Welcome to Buckeye Family Healthcare 3477 Commerce Pkwy. Ste A. Wooster, Ohio 44691

We are honored that you have chosen one of our health care providers. Our goal is to provide the highest quality care for all our patients in a timely and respectful manner.

We will do our best to provide you with same-day patient care, for urgent or sick visits. You will need to bring your insurance card and a photo ID with you for every appointment. Please let our staff know if you have had any information changes since your last appointment. If you are unable to provide us with your insurance card, your appointment may need to be rescheduled. You may be asked to fill out new registration forms annually, so we may update your information.

Co-Pays/Billing Policy:
All co-pays and past due balances are expected at time of service, unless a prior agreement has been made with our billing department. Our billing department is located off site, if you have any questions about coverage you can contact them directly at 1-800-527-0336. We accept cash, Visa, Mastercard and CareCredit. We also accept payments by check and debit cards.
Our billing company (51 Oakwood, Inc.) will file all claims with your insurance company as a courtesy. Please keep in mind that the payment remains your responsibility. If your insurance changes it is your responsibility to contact our office or billing company. We bill insurance in accordance with all federal, state and other contractual requirements in cases where we have an agreement, or we are a participating provider. We expect payment in full of you if your insurance company delays processing of your claim for over 90 days. You agree to pay any portion of the charges not covered by insurance. If your insurance company sends payments directly to you, send or drop off the payment to Buckeye Family Healthcare and it will be applied to your account.
If you have NO health insurance, we offer a price break on all services. The price break is based on the Medicare allowable rate. Payment is due at the time of service unless you have made previous arrangements with our office manager or billing department.
Buckeye Family Healthcare preserves the right to refuse any patients with a balance greater than $250.and (or) are not making regular payments on an outstanding balance. Accounts will be sent to collections for balances not paid after receipt of four (4) statements unless payment arrangements were made with the practice manager or billing company.
If your account is placed into collections, a collection fee will be applied, along with any attorney fees and/or court costs that may be necessary for recovery of the outstanding balance(s). In the event of a return /NSF check, there will be a $35 NSF charge added to the balance.

Appointments/Cancelation Policy:
We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 10 minutes late. Arriving late can throw your doctor's entire schedule off and may cause other sick or urgent patients to become agitated or possibly reschedule, leaving a gap in the doctor's schedule. We strive to stay on time and we ask that you pay us the same courtesy. From time to time, a patient emergency arises, causing the doctor to be running late, for your scheduled visit. You will have the option to re-schedule or stay to be seen. Our receptionist will keep you informed of how long of a delay you may experience.
Please bring all your prescriptions and over-the-counter medications with you at each visit.

No call/No show Policy:

- If you do not call to cancel in ample time (24 hours before your scheduled visit) or do not show up for your **new patient** appointment, the appointment will **not** be rescheduled;
- After two (2) no-show appointments, you will be sent a final warning, a third (3) no-show appointment will result in dismissal from the practice.

We understand that appointments sometime need to be changed, so we ask that you call in advance (**24 hours before your scheduled appointment time**) if you cannot keep your scheduled appointment. Failure to call and cancel in ample time will result in a charge of **$35.00**.

Initial ______________

Medication/Refill Policy:
Providing the highest quality of professional care to our patients is very important to us. Therefore, the following guidelines for dispensing medications in our office have been established:

1. ***Buckeye Family Healthcare does not offer regularly scheduled chronic pain management and will not dispense chronic pain medication regularly*** (for example, chronic daily narcotics). We will provide you with a referral to a pain management center if you need or request this specialized form of care after evaluation by one of our physicians. Short term narcotics may be prescribed based on severity and physician preference.
2. If you are on a medication that requires refills for a chronic disease (for example, high blood pressure or diabetes), you will be given ample refills for 30 or 90 days at a time during your office visit.
    a. When you are down to a 30-day supply of medication, we ask that you call and schedule your follow-up office visit, (if you have not done so already) in order to be re-evaluated and have your medications adjusted or refilled. We ask that you allow enough time for us to make an appointment so you're not without your medication.
    b. We understand that in some cases this is overlooked, please be aware that our nurses are working during office hours with the doctor and the patients scheduled that day. If you call in for a refill, this refill may not be addressed until after business hours. **We ask that you allow 24-48 hours for refills to be completed.** Please call your pharmacy **first** before calling back into the office. If there is a problem refilling your prescription one of our staff members will be in contact with you.
3. For the safety and well-being of our patients,
    a. Requests for **new** medications (including antibiotics) and medication refills will not be taken over the phone or over the internet during office hours without an appointment and evaluation by the physician. This is an interruption to our physicians while they are trying to focus and care for their scheduled patients.
    b. No **new** medications (including antibiotics) will be called in over the phone after office hours by the physicians. If you are seeking a **new** prescription, you will need to schedule an appointment.
    c. We understand that unexpected situations arise, thus a small refill of a chronic medication will be granted for one or two days on an as-needed basis determined by your physician **after** regular business hours for urgent needs only. Please note if a physician prescribes you a medication after regular business hours a **$25.00 fee** will be apply to your patient account.

