VIOLA STARTZMAN CLINIC

New Medical Patient Intake Packet

Welcome to the Viola Startzman Clinic. We provide medical and dental care to residents of Wayne County. In order to establish as a patient, all patients must provide the following documentation:

1. Proof of Residency in Wayne County, Ohio
2. State issued Photo ID (strictly for picture purpose only)
3. Insurance Card (if applicable)

Your proof of residency must have your name AND address on it and must be dated or postmarked within 30 days of service. Please provide one of the following documents as proof of Wayne County residency at the time of service.

Examples of Proof of Residency:

- Lease agreement -or- Rent receipt -or- Utility bill
- Wayne Metropolitan Housing Authority agreement
- Property tax statement
- Mail from any Wayne County agency *(i.e. Wayne County Job and Family Service, Wayne County Public Schools, etc.)*
- Verification letter from residential agency *(i.e. Salvation Army, Every Woman's House, etc.)*
- Mail from local government agency *(i.e. Social Security office)*

Drivers License or P.O. Box Number is NOT accepted as Proof of Residency

To qualify for Charitable Care (free or discounted care), patients will be asked to provide Proof of Income and complete the Charitable Care Application.

Examples of Proof of Income are:

- Medicaid Insurance Card
- Food Assistance Award Letter
- Current pay stub
- Unemployment benefit statement
- Social Security Income or Disability statement
- Pension award letter
- Child support documentation
- Bank account statement (reflecting direct deposit of income)

VIOLA STARTZMAN CLINIC

1874 Cleveland Road | Wooster, OH 44691
Phone (330) 262-2500 Fax (330) 264-8713
www.startzmanfreeclinic.org

United Way

ADMISSION RECORD

PATIENT NAME: _____
Last First Middle

SOCIAL SECURITY NUMBER: _____-_____-_____ BIRTH DATE: _____

PHYSICAL ADDRESS: _____
Street Address City State Zip

MAILING ADDRESS: _____

MAIN PHONE: _____-_____-_____ ALTERNATE PHONE: _____-_____-_____

☐ Please check if we may leave a message on the phone numbers listed above

EMAIL ADDRESS: _____

YOUR EMPLOYER: _____

Please check the appropriate boxes.

RACE:
- ☐ African American or Black
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Mixed
- ☐ Native American/Indian
- ☐ White
- ☐ Other
- ☐ Unknown

SEX:
- ☐ Male
- ☐ Female

MARITAL STATUS:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Legally Separated

FINANCIAL:
- ☐ Employed
- ☐ Unemployed
- ☐ Self-Employed
- ☐ Retired
- ☐ Disabled
- ☐ Student

I understand that I must meet the following criteria to be eligible to receive services:

- *If I want free or discounted care, I will complete the Charitable Care Application and submit the required proof of income.*
- *I live in Wayne County*
- *I am able to provide the Proof of Residency documents requested*
- *I understand that all statements contained herein are true to the best of my knowledge. I also understand that if I have falsified any documents, I will no longer be eligible to receive services at Viola Startzman Clinic. If falsification is discovered, I will be immediately dismissed and be required to pay in full for any care previously received*
- *If appropriate, I must comply with the rules of the Medication Assistance Program (MAPS)*

_____ _____
Signature of Patient or Person Authorized to Consent Date

PATIENT HEALTH HISTORY FORM

NAME:_____DOB:_____DATE:_____

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please fill in all pages, if you cannot remember specific details; please provide information to the best of your recollection. If you are uncomfortable with any question, do not answer it.

What is the reason you are seeking care at the Viola Startzman Clinic?

_____

Are you currently receiving care from any other Medical or Dental Providers?

☐ Yes ☐ No If yes, please provide Name/Address:_____

MEDICATIONS - Please list all current medication including prescription drugs, over the counter and any herbal/vitamins

Name of Medication	Dosage	How Many Times Per Day

ALLERGIES/ADVERSE REACTIONS - Please list any Allergies or Adverse Drug Reactions including type or reaction

Name of Substance	Type of Reaction

Tobacco Use

Smoke Cigarettes ☐Never ☐ Yes ☐ No
Quit date_____
If yes, for how long did you quit_____
Current Smoker - Packs per day_____

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
Have you tried quitting ☐ Never ☐ Yes ☐ No
If yes, for how long did you quit_____

Medical History

Do you have a history of:

☐ Congestive heart failure
☐ Diabetes
☐ Heart murmur/MVP
☐ Joint replacement
☐ Hepatitis A, B or C (please circle)
☐ High blood pressure
☐ Seizures
☐ Heart attack
☐ HIV
☐ Other _____

Do you or anyone in your family have or has had a bleeding/clotting disorder?

