____ NO _____ YES
40. Low blood pressure?	_____ NO _____ YES	_____ NO _____ YES
41. Any chest pains or palpitations?	_____ NO _____ YES	_____ NO _____ YES
42. Shortness of breath with normal activities?	_____ NO _____ YES	_____ NO _____ YES
Gastrointestinal:		
43. Abdominal pain?	_____ NO _____ YES	_____ NO _____ YES
44. Frequent diarrhea?	_____ NO _____ YES	_____ NO _____ YES
45. Constipation?	_____ NO _____ YES	_____ NO _____ YES
46. Heart burn?	_____ NO _____ YES	_____ NO _____ YES
47. Unexplained nausea or vomiting?	_____ NO _____ YES	_____ NO _____ YES
48. History of hepatitis?	_____ NO _____ YES	_____ NO _____ YES
49. Ulcers?	_____ NO _____ YES	_____ NO _____ YES
Urinary:		
50. Frequent urination?	_____ NO _____ YES	_____ NO _____ YES
51. Painful urination?	_____ NO _____ YES	_____ NO _____ YES
52. Urinary infections?	_____ NO _____ YES	_____ NO _____ YES
Endocrine:		
53. History of thyroid problems?	_____ NO _____ YES	_____ NO _____ YES
54. Heat intolerance?	_____ NO _____ YES	_____ NO _____ YES
55. Cold intolerance?	_____ NO _____ YES	_____ NO _____ YES
56. Excessive sweating?	_____ NO _____ YES	_____ NO _____ YES
57. Recent increased thirst?	_____ NO _____ YES	_____ NO _____ YES
58. Recent increased appetite?	_____ NO _____ YES	_____ NO _____ YES
FOR MEN ONLY		
59. Do you have a history of prostate problems?	_____ NO _____ YES	_____ NO _____ YES
FOR WOMEN ONLY		
60. Personal history of breast disease?	_____ NO _____ YES	_____ NO _____ YES
61. A family history of breast cancer?	_____ NO _____ YES	_____ NO _____ YES
62. Have you ever been pregnant?	_____ NO _____ YES	_____ NO _____ YES
63. If YES, how many times? _______	_____ NO _____ YES	_____ NO _____ YES
64. Personal history of ovarian cancer?	_____ NO _____ YES	_____ NO _____ YES

SPECIAL NEEDS *(check all that apply)* ____ None

____ Religious ____ Cultural ____ Emotional ____ Communication ____ Physical ____ Medical

Specify ____

Patient Signature ______________________________________ Date____________________

Coordinated Health

MEDICAL HISTORY/MEDICATION FORM

Patient Name______________________________ DOB__________

Family Physician ______________________ Occupation ______________________

Employer______________________ Length of Service ______________________

PAST MEDICAL HISTORY

History of:	Details	History of:	Details
❑ Cancer		❑ Diabetes	
❑ High Blood Pressure		❑ Thyroid	
❑ High Cholesterol		❑ Other	
❑ Gastrointestinal		❑ Other	
❑ Musculoskeletal		❑ Other	

SURGICAL HISTORY

Type of Surgery:	Details	Type of Surgery:	Details
❑ Cardiac		❑ Hernia	
❑ Gall Bladder		❑ GYN	
❑ Appendix		❑ Breast	
❑ Musculoskeletal		❑ Hysterectomy	
❑ Tonsils		❑ Other	

FAMILY HISTORY

Family History of:	Details	Family History of:	Details
❑ Cancer		❑ Diabetes/Renal	
❑ Heart Disease		❑ Other	

SOCIAL HISTORY

Do you smoke? ❑ No ❑ Yes ______ packs per day **Do you drink alcohol?** ❑ No ❑ Yes ______ drinks per day

ALLERGIES *(medications, metals, x-ray dyes or other substances)*: ❑ No ❑ Yes (If yes, please list names of allergen and type of reaction.)

____

____

Have you ever experienced a reaction to anesthesia? ❑ No ❑ Yes If yes, explain______________________________

PRESENT MEDICATIONS *(List any supplements/medications you are taking to include aspirin, vitamins, laxatives, calcium, etc.)*

Name of medication/supplement/vitamin, etc.	Dose (include strength and # of pills per day)	How long have you been taking this?

Patient Information Form

Date:	
Account Number:	
Name:	
Address:	
Home Phone:	
Work Phone:	
Cell Phone:	
Employer:	
Employer Address:	
Email Address:	
Social Security Number:	
Sex:	
Date of Birth:	
Marital Status:	
Emergency Contact:	
Emergency Contact Phone Number:	
Primary Care Physician:	
Referring Physician:	
Pharmacy Name:	
Pharmacy Address / Phone Number:	
Which of the following coverage types are you going to treat under (circle one):	**Group Health Insurance** **Workman's Compensation** **Motor Vehicle Insurance**
Has your insurance changed since the last time you were here or have you received new insurance cards (circle one):	**Yes** **No**
Subscriber's name (Primary Group Health Insurance):	
Subscriber's Date of Birth (Primary Group Health Insurance):	
Subscriber's Relationship (Primary Group Health Insurance):	
Subscriber's name (Secondary Group Health Insurance):	
Subscriber's Date of Birth (Secondary Group Health Insurance):	
Subscriber's Relationship (Secondary Group Health Insurance):	
Maiden Name:	
Referred By:	

