Lifecare™
Family Health & Dental Center

# 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:** ______________________

**Race (Check One):**

☐ White ☐ Native Hawaiian

☐ Black ☐ Pacific Islander

☐ Amer. Indian/ Alaska Native ☐ Asian

☐ More than One Race

☐ Choose not to disclose

**Ethnicity (Check One):**

☐ Hispanic ☐ Non-Hispanic

☐ Choose not to disclose

**Sex At Birth (Check One):**

☐ Male ☐ Female

**Veteran (Check One):**

☐ Yes ☐ No

**Check if any of these apply to you:**

☐ Homeless ☐ Live in Public Housing

**Preferred Language (Check One):**

☐ English ☐ Spanish

☐ Other:______________________

**Sexual Orientation (Check One):**

☐ Lesbian/Gay ☐ Straight

☐ Bisexual ☐ Something Else

☐ Don't Know ☐ Choose not to disclose

**Gender Identity (Check One):**

☐ Male ☐ Transgender Female to Male

☐ Female ☐ Transgender Male to Female

☐ Other ☐ Choose not to disclose

## 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):______________________

Lifecare™ Family Health & Dental Center

# 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 | ☐ $12,060 | ☐ $12,061 - $18,090 | ☐ $18,091 - $24,120 | ☐ $24,121 |
| 2 | ☐ $16,240 | ☐ $16,241 - $24,360 | ☐ $24,361 - $32,480 | ☐ $32,481 |
| 3 | ☐ $20,420 | ☐ $20,421 - $30,630 | ☐ $30,631 - $40,840 | ☐ $40,841 |
| 4 | ☐ $24,600 | ☐ $24,601 - $36,900 | ☐ $36,901 - $49,200 | ☐ $49,201 |
| 5 | ☐ $28,480 | ☐ $28,481 - $43,170 | ☐ $43,171 - $57,560 | ☐ $57,561 |
| 6 | ☐ $32,960 | ☐ $32,961 - $49,440 | ☐ $49,441 - $65,920 | ☐ $65,921 |
| 7 | ☐ $37,140 | ☐ $37,141 – $55,710 | ☐ $55,711 - $74,280 | ☐ $74,281 |
| 8 | ☐ $41,320 | ☐ $41,321 - $61,980 | ☐ $61,981 - $82,640 | ☐ $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:____________

# Pediatric Health History
## Lifecare Family Health & Dental Center, Inc.

**Child's Legal Name:** ______________________ **Date of Birth:** ______________________

**Mother's Name:** ______________________ **Father's Name:** ______________________

**Parent's marital status:** [ ] single [ ] married [ ] divorced [ ] separated [ ] widowed **Child's Sex:** Male Female

**Legal guardian's name:** ______________________ **Child adopted:** [ ] Yes [ ] No

**Allergies (medication and foods):** ______________________

**List all surgeries/hospitalizations/Accidents/Serious illness the child has had. Please include the date.**

| Surgery/hosp./accident/illness | Date | Treating physician/Surgeon |
|---|---|---|
| | | |
| | | |
| | | |

**List any chronic medical conditions (diabetes, high blood pressure, etc) Please include the date.**

| Illness | Date or Year of Onset | Condition at Present |
|---|---|---|
| | | |
| | | |
| | | |

**Does your child see another medical provider for treatment of a medical condition?** [ ] Yes [ ] No If yes, please list:

Medical Specialist: ______________________ Phone #: ______________ Specialty: ______________

Medical Specialist: ______________________ Phone #: ______________ Specialty: ______________

**Are vaccines up to date?** [ ] Yes [ ] No **Do you have their vaccine record?** [ ] Yes [ ] No

**Child & Family History**

**Child's Birth Weight:** __________ **Was birth premature?** [ ] Yes [ ] No **Was birth:** [ ] Vaginal [ ] C-Section

**Last Dental Visit:** ______________ **Have they had sealants placed on their molars?** [ ] Yes [ ] No

**Place an "X" in any box that applies to your child, their mother, or father** (M=mother, F=father)

| | Child | M | F | | Child | M | F | | Child | 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:______ | | | | ☐ **No family history** | | | |
| Other: (Specify) | | | | | | | | | | | |

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

Name: ______________________________ Date of Birth: ______________________

PLEASE COMPLETE THIS SECTION FOR **CHILDREN OVER THE AGE OF 12**

**Tobacco:** My Child

[ ] Has never used any tobacco

[ ] Smokes Cigarettes, Cigars, or Pipe

[ ] Chews tobacco

Tobacco indicated above:

- Amount per day____________
- Started at Age ___________

[ ] Quit using tobacco

- Date: __________________

**Alcohol:** My Child

[ ] never consumes any alcohol

[ ] drinks alcohol 3 to 4 times yearly

[ ] drinks alcohol once a week

[ ] drinks alcohol 2 to 3 times per week

[ ] Drinks alcohol daily Amount_______

[ ] Beer [ ] Wine [ ] Liquor

[ ] Has quit drinking

- Date he/she quit drinking ____________

**Drug Use:** My Child

[ ] Has never used any illicit drugs

[ ] Used illicit drugs in the past

[ ] Is currently using illicit drugs

- Drugs used: ______________
- Date quit: ______________

**Caffeine Use:** My Child

[ ] Does not drink any caffeinated beverages

[ ] Drink caffeinated beverages

- Amount per day_____________

**Female children:**

[ ] Is your child pregnant?

[ ] Does she think she may be pregnant?

[ ] Is she using contraceptives? (oral, implants, injections)

[ ] Is she nursing?

**Pharmacy Information**

Local Pharmacy Name:______________________________Phone:____________________________

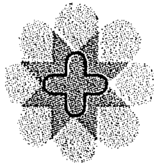
Mail Order Name:__________________________________

List all prescription medications, over-the-counter medicines, or supplements your child is currently taking on a regular basis.

☐ **My child does not take any medications, over-the-counter medicine, or supplements on a regular basis.**

| Name of Medication | Dosage | Frequency- (How many times a day) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Parent/Legal Guardian Signature: ____________________________ Date: ____________________




**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: __________________

# Authorization for Treatment of a Minor

**Patient Name:** ______________________ **Date of Birth:**__________

I authorize the individuals listed below to bring my child to the office and sign for assessment and treatment of my child in the event I am unable to bring them myself.

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 my child to the person or persons identified above:

Entire patient record; <u>**or**</u>, check <u>**only**</u> 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): ______________________

**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.

Parent/Guardian signature: ______________________ Date: __________

(Must be updated annually)

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

# 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.

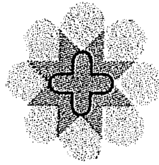
**Non-Conditioning statement:** The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

**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.




## Authorization for Disclosure of Protected Health Information

Patient Name: ______________________________
Social Security Number: ______________________ Date of Birth: ______________

**Entity Requested to <u>Release</u> Information:**
Practice Name: ______________________________
Address: ______________________________
Phone: ______________________ Fax: ______________________

**Entity Authorized to <u>Receive</u> 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; <u>or</u>, check <u>only</u> 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)

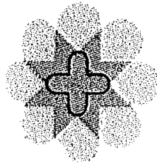
______________________________ ________________

Patient signature Date

______________________________ ________________

Parent/Guardian signature (For Patients under 18) Date

Revised: 01/11/2015



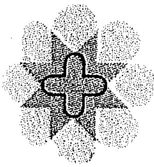

Patient Name: ______________________ Date of Birth: ______________

**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: ________________

Revised 01/20/2017



# Lifecare™
Family Health & Dental Center

## 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: ______________

## 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:__________________________________________

Created: 8/12/15

**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.**