

PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____

Street Address: _____

City, State, Zip Code: _____ County: _____

Primary Number: _____ Additional Number: _____

Marital Status: (check one): Single Married Divorced Widowed Separated

E-Mail Address: _____

Employment Status: (check one): Full Time Part Time Not Employed Self Employed Retired

Occupation: _____ *Primary Care Provider: _____

<p>Race (Check One):</p> <p><input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian</p> <p><input type="checkbox"/> Black <input type="checkbox"/> Pacific Islander</p> <p><input type="checkbox"/> Amer. Indian/ Alaska Native <input type="checkbox"/> Asian</p> <p><input type="checkbox"/> More than One Race</p> <p><input type="checkbox"/> Choose not to disclose</p> <p>Ethnicity (Check One):</p> <p><input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic</p> <p><input type="checkbox"/> Choose not to disclose</p>	<p>Sex At Birth (Check One):</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Veteran (Check One):</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Check if any of these apply to you:</p> <p><input type="checkbox"/> Homeless <input type="checkbox"/> Live in Public Housing</p> <p>Preferred Language (Check One):</p> <p><input type="checkbox"/> English <input type="checkbox"/> Spanish</p> <p><input type="checkbox"/> Other: _____</p>	<p>Sexual Orientation (Check One):</p> <p><input type="checkbox"/> Lesbian/Gay <input type="checkbox"/> Straight</p> <p><input type="checkbox"/> Bisexual <input type="checkbox"/> Something Else</p> <p><input type="checkbox"/> Don't Know <input type="checkbox"/> Choose not to disclose</p> <p>Gender Identity (Check One):</p> <p><input type="checkbox"/> Male <input type="checkbox"/> Transgender Female to Male</p> <p><input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female</p> <p><input type="checkbox"/> Other <input type="checkbox"/> Choose not to disclose</p>
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LEGAL GUARDIAN - MUST be completed if patient is under the age of 18

Parent Name/Legal Guardian: _____

Social Security Number: _____ Relationship to Patient: _____

If different from above:

Street Address: _____ Phone Number: _____

City, State, Zip Code: _____ County: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Relationship: _____

Phone Number (s): _____

PATIENT DEMOGRAPHIC FORM

PATIENT NAME: _____ D.O.B.: _____

INSURANCE INFORMATION

Do you have health insurance? Yes No

Primary Insurance: _____ ID#: _____ Group #: _____

Policyholder Name: _____ D.O.B.: _____

Relationship to Patient: _____

Secondary Insurance: _____ ID#: _____ Group #: _____

Policyholder Name: _____ D.O.B.: _____

Relationship to Patient: _____

***** REQUIRED INFORMATION *****

Lifecare receives funding to offset the costs of treating uninsured or underinsured patients. We are required to report certain demographics on all of our patients including race, family size, and income. Reporting these items assists us to receive funding to continue providing care to all of our patients. Reported information **does not contain your name, address, or social security information.**

Please circle household size and check the correct income box in the same line

Household Members	Income Less Than:	Income In Between:	Income In Between:	Income More Than:
1	<input type="checkbox"/> \$12,060	<input type="checkbox"/> \$12,061 - \$18,090	<input type="checkbox"/> \$18,091 - \$24,120	<input type="checkbox"/> \$24,121
2	<input type="checkbox"/> \$16,240	<input type="checkbox"/> \$16,241 - \$24,360	<input type="checkbox"/> \$24,361 - \$32,480	<input type="checkbox"/> \$32,481
3	<input type="checkbox"/> \$20,420	<input type="checkbox"/> \$20,421 - \$30,630	<input type="checkbox"/> \$30,631 - \$40,840	<input type="checkbox"/> \$40,841
4	<input type="checkbox"/> \$24,600	<input type="checkbox"/> \$24,601 - \$36,900	<input type="checkbox"/> \$36,901 - \$49,200	<input type="checkbox"/> \$49,201
5	<input type="checkbox"/> \$28,480	<input type="checkbox"/> \$28,481 - \$43,170	<input type="checkbox"/> \$43,171 - \$57,560	<input type="checkbox"/> \$57,561
6	<input type="checkbox"/> \$32,960	<input type="checkbox"/> \$32,961 - \$49,440	<input type="checkbox"/> \$49,441 - \$65,920	<input type="checkbox"/> \$65,921
7	<input type="checkbox"/> \$37,140	<input type="checkbox"/> \$37,141 - \$55,710	<input type="checkbox"/> \$55,711 - \$74,280	<input type="checkbox"/> \$74,281
8	<input type="checkbox"/> \$41,320	<input type="checkbox"/> \$41,321 - \$61,980	<input type="checkbox"/> \$61,981 - \$82,640	<input type="checkbox"/> \$82,641

Federal Poverty Guidelines as of 01/2017

REDUCED RATE PROGRAM

Are you interested in applying for our Reduced Rate Program? Yes No

Lifecare offers a Reduced Rate Program as our way to offer our services at a lower cost to families who meet **certain requirements**. The reduced rates are divided into different categories based on household size and gross income. Patients that qualify for the program would pay for services according to what category they fall into.

