HOPEWELL
HEALTH CENTERS

Lancer Care Clinic

740.662.0541

Grade (2018-2019): _____

Student's Name	Home Phone	Date of Birth
Address	City	Zip Code
Parent/Guardian's Name	Cell Phone	Email
Parent/Guardian's Name	Cell Phone	Email

List two others who will assume responsibility for your student in the event you cannot be contacted.

Name/Relationship	Home Phone	Cell Phone
Name/Relationship	Home Phone	Cell Phone

HEALTH CONCERNS: (*Please include information important for EMS)*

Allergies (Food and/or Medications):

Medications* (Daily Meds, Inhalers, or As Needed):

****You must notify the Lancer Care Clinic of any changes in medications or dosages throughout the school year.***

Will your student take daily medications at school? YES NO

If YES, you must complete the required Medication Administration Form.

Hopewell Health Centers, Inc. –Billing Application Form

Patient Information:

_____ Date of Birth _____ Social Security #_____

Last First M

_____ Phone _____ Cell_____ Msg/Work_____

Address (Street and Post Office)

_____ Email Address_____

City State Zip County

Responsible Party ____Self ____Other

Relationship _____

_____

Name

_____

Address

_____

City State Zip Phone#

Preferred Pharmacy _____

Emergency Contact Information

Name_____ Phone _____ Relationship_____

Insurance

Primary Insurance _____

Policy Holder_____

Name

Social Security #_____ DOB_____

Insurance ID # _____

Employer_____

Secondary Insurance_____

Policy Holder_____

Name

Social Security#_____ DOB_____

Insurance ID # _____

Employer _____

(Circle One)

Gender Identity: Male Female Transgender (female to male) Transgender (male to female) Other Choose not to disclo

Sexual Orientation: Lesbian or Gay Straight Bisexual Something Else Don't know Choose not to disclo

Marital Status: Single Married Divorced Partner Unknown Widowed Legally Separated

Veteran? Yes No **Learning Preference:** Oral Visual Written **Language:** English or Other: _____

Race: White Black or African American American Indian/Alaska Native Asian Native Hawaiia
Other Pacific Islander Other Race Refused to Report

Ethnicity: Hispanic or Latino Not Hispanic or Latino Refused to Report

HOPEWELL
HEALTH CENTERS

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Health Insurance Portability and Accountability Act (HIPAA) Laws prevent us from discussing your protected health information with family or friends unless you designate an individual with whom we may release information to. Please complete this form if you would like to designate an individual to whom we may release your protected health information.

Patient's Name: _____ Date of Birth: _____

Address: _____

_____

Phone Number: _____

I authorize Hopewell Health Centers to discuss my protected health information with the following individual(s) listed below:

1. Name: _____ DOB: _____ Relationship: _____ Ph #: _____

2. Name: _____ DOB: _____ Relationship: _____ Ph #: _____

3. Name: _____ DOB: _____ Relationship: _____ Ph #: _____

Completion of this form authorizes the release of all information regarding my medical conditions or anything regarding my care. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed by such person or entity and may no longer be protected by federal or state law.

I certify that I have made this request voluntarily. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by HHC in reliance on this authorization.

Patient's Signature: _____ Date: _____

Legal Guardian: _____ Date: _____

Employee Signature: _____ Date: _____

******This IS NOT a Medical Record Release******

Hopewell Health Centers, Inc.

Consent for Evaluation and Treatment

Hopewell Health Centers (HHC) is dedicated to providing primary care, dental and mental health services to residents of our communities. Because physical and emotional problems often go together, we believe the best care is given when health care providers work together. HHC patients may be referred to providers from other health care specialties within the HHC treatment team.

Patients are seen by appointment only, except in emergencies. Patients must call in advance if they cannot keep their appointment.

HHC will use and share patient information for treatment, payment and health care operations, otherwise information about a patient will NOT be given to anyone outside HHC, including family and friends, unless the patient (parent or legal guardian, if a minor) gives written permission. However, we may release patient information to others without the patient's permission if:

1) The patient poses a threat to him/herself or others.
2) The patient is unable to protect him/herself from risk of harm.
3) The patient is in the legal custody of a government agency or facility.
4) There is evidence of child abuse, elder abuse or abuse of a DD person.
5) The patient's clinical records are requested under court order.
6) Other areas as noted in the Notice of Privacy Practices.