Paperwork/ Medical Records Request Policy:
Buckeye Family Healthcare will provide your records to you once you have completed the Patient Authorization Form/ Disclosure of Protected Health Information (PHI) Form. Your request will be processed and fulfilled within thirty (30) business days. We can either mail or fax the records according to the information you provide on the authorization form. **Your 1st copy is FREE!** A fee will apply to any additional records requests. Charges for additional copies: Pages 1-20 $15.00, Pages 21-50 $25.00 and Pages 51+ $40.00.
Buckeye Family Healthcare will apply a fee of **$20.00** to your account for any letters or forms requested for the physician to complete outside a scheduled office visit. **For example: If you stop into the office and drop off forms for one of our doctors to complete, you will be charged a $20.00 fee. Forms include, but are not limited to: FMLA, disability, motor vehicle division, continuation of pay, payment of car loans, payment of mortgages, industrial information, etc. Letters include, but are not limited to: attorneys, insurance companies, employers, school, airlines, travel agencies, gyms, etc.** We ask that you allow 3 business days for forms to be completed and 24-48 hours for letters. If you need them **same day** an addition fee will be collected, and the total will be **$35.00**. All fees are patient responsibility and must be paid in advance. No exceptions for same day service.

HIPAA Compliance/ Patient privacy Policy:
To comply with federal laws such as HIPAA, as well as Ohio State and Federal statutes, this office **MUST** have a signed authorization form from each patient or responsible party stating to whom we are authorized to release information to each calendar year. There is a form located in your new patient packet and can be obtained from the receptionist. Please be sure to sign the form. Unsigned requests cannot be processed.

Initial _______________

After Hours Policy:
If you need to reach one of our physicians after hours, you can reach the hospital registry at **330-263-8500**. Your doctor will be contacted and will call you back within **1 hour**. If you do not receive a call within **1 hour** you may contact the doctor's registry again. Our office hours for patient care are Monday's, Wednesday's and Friday's 8am - 4:30pm and Tuesday's and Thursday's 8am – 6:30pm. Office phone 330-601-0999

Lab Services:
Buckeye Family Healthcare works closely with the Wooster Community Hospital laboratory services and imaging resources. As a convenience to our patients the Wooster Community Hospital has provided our office with draw station. Our electronic medical record allows us to receive patient results quickly and efficiently through our direct link with them. This is an important resource in meeting our goal of providing high quality care in a timely manner.

All of us here at Buckeye Family healthcare would like to welcome to the practice and thank you for choosing Buckeye Family Healthcare for your health care needs.

I have read, understand and agree with all of Buckeye Family Healthcare's policies listed on all 3 pages of this welcome letter.
I understand the charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.
I acknowledge that these policies do not obligate Buckeye Family Healthcare to extend credit.
I authorize my insurance benefits to be paid directly to Buckeye Family Healthcare.
I authorize Buckeye Family Healthcare to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Patient Name (print)________________________________ DOB:________________

Guardian/POA(print)____

Signature: ____ Date: ________________

Buckeye Family Healthcare

3477 Commerce Parkway, Suite A, Wooster, Ohio 44691 P: 330-601-0999 F: 330-601-0935

PATIENT INFORMATION

LAST NAME ______________________ FIRST NAME ______________________ MI ______

STREET ADDRESS ____ APT # __________

CITY ______________________________ STATE _____________________ ZIP ________

HOME PHONE ( ) __________________ WORK PHONE ( ) __________________

SOCIAL SECURITY # ___________________________ MARITAL STATUS M SD W (circle one)

MALE or FEMALE (circle one) DATE OF BIRTH ______________________________________

EMERGENCY CONTACT _______________________________ PHONE ( ) __________

NEAREST RELATIVE (not living with you) __________________ PHONE ( ) __________

DRUG ALLERGIES (if any) ____

EMAIL ADDRESS ____

PRIMARY INSURANCE INFORMATION (person who holds policy)

INS. CO. NAME _________________________ ID# _________________ GROUP # ________

LAST NAME ______________________ FIRST NAME ______________________ MI ______

RELATIONSHIP TO PATIENT ________________ HOME PHONE ( ) ________________

STREET ADDRESS ___________________________ WORK PHONE ( ) ________________

____ DATE OF BIRTH ____________________

CITY _____________________________________ MALE or FEMALE (circle one)

STATE ______________________ ZIP __________ SOCIAL SECURITY # ________________

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Buckeye Family Healthcare to furnish insurance carriers concerning my illness and subsequent treatments/procedures, and to allow insurance carriers to supply any required information to Buckeye Family Healthcare. I hereby assign all payments for medical services rendered for my dependents or myself to be paid directly to my physician(s). I fully understand I am solely responsible for any amount not covered by insurance. I understand that co-payments are due at the time of service and I am responsible for full payment of my bills within 30 days of receipt of my monthly statement.