Patient Signature ______________________________

Coordinated Health

Patient Information Form

Race:	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American	☐ Declined ☐ Native Hawaiian or Other Pacific Islander ☐ Not Reported	☐ Unknown ☐ White
Ethnicity:	☐ Declined ☐ Hispanic or Latino	☐ Non-Hispanic or Latino ☐ Not Reported	☐ Unknown
Language:	☐ Amharic ☐ Arabic ☐ Armenian ☐ Bengali ☐ Cajun ☐ Chinese ☐ Croatian ☐ Czech ☐ Danish ☐ Declined ☐ Dutch ☐ English ☐ Finnish ☐ Formosan ☐ French ☐ French Creole ☐ German ☐ Greek	☐ Gujarathi ☐ Hebrew ☐ Hindi (Urdu) ☐ Hungarian ☐ Ilocano ☐ Italian ☐ Japanese ☐ Korean ☐ Kru ☐ Lithuanian ☐ Malayalam ☐ Mandarin ☐ Miao (Hmong) ☐ Moni-Khmer (Cambodian) ☐ Navaho ☐ Norwegian ☐ Not Reported ☐ Panjabi	☐ Pennsylvania Dutch ☐ Persian ☐ Polish ☐ Portuguese ☐ Romanian ☐ Russian ☐ Samoan ☐ Serbocroatian ☐ Slovak ☐ Spanish ☐ Swedish ☐ Syriac ☐ Tagalog ☐ Thai (Laotian) ☐ Turkish ☐ Ukrainian ☐ Unknown ☐ Vietnamese ☐ Yiddish

Patient Signature ______________________________

Coordinated Health

IMPORTANT PATIENT POLICIES

A. FINANCIAL POLICY AND ASSIGNMENT

While the filing of your insurance claims is a courtesy that we extend to our patients, we must emphasize that our relationship is with the undersigned and not with your insurance company. Because you have the relationship with your insurance company, if you are uncertain as to whether your insurance company will cover services rendered and/or supplies provided by CH, then you should contact your insurance company prior to incurring the expenses for such supplies and/or services.

Unless otherwise agreed by CH, payment for services is due at the time the services are rendered and/or supplies are provided. Some insurance companies may require referrals for services. It is your responsibility to obtain the referral prior to the time of service. If a referral is not presented before the service, the undersigned will be legally responsible for payment.

The undersigned hereby agrees to assign to CH all payments and benefits to which the below identified patient may be entitled for services rendered and/or supplies provided by CH and to be legally responsible to reimburse CH within thirty (30) days after receipt of a bill from CH for any amount that is not covered by the insurance companies, health maintenance or preferred provider organizations and/or other third parties that have been identified as being responsible for payment of the services rendered and/or supplies provided by CH to the below identified patient. Any bill from CH that is not paid by the undersigned within 90 days past shall be sent to collections. In that event, the undersigned will be legally responsible to reimburse CH for all reasonable collection and/or attorney fees and/or costs incurred by CH.

Patient's Initials ________

B. AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

I hereby authorize CH Hospital of Allentown, L.L.C and CHS Professional Practice, P.C. (CH) and its physicians, physician assistants, podiatrists, chiropractors, physical therapists and/or other employees and/or agents to furnish and/or to receive any & all information relating to the medical condition, care, treatment and/or history of the below identified patient to and/or from the following: all insurance companies, health maintenance or preferred provider organizations and/or other third parties that may be responsible for payment of the services rendered and/or supplies provided by CH; other health care providers and/or pharmacies of the below identified patient; any third party payors that are or have been responsible for pharmacy benefits of the below identified patient; and/or to all employers and/or schools of the below identified patient.

Patient's Initials ________

C. NO GUARANTEE OF CURE OR OUTCOME

I understand that no guarantee of a cure or an outcome of care/treatment can be or is given.

Patient's Initials ________

D. DISCLOSURE OF FINANCIAL INTEREST IN REFERRALS AND YOUR FREEDOM TO CHOOSE ALTERNATE PROVIDER

WE ARE REQUIRED TO NOTIFY YOU THAT CH AND/OR ITS PHYSICIANS AND/OR ITS OTHER HEALTH CARE PROVIDERS MAY REFER YOU FOR A MEDICAL SERVICE, PRODUCT OR DEVICE OR TO A FACILITY OR BUSINESS IN WHICH ONE OR MORE OF OUR PHYSICIANS HAS A FINANCIAL INTEREST. IF THAT HAPPENS, BE ADVISED THAT YOU WILL ALWAYS HAVE THE FREEDOM TO CHOOSE AN ALTERNATE PROVIDER. FURTHER, BE ADVISED THAT A LIST OF THE FACILITIES OR BUSINESSES IN WHICH ONE OR MORE OF OUR PHYSICIANS HAS A FINANCIAL INTEREST WILL BE PROVIDED TO YOU UPON YOUR REQUEST.

Patient's Initials ________

E. ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

CH has a detailed document called "Notice of Privacy Practices". It contains information about the policies and practices of CH regarding patient privacy. By signing below, the undersigned acknowledges the following about the "Notice of Privacy Practices" of CH: (a) you were offered a copy of it on the below date; and (b) you may review a copy of it on the Internet by going to www.coordinatedhealth.com and/or by requesting it at the front desk of any office of CH.

Patient's Initials ________

I HAVE REVIEWED THE ABOVE AND AGREE WITH ANY TERMS AND/OR CONDITIONS SET FORTH THEREIN.

____________________________	____________________________
Patient Account Number	Patient Name
____________________________	____________________________
Date	Signature of Patient or Legal Guardian