☐ You ☐ Mother ☐Father ☐ Siblings

Drug Use & Piercings

Do you use drugs for recreational purposes ☐ Yes ☐ No
If yes, what type_____
How much_____
Have you ever used needles to inject drugs ☐ Yes ☐ No

Have you regularly used other drugs ☐ Yes ☐ No
Dependent on prescription drugs ☐ Yes ☐ No
Dependent on street drugs ☐ Yes ☐ No
Do you have piercings in your mouth ☐ Yes ☐ No

Immunizations

Check all that apply- provide dates if known

☐ Tetanus _____
☐ Varcella (Chicken Pox shot or illness_____
☐ Pneumovax (pneumonia)_____
☐ Influenza (flu shot)_____
☐ Hepatitis A_____ Hepatitis B_____
☐ MMR _____
☐ Meningitis _____
☐ Zostavaz (shingles) _____
☐ HPV _____

On behalf of myself or my minor child, I acknowledge and consent to the statement made in this form.

Consent to Health Care Services: I am requesting that health care services be provided to me (or my minor child) at Viola Startzman Clinic. I voluntarily consent to all medical treatment and health care-related services that the caregivers at Viola Startzman Clinic consider to be necessary for me or my child.

Financial Responsibility:

Assignment of Benefits/Third-Party Payers: In consideration of all health care services rendered or about to be rendered to me (or my minor child), I hereby assign to Viola Startzman Clinic all right, title and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding the Viola Startzman Clinic's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by Viola Startzman Clinic to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third party payer.

Patient Rights and Responsibilities: Information is posted throughout the Clinic. If you would like a copy of the Patient Rights and Responsibilities for the Viola Startzman Clinic, please let our staff know.

Uses and Disclosures of Health Information: I have received Viola Startzman Clinic's Notice of Privacy Practices. The Notice of Privacy Practices explains how Viola Startzman Clinic may use and disclose confidential health information that identifies me (or my minor child) as described in the Notice of Privacy Practices. In doing so, I consent to the release of my (or my minor child) health information and financial account information to all third-party payers and/or their agents that are identified by Viola Startzman Clinic, its billing agents, collections agents, attorneys, consultants, and/or other agents that represent Viola Startzman or provide assistance to the Clinic for the purpose of securing payment from all parties who are potentially liable for payment for my (or my minor child) health care, including substance abuse, psychiatric care, or HIV, if applicable. I can revoke my consent in writing at any time except to the extent that Viola Startzman Clinic has already relied on my consent.

I understand that all statements contained herein are true to the best of my knowledge. I also understand that if I have falsified any documents, I will no longer be eligible to receive services at Viola Startzman Clinic. If falsification is discovered, patient will be immediately dismissed and be required to pay in full for any care they previously received.

Summary Notice of HIPAA 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 AND REPORT ANY GRIEVANCE TO: Viola Startzman Clinic: 1874 Cleveland Road, Wooster, Ohio 44691, 330-262-2500

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the Patient, significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

We have prepared this "Summary Notice of HIPAA Privacy Practices" to explain how we are required to maintain the privacy of your health information and how we may use and disclose your health information. A Notice of HIPAA Privacy Practices containing a more complete description of the uses and disclosures of your health information is available to you upon request.

We may use and disclose your medical records for each of the following purposes: treatment, payment, and health care operations:

- TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers. This includes appointment reminders.
- PAYMENT means such activities as obtaining payment or reimbursement for services, billing or collection activities and utilization review by you, an insurance company, or a third party.
- HEALTH CARE OPERATIONS include managing your Electronic Medical Record to facilitate diagnostic medical consultations with participating physicians, as well as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service.
- We may also create and distribute de-identified health information by removing all references to individually identifiable information.
- We may contact you to provide information about our services or other health-related services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Viola Startzman Clinic Privacy Officer:

1. You have the right to request that you receive communications containing your protected health information from us by alternative means or at alternative locations. For example, you may ask that we only contact you at home or by mail.
2. Except under certain circumstances, you have the right to inspect and copy medical, billing and other records used to make decisions about you. If you ask for copies of this information, we may charge you a nominal fee for copying and mailing.
3. You have the right to ask for restrictions on the ways we use and disclose your health information for treatment, payment and health care operations. You may also request that we limit our disclosures to persons accosting your care. We will consider your request, but are not required to accept it.

If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Under certain circumstances, we may deny your request, such as when the information in accurate and complete. You have a right to receive a list of certain instances when we have used or disclosed your medical information. If you ask for this information from us more than once every twelve months, we may charge you a fee.

I authorize Viola Startzman Clinic to discuss my health information with the following persons:

Name: _____ Relationship to me: _____ Phone Number: _____

In the case of an Emergency please contact:

Name: _____ Relationship to me: _____Phone Number: _____

_____ _____

Signature of Patient or Person Authorized to Consent **Date**