

## 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 your 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.

## 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 any of the following? If yes, are you being treated by a doctor?*

### General:

- 1. Recent unexplained changes in weight  N  Y  Treated
- 2. Unexplained fevers  N  Y  Treated
- 3. Night sweats  N  Y  Treated
- 4. Weakness or fatigue  N  Y  Treated
- 5. Loss of appetite  N  Y  Treated
- 6. Immune deficiencies  N  Y  Treated

### Musculo-skeletal:

- 7. Joint pain  N  Y  Treated
- 8. Joint swelling  N  Y  Treated
- 9. Muscle pain  N  Y  Treated
- 10. Muscle cramps  N  Y  Treated
- 11. History of back pain  N  Y  Treated

### Skin:

- 12. Rashes  N  Y  Treated
- 13. Changes in skin  N  Y  Treated
- 14. Changes in nails  N  Y  Treated
- 15. Changes in hair (e.g. - dryness)  N  Y  Treated

### Head:

- 16. Frequent headaches  N  Y  Treated

### Eyes:

- 17. Eye pain (discomfort)  N  Y  Treated
- 18. Double vision  N  Y  Treated
- 19. Blurred vision  N  Y  Treated

### Ears, Nose & Throat:

- 20. Ringing in the ears  N  Y  Treated
- 21. Ear pain  N  Y  Treated
- 22. Nasal discharge  N  Y  Treated
- 23. Nasal bleeding  N  Y  Treated
- 24. Sinus pain  N  Y  Treated
- 25. Soreness  N  Y  Treated
- 26. Hoarseness  N  Y  Treated
- 27. Difficulty swallowing  N  Y  Treated
- 28. Dry mouth  N  Y  Treated

### Hematological/Lymphatic

- 29. Swollen glands  N  Y  Treated
- 30. Bruise easily  N  Y  Treated

### Respiratory:

- 31. Chest pain  N  Y  Treated
- 32. Wheezing  N  Y  Treated
- 33. Coughing  productive  dry  N  Y  Treated
- 34. History of tuberculosis  N  Y  Treated
- 35. History of smoking  N  Y  Treated

### Neurological:

- 36. Fainting or blackouts  N  Y  Treated
- 37. History of seizures  N  Y  Treated
- 38. Mood swings  N  Y  Treated
- 39. Depression  N  Y  Treated
- 40. Anxiety  N  Y  Treated
- 41. Memory loss  N  Y  Treated
- 42. Numbness  N  Y  Treated
- 43. Tingling  N  Y  Treated
- 44. Loss of bowel control  N  Y  Treated
- 45. Loss of bladder control  N  Y  Treated

### Cardiovascular:

- 46. History of heart problems  N  Y  Treated
- 47. High blood pressure  N  Y  Treated
- 48. Low blood pressure  N  Y  Treated
- 49. Chest pains or palpitations  N  Y  Treated
- 50. Shortness of breath w/normal activities  N  Y  Treated
- 51. Dizziness  N  Y  Treated
- 52. Loss of Consciousness  N  Y  Treated

### Gastrointestinal:

- 53. Abdominal pain  N  Y  Treated
- 54. Frequent diarrhea  N  Y  Treated
- 55. Constipation  N  Y  Treated
- 56. Heart burn  N  Y  Treated
- 57. Unexplained nausea or vomiting  N  Y  Treated
- 58. History of hepatitis  N  Y  Treated
- 59. Ulcers  N  Y  Treated
- 60. Change in appetite  N  Y  Treated
- 61. Dark or bloody stool  N  Y  Treated

Continued on back

**Urinary:**

- 62. Frequent urination  N  Y  Treated
- 63. Painful urination  N  Y  Treated
- 64. Urinary infections  N  Y  Treated
- 65. Urinary urgency  N  Y  Treated
- 66. Blood in urine  N  Y  Treated
- 67. Urinary incontinence  N  Y  Treated
- 68. Get up at night to urinate  N  Y  Treated