There are fees for all services, and patients are asked to pay on the day they are seen. Health insurance policies may cover a portion of the fees and staff will help the patient in making claims. Patients are asked to tell HHC staff about changes in financial status.

The professional staff of this facility will depend on statements made by the patient, the patient's medical history, and other information to evaluate his/her condition and decide on the best treatment. The evaluation and treatment of children and adolescents often requires the involvement of the parent(s) and/or other family members.

A photograph may be taken of the patient to ensure proper identification. Some services at HHC may involve the use of telemedicine equipment and interaction with providers who are not physically onsite. These sessions are transmitted via secure, dedicated high-speed lines and are not videotaped, routed through the internet or saved in any way.

Health professions are not exact sciences and no guarantees are made concerning the course of treatment proposed by the provider. Any questions about the benefits, risks, available options, or the limits of confidentiality should be directed to the treatment staff.

In treating patients, studies including x-rays, laboratory tests, EKGs or psychological tests may be warranted. There are risks involved in taking any medications and any questions about medications will be answered by the medical staff.

I am 18 years of age or older, I can consent for all health services; otherwise my parent or legal guardian will need to consent for services, except for certain circumstances.
By signing this form, (parent or legal guardian signature, if required) I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered. I understand that I agree to be truthful in providing information.

Thus, I hereby ask and agree to evaluation and treatment for myself and/or my child, including any studies or procedures that HHC professional staff decide are necessary.

Patient's or Guardian's Signature	Printed Name	Date	Patient DOB
Witness Signature	Printed Name	Date	

Client Name if other than signee: _____

Hopewell Health Centers, Inc.

To Our Patients

Our goal at Hopewell Health Centers,Inc. is to provide quality medical care. Because of our concern for your health and well-being there are certain types of medication that we may not provide to you.

Examples include the following

OXYCONTIN	XANAX
OXYCODONE	VALIUM
HYDROCODONE	RESTORIL
PERCOCET	KLONOPIN
PERCODAN	ATTVAN
LORTAB	AMBIEN
LORCET	LIBRUM
MORPHINE/MS CONTIN	SOMA
TYLENOL #3	METHADONE
TYLOX	VICODIN
ULTRAM	CONCERTA
SENTANYL	ADDERALL
BUTRANS	RITALIN
OPANA	VYVANSE

FOR ADULTS

If you are already taking any of the above medications, your provider may want to talk to you about alternative treatments

If you are a new patient, please be aware that it is unlikely your provider will prescribe any of the above medications for you.

If you have questions or concerns about this policy, please feel free to discuss them with your provider

Patient Signature _____ Date _____

Employee Signature _____ Date _____

Hopewell Health Centers, Inc.
Notice of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding Your Physical and Mental Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as an:

*Basis for planning your care and treatment
*Means of communication among the many health professionals who contribute to your care
*Legal document describing the care you received
*Means by which you or a third-party payer can verify that services billed were actually provided
*A tool in educating health professionals
*A source of data for medical research
*A source of information for public health officials charged with improving the health of the nation
*A source of data for facility planning and marketing
*A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve
*Understanding of what is in your record and how your health information is used to help you to:
    *Ensure its accuracy
    *Better understand who, what, when, where, and why others may access your health information
    *Make more informed decisions when authorized disclosures to others

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

*Request a restriction on certain uses and disclosures of your information
*Obtain a paper copy of the notice of information practices upon request
*Inspect and copy your health record
*Request amendment of your health record
*Obtain an accounting of disclosures of your health information
*Request communications of your health information by alternatives means or at alternative locations
*Revoke or amend your authorization to use or disclose health information except to the extent that action has already been taken
*Restrict Disclosure of protected health information to your health plan if you as an individual has paid for the service out of pocket in full

Our Responsibilities

*Maintain the privacy of your health information
*Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
*Abide by the terms of this notice
*Notify you if we are unable to agree to a requested restriction
*Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
*We are required to notify affected individuals following a breach of unsecured protected health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. A current copy will be kept on site for you to review.

Examples of Disclosures for Treatment, Payment, and Health Operations

We will use your health information to provide treatment.
We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him/her in treating you once you're discharged from this facility (if applicable).

