

## 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.



# Coordinated Health

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**IMPORTANT:** Please use symbols below to indicate the location & level of your pain during the last week, with "0" being no pain and "10" being intensely severe pain.

**Pain level now**      0 1 2 3 4 5 6 7 8 9 10

**At its worst**        0 1 2 3 4 5 6 7 8 9 10

**At its best**         0 1 2 3 4 5 6 7 8 9 10

**At night**            0 1 2 3 4 5 6 7 8 9 10

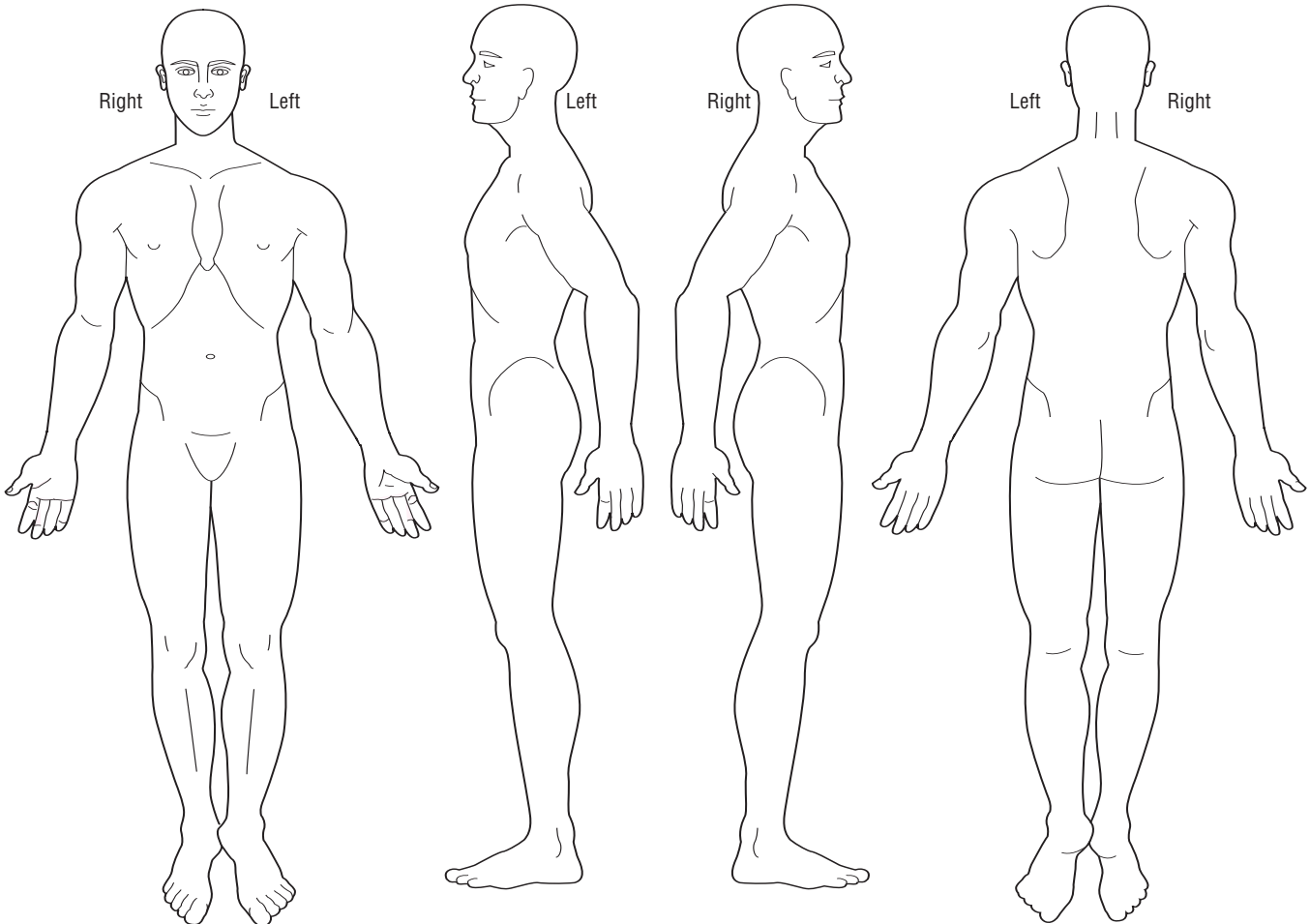
**Pins/Needles**      0 0 0 0

**Numbness**         = = = =

**Burning**            X X X X

**Stabbing**          / / / /

**Ache**                ^ ^ ^ ^





# Coordinated Health Spine

Name: \_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

## Injury Information

When did your pain or injury begin? \_\_\_\_\_

Work Related Injury: Yes / No

Motor Vehicle Accident: Yes / No

How did your injury occur? \_\_\_\_\_

\_\_\_\_\_

Where is your pain located? \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

Worse? \_\_\_\_\_

## Past Treatment

In chronological order, please list any physicians you have seen since your injury and any treatment/tests you have received:

Dates (From - To)	Physician	Treatment/Test	Medications
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had the following treatments or tests for the current pain/injury?

Physical Therapy: Y / N      Chiropractic: Y / N      Nerve Block/Epidural: Y / N      Biofeedback: Y / N

Surgery: Y / N      Acupuncture: Y / N      MRI: Y / N      CT Scan: Y / N      X-ray: Y / N      EMG: Y / N      Bone Scan: Y / N

## Goals

What are your goals for Treatment? \_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



# 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:**

	<b>HAVE YOU HAD?</b>	<b>ARE YOU BEING TREATED BY A DR. FOR?</b>
<b>General:</b>		
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
<b>Musculo-skeletal:</b>		
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
<b>Skin:</b>		
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
<b>Head:</b>		
16. Frequent headaches?	___ NO ___ YES	___ NO ___ YES
<b>Eyes:</b>		
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
<b>Ears, Nose &amp; Throat:</b>		
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
<b>Respiratory:</b>		
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

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**FOR MEN ONLY**

- 59. Do you have a history of prostate problems?  NO  YES  NO  YES

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**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

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**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
<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

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

**Patient Signature** \_\_\_\_\_



## Patient Information Form

<b>Race:</b>	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Declined <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Not Reported <input type="checkbox"/> Unknown <input type="checkbox"/> White																																																									
<b>Ethnicity:</b>	<input type="checkbox"/> Declined <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Not Reported <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
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**Patient Signature**

\_\_\_\_\_



## 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