**Endocrine:**

- 69. History of thyroid problems  N  Y  Treated
- 70. Heat intolerance  N  Y  Treated
- 71. Cold intolerance  N  Y  Treated
- 72. Excessive sweating  N  Y  Treated
- 73. Recent increased thirst  N  Y  Treated
- 74. Recent increased appetite  N  Y  Treated
- 75. Tremors  N  Y  Treated

**Integumentary/Breasts:**

- 76. Nodules  N  Y  Treated
- 77. Change in moles or freckles  N  Y  Treated
- 78. Change in hair growth, loss, texture  N  Y  Treated
- 79. Breast or nipple discharge  N  Y  Treated
- 80. Breast pain  N  Y  Treated

**FOR MEN ONLY**

- 81. History of prostate problems  N  Y  Treated

**FOR WOMEN ONLY**

- 82. Personal history of breast disease  N  Y  Treated
- 83. Family history of breast cancer  N  Y  Treated
- 84. Have you ever been pregnant  N  Y  Treated  
If YES, how many times \_\_\_\_\_
- 85. Personal history of ovarian cancer  N  Y  Treated

**Gynecological:**

- 86. Bleeding or pain during intercourse  N  Y  Treated
- 87. Unusual vaginal discharge or odor  N  Y  Treated
- 88. Vulvar or vaginal itching or burning  N  Y  Treated
- 89. Pelvic pain  N  Y  Treated
- 90. Date of last menstrual period \_\_\_\_\_

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

- Religious  Cultural  Emotional  Communication  Physical  Medical

Specify \_\_\_\_\_

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**NOTES** \_\_\_\_\_

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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 |
|--|---------|-----------------------------------|---------|
| <input type="checkbox"/> Cancer              | _____   | <input type="checkbox"/> Diabetes | _____   |
| <input type="checkbox"/> High Blood Pressure | _____   | <input type="checkbox"/> Thyroid  | _____   |
| <input type="checkbox"/> High Cholesterol    | _____   | <input type="checkbox"/> Other    | _____   |
| <input type="checkbox"/> Gastrointestinal    | _____   | <input type="checkbox"/> Other    | _____   |
| <input type="checkbox"/> Musculoskeletal     | _____   | <input type="checkbox"/> Other    | _____   |

### SURGICAL HISTORY

| Type of Surgery:                         | Details | Type of Surgery:                      | Details |
|--|---------|---------------------------------------|---------|
| <input type="checkbox"/> Cardiac         | _____   | <input type="checkbox"/> Hernia       | _____   |
| <input type="checkbox"/> Gall Bladder    | _____   | <input type="checkbox"/> GYN          | _____   |
| <input type="checkbox"/> Appendix        | _____   | <input type="checkbox"/> Breast       | _____   |
| <input type="checkbox"/> Musculoskeletal | _____   | <input type="checkbox"/> Hysterectomy | _____   |
| <input type="checkbox"/> Tonsils         | _____   | <input type="checkbox"/> Other        | _____   |

### FAMILY HISTORY

| Family History of:                     | Details | Family History of:                      | Details |
|--|---------|---|---------|
| <input type="checkbox"/> Cancer        | _____   | <input type="checkbox"/> Diabetes/Renal | _____   |
| <input type="checkbox"/> Heart Disease | _____   | <input type="checkbox"/> 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