We will use your health information to secure payment for services.
For Example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.
For Example: Members of the clinical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

HOPEWELL
HEALTH CENTERS

PATIENT/CLIENT/PARTICIPANT CODE OF CONDUCT

Hopewell Health Centers, Inc. ("HHC") adopts this Code of Conduct in order to define acceptable standards of behavior for patients/clients/participant (referred to as Patient within the remainder of this protocol) and to provide a procedure for action whenever there are grounds to suspect that a patient has engaged in disruptive or unacceptable behavior. All patients, as a condition of their continued treatment by an HHC provider, will abide by HHC rules, regulations, policies, and all other lawful standards.

The code of conduct also applies to chaperones and caregivers who may bring the patient into the office for their appointments.

1. Patient will treat all staff members with respect with words, body language, or gestures.
2. Patient will refrain from any form of violence (verbal, sexual, or physical) to any person. This includes sexual, ethnic, or other types of harassment, whether verbal or physical in nature.
3. Patient will be honest and factual with all communication with HHC staff
4. Patient will be considered non-compliant for repeated and/or deliberate violation of HHC rules or policies.
5. Possession of illicit drugs or alcohol on the premises is not allowed.
6. Legal prescriptions and over the counter drugs may be brought on premises and used in their prescribed manner.
7. Our centers are smoke free as of January 1, 2016. Until that time smoking is permitted except within 20 feet of any building access. After that date no smoking will be permitted on the premises.
8. Weapons (including but not limited to firearms) are not allowed within our buildings
9. HHC expects clients to attend all treatment sessions "straight/sober". Attending sessions/appointments "under the influence" may be grounds for restriction of privileges, rights, and services, or termination/discharge.
10. HHC workforce members may transport persons that are "straight/sober". Persons believed to be under the influence at any HHC facility will be given the opportunity to call someone to pick them up; if they leave the facility driving a vehicle, law enforcement will be notified.

REPORTS OF DISRUPTIVE BEHAVIOR

1. If any individual working at HHC reasonably believes that a patient is engaging in disruptive behavior or has broken our Code of Conduct protocol, he or she will discuss directly with the client/patient, document the incident, and advise their immediate supervisor as soon as possible.

ACTION

1. Site Manager/Clinic Director will review the information provided.
2. Site Manager/Clinic Director will interview all staff involved, as well as the patient, chaperone, and caregiver.
3. If patient is determined to be in non-compliance with the patient code of conduct, he or she may be discharged or terminated from the practice.

Approved: 05-13-15

Hopewell Health Centers, Inc.
Patient Acknowledgement Form for
Receipt of Health Information Privacy Practices

I, _____ (Patient), _____ (D.O.B.), understand that as part of my (or my child's) health care, this office keeps health records describing my health history, a list of symptoms or medical problems, details on the doctor's examination of me, results from tests that I've had, my diagnosis, treatment, and any future plans for treatment. I understand that this record serves as:

- A way for my health care provider to plan my care and treatment
- A way for all the health professionals involved in my care to have the same information
- Information that can be given to my insurance company or the agency paying for my care so they can make sure I received the services that Hopewell Health Centers billed for,
- And as a way for Hopewell Health Centers to make sure they are providing me with the best care possible.

Hopewell Health Centers also has a No Show policy which is:

- All patients must call 24 hrs in advance to cancel appointment
- Do not leave a message with the answering service, you must speak with the office staff
- Medical and Behavioral Health new patients who no show cannot reschedule for 3 months
- Dental new patients who no show cannot reschedule for 6 months
- 3 no shows in a 12 month period can result in dismissal from the practice

I have also been given a copy of the *Notice of Information Privacy Practices* and *Patient Code of Conduct* that tells more about the items listed above. I understand that if I have any questions either now or in the future about this information, I can talk to a staff member.

If I am attending a Behavioral Health appointment I have been given the *Consumer Handbook* which also contains client's rights information.

Patient/Guarantor Signature _____ Date: _____

Employee Signature _____ Date _____

Revised 6/13, 6/15

If you have

Medicare

please continue

to the next

page.....