Patient/Responsible Party Signature ________________________________ Date ____________

Patient Name ____________________ DOB ________

Buckeye Family Healthcare

3477 Commerce Parkway, Suite A. Wooster, Ohio 44691 P: 330-601-0999 F: 330-601-0935

PATIENT REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF PROTECTED HEALTH INFORMATION

As stated in our Notice of Privacy Practices, you may request that we communicate confidential health information to you by alternate means or in alternate locations. The Privacy Rule requires us to accommodate requests if reasonable.

Please indicate your request regarding our communication of *Protected Health Information* by checking the boxes you agree with below.

HIPAA Release Form

[ ] I authorize the release of my *Protected Health Information* including diagnosis, imaging, lab results, records; examination rendered to me and claim information to myself and the following people.

[ ] Spouse ____

[ ] Sibling(s) ____________________ ____________________

[ ] Child(ren) ____________________ ____________________

[ ] Power of Attorney ________________________________

(If you have a Living Will, POA, DNR, etc., it is your responsibility to provide a copy for your file.)

[ ] Other ____________________ ____________________

[ ] Medical information is ***NOT*** to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing. Initial______

Messages – [ ] No- messages [ ] yes- leave detailed message [ ] only- request return call

[ ] home (___)______________ [ ] work (___)______________ [ ] cell number: (___)______________

HIPAA Authorization

I authorize Buckeye Family Healthcare to use or disclose my protected health information from my health record to specialists, clinics or hospitals. This will be information only pertinent to my current treatment and will be disclosed only if I need further care by facilities. This authorization will expire on the day of my death or on the day I terminate my care with Buckeye Family Healthcare, whichever event comes first.

Print name ________________________________ DOB ______________

Signature ________________________________ Date ______________

Buckeye Family Healthcare

3477 Commerce Parkway, Suite A, Wooster, Ohio 44691 P: 330-601-0999 F: 330-601-0935

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, ________________________________, born ____/____/________, authorize Buckeye Family Healthcare to ____ disclose to, or ____ request from the following person/entity the protected health information described below in accordance with this authorization:

________________________________ by ____ Mail
Name of previous physician

____ Fax to 330-601-0935

________________________________ ____ Will pick up on: ________________ (date)
Street address

____ Other: ____________________

________________________________ ________________________________
City, State, ZIP

PROTECTED HEALTH INFORMATION TO BE DISCLOSED

_____ 1. I authorize ALL information in my medical record form to be disclosed according to the terms of this authorization.

_____ 2. In addition, please release X-rays of (body part): ______________________________

_____ 3. In addition, I authorize the following protected health information to be disclosed according to the terms of this Authorization.

INITIAL ONE OF THE FOLLOWING:

_____ I consent to the disclosure of any information pertaining to alcohol abuse, drug abuse, psychiatric condition, any condition related to sexually transmitted disease and/or HIV and AIDS.

_____ I DO NOT consent to the disclosure of any information pertaining to alcohol abuse, drug abuse, psychiatric condition, any condition related to sexually transmitted disease and/or HIV and AIDS.

1. This authorization shall be in full force and effect for sixty (60) days from the date of the signing, at which time this authorization will expire.
2. My permission is extended only for the purposes as stated on this authorization, and I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Buckeye Family Healthcare. I understand that a revocation is not effective to the extent that Buckeye Family Healthcare has relied on the use or disclosure of the presented health information.
3. I understand that I will be responsible for any charges incurred for the copying and/or faxing of my medical record as permitted by law. _______ (initial)
4. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
5. Buckeye Family Healthcare will not condition my treatment on whether I provide authorization for the requested use or disclosure.
6. I understand that I have the right to refuse to sign this authorization. I further understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted by law.

________________________________ ________________________________
Signature of patient or guardian   Date

________________________________ ________________________________
Street address   Home phone number

________________________________ ________________________________
City, State, ZIP   Work phone number

Buckeye Family Healthcare
3477 Commerce Parkway, Suite A, Wooster, Ohio 44691 P: 330-601-0999 F: 330-601-0935

PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT RIGHTS

- ❑ Patients have the right to create Advance Directive which will let providers and others know the person's wishes regarding medical treatment.
- ❑ Patients have the right to assert complaints and grievances about the providers and their health care provided.
- ❑ Patients have the right to be informed about the role of medical students/supervised practitioners and the right to refuse such care.