|  |   |   |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
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| <b>Race:</b>                           | <input type="checkbox"/> American Indian or Alaskan Native<br><input type="checkbox"/> Asian<br><input type="checkbox"/> Black or African American<br><input type="checkbox"/> Declined<br><input type="checkbox"/> Native Hawaiian or Other Pacific Islander<br><input type="checkbox"/> Not Reported<br><input type="checkbox"/> Unknown<br><input type="checkbox"/> White  |   |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
| <b>Ethnicity:</b>                      | <input type="checkbox"/> Declined<br><input type="checkbox"/> Hispanic or Latino<br><input type="checkbox"/> Non-Hispanic or Latino<br><input type="checkbox"/> Not Reported<br><input type="checkbox"/> Unknown  |   |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
| <b>Language:</b>                       | <table border="0"> <tr> <td><input type="checkbox"/> Amharic</td> <td><input type="checkbox"/> Gujarathi</td> <td><input type="checkbox"/> Pennsylvania Dutch</td> </tr> <tr> <td><input type="checkbox"/> Arabic</td> <td><input type="checkbox"/> Hebrew</td> <td><input type="checkbox"/> Persian</td> </tr> <tr> <td><input type="checkbox"/> Armenian</td> <td><input type="checkbox"/> Hindi (Urdu)</td> <td><input type="checkbox"/> Polish</td> </tr> <tr> <td><input type="checkbox"/> Bengali</td> <td><input type="checkbox"/> Hungarian</td> <td><input type="checkbox"/> Portuguese</td> </tr> <tr> <td><input type="checkbox"/> Cajun</td> <td><input type="checkbox"/> Ilocano</td> <td><input type="checkbox"/> Romanian</td> </tr> <tr> <td><input type="checkbox"/> Chinese</td> <td><input type="checkbox"/> Italian</td> <td><input type="checkbox"/> Russian</td> </tr> <tr> <td><input type="checkbox"/> Croatian</td> <td><input type="checkbox"/> Japanese</td> <td><input type="checkbox"/> Samoan</td> </tr> <tr> <td><input type="checkbox"/> Czech</td> <td><input type="checkbox"/> Korean</td> <td><input type="checkbox"/> Serbocroatian</td> </tr> <tr> <td><input type="checkbox"/> Danish</td> <td><input type="checkbox"/> Kru</td> <td><input type="checkbox"/> Slovak</td> </tr> <tr> <td><input type="checkbox"/> Declined</td> <td><input type="checkbox"/> Lithuanian</td> <td><input type="checkbox"/> Spanish</td> </tr> <tr> <td><input type="checkbox"/> Dutch</td> <td><input type="checkbox"/> Malayalam</td> <td><input type="checkbox"/> Swedish</td> </tr> <tr> <td><input type="checkbox"/> English</td> <td><input type="checkbox"/> Mandarin</td> <td><input type="checkbox"/> Syriac</td> </tr> <tr> <td><input type="checkbox"/> Finnish</td> <td><input type="checkbox"/> Miao (Hmong)</td> <td><input type="checkbox"/> Tagalog</td> </tr> <tr> <td><input type="checkbox"/> Formosan</td> <td><input type="checkbox"/> Moni-Khmer (Cambodian)</td> <td><input type="checkbox"/> Thai (Laotian)</td> </tr> <tr> <td><input type="checkbox"/> French</td> <td><input type="checkbox"/> Navaho</td> <td><input type="checkbox"/> Turkish</td> </tr> <tr> <td><input type="checkbox"/> French Creole</td> <td><input type="checkbox"/> Norwegian</td> <td><input type="checkbox"/> Ukrainian</td> </tr> <tr> <td><input type="checkbox"/> German</td> <td><input type="checkbox"/> Not Reported</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Greek</td> <td><input type="checkbox"/> Panjabi</td> <td><input type="checkbox"/> Vietnamese</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Yiddish</td> </tr> </table> | <input type="checkbox"/> Amharic            | <input type="checkbox"/> Gujarathi | <input type="checkbox"/> Pennsylvania Dutch | <input type="checkbox"/> Arabic | <input type="checkbox"/> Hebrew | <input type="checkbox"/> Persian | <input type="checkbox"/> Armenian | <input type="checkbox"/> Hindi (Urdu) | <input type="checkbox"/> Polish | <input type="checkbox"/> Bengali | <input type="checkbox"/> Hungarian | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Cajun | <input type="checkbox"/> Ilocano | <input type="checkbox"/> Romanian | <input type="checkbox"/> Chinese | <input type="checkbox"/> Italian | <input type="checkbox"/> Russian | <input type="checkbox"/> Croatian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Samoan | <input type="checkbox"/> Czech | <input type="checkbox"/> Korean | <input type="checkbox"/> Serbocroatian | <input type="checkbox"/> Danish | <input type="checkbox"/> Kru | <input type="checkbox"/> Slovak | <input type="checkbox"/> Declined | <input type="checkbox"/> Lithuanian | <input type="checkbox"/> Spanish | <input type="checkbox"/> Dutch | <input type="checkbox"/> Malayalam | <input type="checkbox"/> Swedish | <input type="checkbox"/> English | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Syriac | <input type="checkbox"/> Finnish | <input type="checkbox"/> Miao (Hmong) | <input type="checkbox"/> Tagalog | <input type="checkbox"/> Formosan | <input type="checkbox"/> Moni-Khmer (Cambodian) | <input type="checkbox"/> Thai (Laotian) | <input type="checkbox"/> French | <input type="checkbox"/> Navaho | <input type="checkbox"/> Turkish | <input type="checkbox"/> French Creole | <input type="checkbox"/> Norwegian | <input type="checkbox"/> Ukrainian | <input type="checkbox"/> German | <input type="checkbox"/> Not Reported | <input type="checkbox"/> Unknown | <input type="checkbox"/> Greek | <input type="checkbox"/> Panjabi | <input type="checkbox"/> Vietnamese |  |  | <input type="checkbox"/> Yiddish |