Patient/Parent/Legal Guardian Signature: _____

Relationship if not the patient: _____ Date: _____

Adult Health History
Lifecare Family Health & Dental Center, Inc.

Patient Name: _____ Date of Birth: _____

Allergies (please list medications that you are unable to take for any reason): _____

Do you have a latex sensitivity? Yes No

Have you ever had joint replacement surgery? Yes No If yes, what joint(s)? _____

- Do you require an antibiotic prior to dental procedures? Yes No

List all surgeries you have had (tonsillectomy, appendectomy, etc) please include the year of surgery.

Year	Surgery	Reason	Year	Surgery	Reason

List any serious illness that you have had (diabetes, high blood pressure, etc). Please include the date.

Illness	Date or Year of Onset	Illness	Date or Year of Onset

Do you see another medical provider for treatment of a medical condition? Yes No If yes, please list:

Medical Specialist: _____ Phone #: _____ Specialty: _____

Medical Specialist: _____ Phone #: _____ Specialty: _____

Personal History

Education (Highest grade or degree achieved): _____

<p><u>Tobacco:</u></p> <p>___ I have never used any tobacco</p> <p>___ I smoke or chew tobacco (Circle appropriate choice)</p> <ul style="list-style-type: none"> • Amount per day _____ • Started at Age _____ <p>___ I quit using tobacco</p> <ul style="list-style-type: none"> • Date Quit: _____ 	<p><u>Alcohol:</u></p> <p>___ I have never consumed alcohol</p> <p>___ I drink alcohol</p> <ul style="list-style-type: none"> • How Often _____ • Amount _____ <p>___ I quit drinking</p> <ul style="list-style-type: none"> • Date Quit: _____
<p><u>Drug Use:</u></p> <p>___ I have never used any illicit drugs</p> <p>___ I am currently using illicit drugs</p> <ul style="list-style-type: none"> • Drugs: _____ <p>___ I quit using drugs</p> <ul style="list-style-type: none"> • Date Quit: _____ 	<p><u>Caffeine Use:</u></p> <p>___ I do not drink any caffeine</p> <p>___ I drink caffeinated beverages</p> <p>[] Pop [] Coffee [] Energy Drinks</p> <ul style="list-style-type: none"> • Amount per day _____

Adult Health History
Lifecare Family Health & Dental Center, Inc.

Patient Name: _____ Date of Birth: _____

Place an "X" in any box that applies to you or any family member who has had any of the following conditions.
(M=mother, F=father)

	Self	M	F		Self	M	F		Self	M	F
Diabetes				Rheumatic Fever				Bleeding/Hemophilia			
Glaucoma				Asthma				Leukemia			
Kidney Problems				Emphysema				HIV/AIDS			
High Blood Pressure				TB				Alcohol/Substance Abuse			
Heart Attack				Systemic Lupus				Liver Disease			
Coronary Artery Disease				Sickle Cell Trait				Hepatitis A/B/C			
Heart Murmur				Thyroid Disease				Eating Disorder			
Mitral Valve Prolapse				Arthritis				Mental Illness			
Prosthetic Heart Valve				Stroke				ADD/ADHD (circle one)			
Heart Stents				Neurological Disorder				RSV			
Pacemaker				Cancer Type: _____				<input type="checkbox"/> No family history			
Other: (Specify)											

Family Member	Living (Yes or No)	Cause of Death (if deceased)	Age at death
Mother			
Father			

Prevention Health Care Information

Date of most recent:

- Pap Smear _____ Where: _____ Normal [] Yes [] No
- Mammogram _____ Where: _____ Normal [] Yes [] No
- Colonoscopy _____ Where: _____ Normal [] Yes [] No
- Dental Exam _____ Where: _____ Normal [] Yes [] No



Lifecare™
Family Health & Dental Center

Patient Name: _____ DOB: _____

How should the clinic contact you?