MSP Screening Questionnaire

Patient's Name: _____

Medicare Number: _____

Visit Date: _____

Ask all four questions of each Medicare patient. If the patient responds "yes" to any question, continue to page two, asking all applicable questions. The patient or representative should sign the form whenever possible.

*****It is important to ask all questions and document all answers regarding MSP. A provider may be held liable if an overpayment occurs and Medicare finds that the provider furnished erroneous information or failed to disclose facts it knew were relevant to payment.*****

1. **Is the patient covered by Medicare due to:**
   ( ) Age ( ) Disability ( )ESRD (End Stage Renal Disease)

2. **Is the patient covered by the Veterans Administration, Black Lung Program, or Workers Compensation?**
   ( ) No: Proceed to next question.
   ( ) Yes: Bill insurer prior to Medicare.

3. **Is the patient here today due to illness or injury due to any type of accident?**
   ( ) No: Proceed to next question,
   ( ) Yes: Complete the next page and then continue with the questions below

4. **Is the patient employed or is the spouse employed at the time of this visit?**
   ( ) No: Patient Retirement Date: _____
   Spouse Retirement Date: _____
   ( ) Yes: (Is the patient covered by any EGHP or LGHP?
   Complete next page, Medicare may not be primary)

*****Note: If all answers are "No", bill Medicare as primary. If any response is "Yes", continue with the next page. Medicare may not be primary*****

_____ _____

Signature of Patient or Legal Representative Date

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Patient Name: _____

Medicare #: _____

Service Dates: _____

Check the appropriate box and answer the questions

1. ILLNESS/INJURY CAUSED BY ACCIDENT

A. ( ) Motor Vehicle: Name of Patient's Automobile Insurer

_____

_____

B ( ) Another party was responsible for accident.
Names and Address of Liability Insurer

_____

_____

Name and Address of Attorney

_____

_____

C. ( ) Work Related: Name of Workman's Compensation Insurer

_____

_____

D. ( ) Other Accident (slip and fall, etc); explain where accident occurred:

_____

_____

_____

Has the patient filed or intend to file a liability suit?
( ) No: Bill Medicare and send copies of all pertinent documentation
( ) Yes: Name and address of:

Liability Insurer:_____

_____

Attorney:_____

_____

Bill other insurer prior to Medicare; submit documentation to Medicare if conditional payment is requested.

2. **EMPLOYER GROUP COVERAGE FOR THOSE 65 AND OVER**

A. ( ) Patient employed at time of this service. Give name of patient's company/employer

_____

Does employer employ 20 or more employees? ( ) Yes ( ) No

Does the patient have an Employer Group Health Plan (EGHP) by reason of his/her current employer?

( ) Yes ( ) No

If "NO" give the date of retirement _____

If "YES" give the name of the EGHP _____

Bill EGHP prior to Medicare

B. ( ) Patient's spouse employed at the time of this service? Give name of spouse's

company/employer _____

Does the spouse's employer employ 20 or more employees? ( ) Yes ( ) No

Does the spouse have an EGHP by reason of current employment which covers the patient?

( ) Yes ( ) No

If "NO" give the date of retirement _____

If "YES" give the name of the EGHP _____

Bill EGHP prior to Medicare

B. **EMPLOYER GROUP COVERAGE FOR THOSE YOUNGER THAN 65**

C. A. ( ) Patient is entitled to Medicare solely due to End Stage Renal Disease and in first 18 months of Medicare entitlement. Date of first dialysis treatment or date of kidney transplant

_____

Does patient have coverage through his/her, his/her spouse's, a parent's or a guardian's EGHP?

( ) No: Medicare Primary

( ) Yes: Give name of the employer _____

Give name of EGHP _____

Bill EGHP prior to Medicare

B. ( ) Patient is entitled to Medicare **solely** because of disability (does not have/has not had ESRD)

Does the patient have coverage through his/her, his/her spouse's, a parent's or legal guardian's EGHP?

( ) No: Medicare Primary

( ) Yes: Continue

Does employer(s) employ 100 or more employees?

( ) No: Medicare Primary

( ) Yes: Give name of each insured whose policy covers the patient

a. _____ b. _____

Give name of corresponding employer

a. _____ b. _____

Give name of corresponding EGHP

a. _____ b. _____

Bill EGHPS(s) prior to Medicare