| <input type="checkbox"/> Amharic       | <input type="checkbox"/> Gujarathi  | <input type="checkbox"/> Pennsylvania Dutch |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
| <input type="checkbox"/> Arabic        | <input type="checkbox"/> Hebrew   | <input type="checkbox"/> Persian            |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
| <input type="checkbox"/> Armenian      | <input type="checkbox"/> Hindi (Urdu)   | <input type="checkbox"/> Polish             |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
| <input type="checkbox"/> Bengali       | <input type="checkbox"/> Hungarian  | <input type="checkbox"/> Portuguese         |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
| <input type="checkbox"/> Cajun         | <input type="checkbox"/> Ilocano  | <input type="checkbox"/> Romanian           |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
| <input type="checkbox"/> Chinese       | <input type="checkbox"/> Italian  | <input type="checkbox"/> Russian            |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
| <input type="checkbox"/> Croatian      | <input type="checkbox"/> Japanese   | <input type="checkbox"/> Samoan             |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
| <input type="checkbox"/> Czech         | <input type="checkbox"/> Korean   | <input type="checkbox"/> Serbocroatian      |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
| <input type="checkbox"/> Danish        | <input type="checkbox"/> Kru  | <input type="checkbox"/> Slovak             |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
| <input type="checkbox"/> Declined      | <input type="checkbox"/> Lithuanian   | <input type="checkbox"/> Spanish            |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
| <input type="checkbox"/> Dutch         | <input type="checkbox"/> Malayalam  | <input type="checkbox"/> Swedish            |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
| <input type="checkbox"/> English       | <input type="checkbox"/> Mandarin   | <input type="checkbox"/> Syriac             |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
| <input type="checkbox"/> Finnish       | <input type="checkbox"/> Miao (Hmong)   | <input type="checkbox"/> Tagalog            |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
| <input type="checkbox"/> Formosan      | <input type="checkbox"/> Moni-Khmer (Cambodian)   | <input type="checkbox"/> Thai (Laotian)     |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
| <input type="checkbox"/> French        | <input type="checkbox"/> Navaho   | <input type="checkbox"/> Turkish            |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
| <input type="checkbox"/> French Creole | <input type="checkbox"/> Norwegian  | <input type="checkbox"/> Ukrainian          |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
| <input type="checkbox"/> German        | <input type="checkbox"/> Not Reported   | <input type="checkbox"/> Unknown            |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
| <input type="checkbox"/> Greek         | <input type="checkbox"/> Panjabi  | <input type="checkbox"/> Vietnamese         |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |
|  |   | <input type="checkbox"/> Yiddish            |                                    |   |                                 |                                 |                                  |                                   |                                       |                                 |                                  |                                    |                                     |                                |                                  |                                   |                                  |                                  |                                  |                                   |                                   |                                 |                                |                                 |  |                                 |                              |                                 |                                   |                                     |                                  |                                |                                    |                                  |                                  |                                   |                                 |                                  |                                       |                                  |                                   |   |   |                                 |                                 |                                  |  |                                    |                                    |                                 |                                       |                                  |                                |                                  |                                     |  |  |                                  |

**Patient Signature**

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## 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](http://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