**I wish to be contacted in the following Manner:
(CHECK ALL THAT APPLY)**

____ **Home**

Telephone Number: _____

____ OK to leave message with detailed information.

____ OK to leave message with callback number only.

____ **Cell**

Cell Phone Number: _____

____ OK to leave message with detailed information.

____ OK to leave message with callback number only.

____ **Work**

Work Telephone Number: _____

____ OK to leave message with detailed information.

____ OK to leave message with callback number only.

____ **By Mail ***

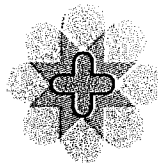
Address: _____

(Note* the clinic will still contact you by phone for appointment reminders and in the case of an emergency.)

Patient signature: _____ Date: _____

I have been offered a copy of Lifecare FHDC's Notice of Privacy Practice.

Patient signature: _____ Date: _____



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Family Health & Dental Center

Limited Patient Authorization for Disclosure of Protected Health Information

(Allows the clinic to discuss your health information with the individuals listed below)

Patient Name: _____ **Date of Birth:** _____

Purpose of request (who will be authorized to receive information) - I authorize the practice to disclose or provide protected health information, about me to the individual(s) listed below. (List each family member, friend, or other individual to receive PHI):

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the person or persons identified above:

Entire patient record; or, check only those items of the record to be disclosed:

- office notes lab results x-rays; hospital,
- nursing home, home health, hospice, and other physician records
- record of HIV and communicable disease testing
- record of mental health or substance abuse treatment
- Other (please specify): _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

Patient Request

Other (please specify): _____

Expirations or termination of authorization: This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

(Please list date of expiration if earlier than end of calendar year): _____

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. You may revoke an authorization at any time, in writing, except to the extent that your Healthcare Provider or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Redisclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Patient signature: _____ **Date:** _____

(Form must be signed and dated each year.)

You have the right to receive a copy of signed authorizations upon request.



Lifecare™
Family Health & Dental Center

Authorization for Disclosure of Protected Health Information

Patient Name: _____
Social Security Number: _____ Date of Birth: _____

Entity Requested to Release Information:

Practice Name: _____
Address: _____
Phone: _____ Fax: _____

Entity Authorized to Receive Information:

Name (Entity or Individual): Lifecare Family Health & Dental Center, Inc.
Address: 2725 Lincoln St East, Canton, OH 44707
Phone: 330-454-2000 Fax: 330-454-6184

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

Entire patient record; or, check **only** those items of the record to be disclosed:

- Office notes Lab results X-rays
- Hospital, nursing home, home health, hospice, and other physician records
- Record of HIV and communicable disease testing
- Record of mental health or substance abuse treatment
- Financial history report (previous 3 years only).

Only send the following: _____

Purpose of disclosure (please describe the purpose of the disclosure or check patient request):

Patient request.

Other (please specify): Transferring care

Expirations or termination of authorization: This authorization will expire at the end of the calendar year in which it was signed, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.
(Please list date of expiration if earlier than end of calendar year): _____

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager.

Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

Redisclosure: We have no control over the entities or person(s) you have listed to receive your protected health information (PHI). Therefore, your PHI disclosed under this authorization will no longer be the responsibility of the practice releasing the PHI and, depending upon the entity receiving it, may no longer be protected by the requirements of the Privacy Rule.

Patient Signature: _____ Date: _____
Copies of signed authorizations are available upon request.



Lifecare Family Health & Dental Center, Inc. Appointments Policy

Your Lifecare Family Health & Dental Center, Inc. (Lifecare FHDC) Providers want to make sure that you and other area residents have access to high quality medical, dental and behavioral health care when you need it. To ensure maximum access to services for all of our patients, please be aware of the following appointment policy:

Contact Information: It is your responsibility to keep your current address and phone number on file with Lifecare FHDC. Please keep Lifecare FHDC up to date anytime your information changes.

Scheduled Appointments: Although Lifecare FHDC will make every effort to remind you of your upcoming appointment by phone, you are ultimately responsible for remembering your appointment date and time.

Canceling Appointments: If you cannot make your scheduled appointment, you must call us at least twenty four (24) hours in advance to let us know so that we can offer your appointment to another patient. Failure to provide at least twenty four (24) hours' notice counts as a missed ("No-Show") appointment.

Missed Appointments: Because of the critical lack of access to medical services in our area, missed appointments are taken very seriously. Patients who "no-show" or cancel with less than twenty four (24) hours' notice for the third time within the calendar year will be discharged from the clinic. Any and all "no-show" appointments from any department within Lifecare FHDC will be counted towards the total number of no shows.

Please contact the clinic if you have any questions about our "No-Show" Policy.

I understand and agree to abide by this "No-Show" Policy.

Patient name (printed)

Patient signature

Date

Parent/Guardian signature (For Patients under 18)

Date



Financial Agreement

I hereby consent to all treatment deemed necessary by the staff of Lifecare Family Health & Dental Center, Inc.. I authorize the Lifecare Family Health & Dental Center, Inc. (LIFECARE FHDC) to use, disclose, and/or receive any or all information relating to my treatment. My provider may contact any other covered entity that has provided services to me for the purpose of obtaining further diagnosis.

LIFECARE FHDC has made prior arrangements with many health plans to accept direct payments. LIFECARE FHDC will bill those plans for which it has made prior arrangement and will only require you to pay the authorized Co-pay at the time of service. I agree that I am responsible for any co-payments, deductibles and fees for non-covered services.

I hereby authorize release of information necessary to file a claim with my insurance company and **assign benefits, otherwise payable to me, to the physician or group indicated on the claim.** I am responsible for any referrals and/or authorizations required by my insurance company. I understand I am financially responsible for any balance not covered by my insurance. My insurance policy, if applicable, is a contract between me and my insurance company. LIFECARE FHDC is not responsible for collecting on an insurance claim or negotiating a settlement on a disputed claim.

As a courtesy to the patient, LIFECARE FHDC will submit claims to any insurance company. If the patient's coverage is with a plan that LIFECARE FHDC does not have prior arrangement, the charges for the patient's care and treatment are the patient's responsibility and due in full at the time of service.

I understand that unless other arrangements have been made in advance by either me or my health coverage provider, **payment is due at the time of service.** For all services rendered to minors, the custodial parent or legal guardian will be responsible for all charges.

For the patient's convenience LIFECARE FHDC will accept Visa, MasterCard, Cash, and Personal Check. **There will be a \$10.00 fee charged to patients for all non-sufficient funds checks and the patient will be required to pay cash for all future visits.**

I further attest that, as of the date of my signature, the income sources listed constitute **all** of my household income, and that the number of family members listed are all solely dependent on that income. I verify my income level is truthful. I understand that LIFECARE FHDC is not in the business of extending credit and I agree to pay the above practice at the time its bill is presented. If prompt payment is not made, LIFECARE FHDC may take action to collect its charges.

I UNDERSTAND THAT THERE MAY BE CHARGES IN ADDITION TO MY COPAY BASED ON THE CLINIC'S SLIDING FEE SCALE. I AGREE TO PAY SAID CHARGES.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____



Lifecare™
Family Health & Dental Center

Patient Name: _____ Date of Birth: _____

CONTROLLED SUBSTANCE/PAIN MEDICATION CONTRACT

1. For some conditions your provider may prescribe a medication classified as a controlled substance. All patients are required to sign this contract in the event that a controlled substance is prescribed.
2. You will keep this medication away from all other persons and will use it only for yourself.
3. You will not acquire narcotics or other controlled medications from any other provider(s) nor will you ingest or otherwise use any such medications including but not limited to illegal substances acquired by you or provided by others.
4. You will not take this medication more often than what is prescribed.
5. You understand that if you report this medication as lost or stolen, an investigation will ensue. We reserve the right to withhold your medication at that time.
6. If the current therapy is providing inadequate control, you cannot change the dosage on your own; you must contact the provider.
7. This prescription must last the full written time frame.
8. You as the patient give us permission to test you for the drug(s) we have prescribed, and other drugs including illegal substances, at our discretion using appropriate tests including a toxicology screen and specific drug tests. If the medication prescribed is not found or if other drugs are found in your system, we reserve the right to withhold your medication.
9. Failure to comply with any of these instructions may result in the immediate dismissal of therapy or care by this provider and/or investigation and/or a report to the appropriate legal authorities.
10. By signing this contract, you understand that you may be required to bring in your prescription for us to count the remaining pills.

Patient signature: _____ Date: _____



Lifecare™
Family Health & Dental Center

AGREEMENT OF TREATMENT EXPECTATIONS AND MEDICAL HOME RESPONSIBILITIES

This is an agreement between two parties: the Health Center and the Patient.

The purpose of this document is a positive one. It attempts to make clear the rights and responsibilities of both parties. It says *who* is to do *what*.

A medical home is a care team working to provide you with the best care possible. We want to include you in making healthcare decisions. We will help coordinate your care with providers outside of Lifecare when needed. We offer clinical advice during and after hours along with early morning appointments.

We promise to treat you to the best of our abilities, consistent with the standards of care in our community. You, in turn promise to be as understanding, cooperative, and responsible as possible.

Attached you will find a copy of Health Center and Patient Responsibilities. Please read them and understand them, as both parties will be held accountable.

This Health Center has a zero tolerance for violence or threat of violence of any kind. Therefore, there will not be any attempt or threat to kick, hit, or otherwise harm any staff member, patient, or visitors. Furthermore, neither party will yell or use profanity when addressing any staff member, patient, or visitors.

I have read (or have had read to me) the "Agreement of Treatment Expectations" and fully understand its contents. I have been given an opportunity to ask questions. **Any violation of this agreement may result in permanent dismissal from office.**

Patient: _____ Date: _____

If not the Patient, Relationship to Patient: _____

Health Center Witness: _____



Lifecare Responsibilities

To treat you with respect, consideration, and dignity. We will:

- Provide an environment that is safe for both patients and staff.
- Maintain confidentiality of your communications and medical records.
- Ensure that no staff member discriminates against you because of age, race, sex, medical condition, physical disability, insurance, or ability to pay.
- Provide you with information about Medical Advance Directives.
- Inform you about major changes in our health center management, policies and procedures, as they relate to your treatment and care.
- Make reasonable attempts to schedule follow-up visits to meet your needs, as our scheduling demands allow.

To provide a treatment environment that is safe for both patients and staff. We will:

- Respond to situations where visitors, family members, other patients, or staff members exhibit behavior deemed to be hazardous to the safety and well-being of everyone in the health center. This may include contacting the appropriate law enforcement authorities.
- Respond to any medical problem that may occur during your visit.

We recognize that we have a responsibility to provide you with quality care. Therefore, we will:

- Provide you with evidence based care and self-management support.
- Practice universal precautions and other policies/procedures to prevent or control infections, and maintain a safe and sanitary environment.
- Participate in programs to ensure safe and quality care to all patients.
- Provide you with information about your medical condition and treatment options.
- Encourage you to participate in all decisions involving both your short and long term goals and plans of care.
- Inform and educate you about the health center and our policies and procedures.
- Inform you of where you can obtain services that we are unable to provide and to assist you, when possible, in obtaining those services and coordinating care.
- Assist you with trying to solve any problem (s) related to your treatment
- Assist you in obtaining Health Insurance coverage.
- Provide you with clinical advice during and after hours.
- Provide you with access to comprehensive services including our own Behavioral Health Specialists, Dental Services, and any others services added to Lifecare in the future.



Patient Responsibilities

I agree to respect the rights of other patients and staff. Therefore, I will:

- Treat other patients and staff with respect, consideration and dignity.
- Respect the rights of other patients to have a safe, clean, calm, adequate treatment, and treatment environment.
- Assure that my activities or my visitor's activities do not interfere with health center operations.
- Verbal abuse, threatening behavior, physical abuse, or sexual harassment of other patients, staff, or visitors will not be tolerated. You may be asked to leave the health center or the appropriate law enforcement officials may be called.

I understand and agree that it is important that I participate in the decisions about my health, treatment, and care options. Therefore, I will:

- Provide accurate information about my medical and social history, including all medical history from care received from outside of Lifecare.
- **Avoid all unnecessary ER visits. Non-emergent clinical advice is available to me by calling 330-454-2000 during office hours and 330-430-1841 after office hours.**
- Participate in the development of my care plan and follow the plan.
- Comply with all my Provider's requests for office visits and referrals.
- Acknowledge that my failure to comply with my treatment plan, referrals, medications, or other Provider's orders may result in declining health or hospitalization.
- Agree to bring my medications into the health center for review when requested.
- Inform ALL other providers of your Lifecare Primary Care Provider.

I agree to be knowledgeable regarding the facility policies and procedures and follow them. Therefore, I will:

- Arrive on time for my scheduled appointment.
- Acknowledge that it is my responsibility to arrange for my own transportation.
- Inform the health center if I am going to be late, with the understanding that I may have to reschedule my appointment.
- Arrive free from the influence of illegal drugs, alcohol, and without a weapon. I also agree to refrain from having them in my possession or using them while I am on the health center's premises.
- Apply for Medicare, Medicaid, or other insurance program when appropriate and maintain coverage to the best of my ability.
- Obtain proper Release of Information forms when transferring records to Lifecare. (Speak to a receptionist for details)
- Inform the health center about personal changes such as, address, telephone number, insurance, and income.
- **I understand that any violation of this agreement may result in the permanent dismissal from the office.**