PATIENT RESPONSIBILITIES

- ❑ To be informed about their insurance plan, including the benefits that are available.
- ❑ To become knowledgeable of the system to access medical care.
- ❑ To keep all scheduled appointments and to notify the provider 24 hours before scheduled appointment time when unable to keep a scheduled appointment.
- ❑ To be on time for all scheduled appointments.
- ❑ To follow all medically appropriate physician orders and prescriptions.
- ❑ To treat personnel with courtesy and respect.
- ❑ To provide complete health status information for accurate diagnosis and appropriate treatment.
- ❑ To always call your preferred care provider (PCP) before receiving urgent care and, when possible, emergency care.
- ❑ To notify your PCP when you receive emergency care within twenty-four (48) hours or as soon as possible.
- ❑ To Follow -up with PCP within 1 week after hospital or ER discharge.

Buckeye Family Healthcare

3477 Commerce Parkway, Suite A, Wooster, Ohio 44691 P: 330-601-0999 F: 330-601-0935

Patient name ______________________ Date of birth ________________

Preferred pharmacy ____

MEDICAL HISTORY

Please mark if you now have, or ever had, any of the medical problems listed below:

- ☐ Adrenal disorder
- ☐ AIDS/HIV
- ☐ Alcohol abuse
- ☐ Allergies (seasonal/hay fever)
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Back problems
- ☐ Bone fractures
- ☐ Bladder/UTI
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Blood transfusion
- ☐ Breast cancer
- ☐ Breast lump or cyst
- ☐ Cancer
- ☐ Carpal tunnel syndrome
- ☐ Cataracts
- ☐ Chronic bronchitis
- ☐ Diabetes
- ☐ Drug abuse
- ☐ Emotional problems (anxiety/depression)
- ☐ Emphysema (COPD)
- ☐ Gallstones
- ☐ Gastrointestinal problems
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Headaches/migraines
- ☐ Hearing problems
- ☐ Heart disease
- ☐ Heart failure
- ☐ Hepatitis A / B / C
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ High or low calcium
- ☐ High triglycerides
- ☐ Hives
- ☐ Hormone deficiency
- ☐ Hypoglycemia
- ☐ Infections - recurrent
- ☐ Irritable bowel syndrome
- ☐ Kidney disease
- ☐ Kidney failure
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Lupus
- ☐ Murmur (heart)
- ☐ Neuropathy (nerve damage)
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Parathyroid
- ☐ Pituitary disorder
- ☐ Pneumonia
- ☐ Polycystic ovary
- ☐ Reflux (GERD)
- ☐ Rheumatoid arthritis
- ☐ Seizures
- ☐ Skin cancer
- ☐ Stroke
- ☐ Thyroid cancer
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Valve problems (heart)
- ☐ Vascular disease
- ☐ Vision problems
- ☐ Vitamin deficiency

Other medical problems or details for above: ______________________________

____

____

____

____

Buckeye Family Healthcare
3477 Commerce Parkway, Suite A, Wooster, Ohio 44691 P: 330-601-0999 F: 330-601-0935

HOSPITALIZATIONS AND SURGERIES

Please include approximate dates:

____
____
____
____
____
____

SOCIAL HISTORY

Tobacco ☐ current smoker ☐ former smoker ☐ never smoked
Alcohol ☐ yes ☐ no Type/amount ______________________
Illegal drugs ☐ yes ☐ no
Exercise ☐ yes ☐ no Type ______________ Frequency ______________

FAMILY HISTORY

Please indicate which family members (e.g. grandfather, mother, brother, etc.) have/had the following:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anesthesia - complications
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disorders (e.g. Lupus, RA)
- ☐ Birth defects
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Blood transfusions
- ☐ Bowel disease
- ☐ Breast cancer
- ☐ Cervical cancer
- ☐ Colon cancer
- ☐ Cancer - other
- ☐ Depression
- ☐ Heart attacks (indicate age at time)
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hormone problems
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Melanoma
- ☐ Mental disorders
- ☐ Osteoporosis
- ☐ Ovarian cancer
- ☐ Parkinson's disease
- ☐ Psychiatric care
- ☐ Respiratory disease
- ☐ Seizures/epilepsy
- ☐ Severe allergies
- ☐ Skin cancer
- ☐ STD
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid disease
- ☐ Ulcer disease
- ☐ Uterine cancer

Other conditions or details for above: ______________________
____
____
____

Buckeye Family Healthcare
3477 Commerce Parkway, Suite A, Wooster, Ohio 44691 P: 330-601-0999 F: 330-601-0935

ALLERGIES

Agent	Reaction	Severity (mild,moderate,severe)

CURRENT MEDICATIONS (Please bring your actual bottles with you to your 1st initial appointment)
Please include prescriptions, over-the-counter medicine, and vitamin/supplements: