Coordinated Health

Appointment Checklist (please bring the following to your appointment):

1. Completed patient information forms (included in this packet)
2. Insurance Card(s)
3. Driver's License or valid photo ID
4. Claim Information (if auto or worker's compensation injury)
5. Copay/Deductible Payment
6. Primary Care Referral (if applicable)
7. Any applicable imaging studies done in the past year (includes X-rays, MRI's, CT scans, and EMG's)

Patient Guidelines:

Thank you for choosing us as your healthcare provider. It is our mission to provide you with an exceptional patient experience and return you to your activities as quickly and safely as possible. Please help us in our mission to provide high quality, integrated care by adhering to the following policies while in our facility:

1. **Check-in** – Check in at the front desk prior to each appointment. Your copay will be collected prior to your appointment and will make a copy of your insurance card.

2. **Check-out** – All patients must check out after each appointment regardless of if a follow-up appointment is necessary.

3. **Copays** – Your copay is due at the time of your appointment. If you do not have your copay, your appointment will be rescheduled. If you insurance changes during the course of your treatment let us know right away so you do not get billed for any unpaid balances.

4. **Referrals** – If your insurance requires a referral, it is your responsibility to bring it with you. You will be responsible for payment of your office visit if you do not have it.

5. **Appointment Times** – If you are 10-15 minutes late for your appointment time, you may be asked to reschedule your appointment. If you know in advance you will be running late, please call and let us know. Being early is helpful, but it does not mean you will be taken back early.

6. **Monitor Children** – If you do bring children to your appointment, we ask that you supervise them and do not leave them alone in the waiting room.

7. **Cell Phones** – Refrain from using your cell phone during your appointment when you are with physician, clinician or other member of our staff.

8. **Form Fee** – There is a $15 fee for all disability or FMLA forms that need to be completed by a doctor. Allow 5-7 business days for your form to be completed. You will be contacted when they are ready.

Coordinated Health

REVIEW OF SYSTEMS

Patient Name _____ Today's Date _____

Please answer the following questions to the best of your ability.

	IN THE PAST 6 MONTHS: HAVE YOU HAD?	ARE YOU BEING TREATED BY A DR. FOR?
General:		
1. Any recent unexplained changes in weight?	_____ NO _____ YES	_____ NO _____ YES
2. Any unexplained fevers?	_____ NO _____ YES	_____ NO _____ YES
3. Night sweats?	_____ NO _____ YES	_____ NO _____ YES
4. Any weakness or fatigue?	_____ NO _____ YES	_____ NO _____ YES
5. Loss of appetite?	_____ NO _____ YES	_____ NO _____ YES
6. Any immune deficiencies?	_____ NO _____ YES	_____ NO _____ YES
Musculo-skeletal:		
7. Any joint pain?	_____ NO _____ YES	_____ NO _____ YES
8. Joint swelling?	_____ NO _____ YES	_____ NO _____ YES
9. Muscle pain?	_____ NO _____ YES	_____ NO _____ YES
10. Muscle cramps?	_____ NO _____ YES	_____ NO _____ YES
11. History of back pain?	_____ NO _____ YES	_____ NO _____ YES
Skin:		
12. Any rashes?	_____ NO _____ YES	_____ NO _____ YES
13. Changes in skin?	_____ NO _____ YES	_____ NO _____ YES
14. Changes in nails?	_____ NO _____ YES	_____ NO _____ YES
15. Changes in hair (e.g. - dryness)?	_____ NO _____ YES	_____ NO _____ YES
Head:		
16. Frequent headaches?	_____ NO _____ YES	_____ NO _____ YES
Eyes:		
17. Any eye pain? (discomfort)	_____ NO _____ YES	_____ NO _____ YES
18. Any double vision?	_____ NO _____ YES	_____ NO _____ YES
19. Any blurred vision?	_____ NO _____ YES	_____ NO _____ YES
Ears, Nose & Throat:		
20. Any ringing in the ears?	_____ NO _____ YES	_____ NO _____ YES
21. Any ear pain?	_____ NO _____ YES	_____ NO _____ YES
22. Any nasal discharge?	_____ NO _____ YES	_____ NO _____ YES
23. Any nasal bleeding?	_____ NO _____ YES	_____ NO _____ YES
24. Any sinus pain?	_____ NO _____ YES	_____ NO _____ YES
25. Any soreness?	_____ NO _____ YES	_____ NO _____ YES
26. Any hoarseness?	_____ NO _____ YES	_____ NO _____ YES
27. Any difficulty swallowing?	_____ NO _____ YES	_____ NO _____ YES
Respiratory:		
28. Any chest pain?	_____ NO _____ YES	_____ NO _____ YES
29. Wheezing?	_____ NO _____ YES	_____ NO _____ YES
30. Coughing?	_____ NO _____ YES	_____ NO _____ YES
31. Do you or have you had tuberculosis?	_____ NO _____ YES	_____ NO _____ YES
32. Are you a smoker?	_____ NO _____ YES	_____ NO _____ YES

OVER →

	IN THE PAST 6 MONTHS: HAVE YOU HAD?	ARE YOU BEING TREATED BY A DR. FOR?
Neurological:		
33. Have you had any fainting or blackouts?	_____ NO _____ YES	_____ NO _____ YES
34. History of seizures?	_____ NO _____ YES	_____ NO _____ YES
35. Any memory loss?	_____ NO _____ YES	_____ NO _____ YES
36. Numbness?	_____ NO _____ YES	_____ NO _____ YES
37A. Tingling?	_____ NO _____ YES	_____ NO _____ YES
37B. Loss of bowel control?	_____ NO _____ YES	_____ NO _____ YES
37C. Loss of bladder control?	_____ NO _____ YES	_____ NO _____ YES
Cardiovascular:		
38. History of heart problems?	_____ NO _____ YES	_____ NO _____ YES
39. High blood pressure?	_____ NO _____ YES	_____ NO _____ YES
40. Low blood pressure?	_____ NO _____ YES	_____ NO _____ YES
41. Any chest pains or palpitations?	_____ NO _____ YES	_____ NO _____ YES
42. Shortness of breath with normal activities?	_____ NO _____ YES	_____ NO _____ YES
Gastrointestinal:		
43. Abdominal pain?	_____ NO _____ YES	_____ NO _____ YES
44. Frequent diarrhea?	_____ NO _____ YES	_____ NO _____ YES
45. Constipation?	_____ NO _____ YES	_____ NO _____ YES
46. Heart burn?	_____ NO _____ YES	_____ NO _____ YES
47. Unexplained nausea or vomiting?	_____ NO _____ YES	_____ NO _____ YES
48. History of hepatitis?	_____ NO _____ YES	_____ NO _____ YES
49. Ulcers?	_____ NO _____ YES	_____ NO _____ YES
Urinary:		
50. Frequent urination?	_____ NO _____ YES	_____ NO _____ YES
51. Painful urination?	_____ NO _____ YES	_____ NO _____ YES
52. Urinary infections?	_____ NO _____ YES	_____ NO _____ YES
Endocrine:		
53. History of thyroid problems?	_____ NO _____ YES	_____ NO _____ YES
54. Heat intolerance?	_____ NO _____ YES	_____ NO _____ YES
55. Cold intolerance?	_____ NO _____ YES	_____ NO _____ YES
56. Excessive sweating?	_____ NO _____ YES	_____ NO _____ YES
57. Recent increased thirst?	_____ NO _____ YES	_____ NO _____ YES
58. Recent increased appetite?	_____ NO _____ YES	_____ NO _____ YES
FOR MEN ONLY		
59. Do you have a history of prostate problems?	_____ NO _____ YES	_____ NO _____ YES
FOR WOMEN ONLY		
60. Personal history of breast disease?	_____ NO _____ YES	_____ NO _____ YES
61. A family history of breast cancer?	_____ NO _____ YES	_____ NO _____ YES
62. Have you ever been pregnant?	_____ NO _____ YES	_____ NO _____ YES
63. If YES, how many times? _____	_____ NO _____ YES	_____ NO _____ YES
64. Personal history of ovarian cancer?	_____ NO _____ YES	_____ NO _____ YES

SPECIAL NEEDS *(check all that apply)* ____ None

____ Religious ____ Cultural ____ Emotional ____ Communication ____ Physical ____ Medical

Specify _____

Patient Signature _____ Date_____

Coordinated Health

MEDICAL HISTORY/MEDICATION FORM

Patient Name _____ DOB _____

Family Physician _____ Occupation _____

Employer _____ Length of Service _____

PAST MEDICAL HISTORY

History of:	Details	History of:	Details
❑ Cancer	_____	❑ Diabetes	_____
❑ High Blood Pressure	_____	❑ Thyroid	_____
❑ High Cholesterol	_____	❑ Other	_____
❑ Gastrointestinal	_____	❑ Other	_____
❑ Musculoskeletal	_____	❑ Other	_____

SURGICAL HISTORY

Type of Surgery:	Details	Type of Surgery:	Details
❑ Cardiac	_____	❑ Hernia	_____
❑ Gall Bladder	_____	❑ GYN	_____
❑ Appendix	_____	❑ Breast	_____
❑ Musculoskeletal	_____	❑ Hysterectomy	_____
❑ Tonsils	_____	❑ Other	_____

FAMILY HISTORY

Family History of:	Details	Family History of:	Details
❑ Cancer	_____	❑ Diabetes/Renal	_____
❑ Heart Disease	_____	❑ Other	_____

SOCIAL HISTORY

Do you smoke? ❑ No ❑ Yes _____ packs per day **Do you drink alcohol?** ❑ No ❑ Yes _____ drinks per day

ALLERGIES *(medications, metals, x-ray dyes or other substances)*: ❑ No ❑ Yes (If yes, please list names of allergen and type of reaction.)

_____

_____

Have you ever experienced a reaction to anesthesia? ❑ No ❑ Yes If yes, explain _____

PRESENT MEDICATIONS *(List any supplements/medications you are taking to include aspirin, vitamins, laxatives, calcium, etc.)*

Name of medication/supplement/vitamin, etc.	Dose (include strength and # of pills per day)	How long have you been taking this?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Coordinated Health

Patient Information Form

Date:	
Account Number:	
Name:	
Address:	
Home Phone:	
Work Phone:	
Cell Phone:	
Employer:	
Employer Address:	
Email Address:	
Social Security Number:	
Sex:	
Date of Birth:	
Marital Status:	
Emergency Contact:	
Emergency Contact Phone Number:	
Primary Care Physician:	
Referring Physician:	
Pharmacy Name:	
Pharmacy Address / Phone Number:	
Which of the following coverage types are you going to treat under (circle one):	**Group Health Insurance** **Workman's Compensation** **Motor Vehicle Insurance**
Has your insurance changed since the last time you were here or have you received new insurance cards (circle one):	**Yes** **No**
Subscriber's name (Primary Group Health Insurance):	
Subscriber's Date of Birth (Primary Group Health Insurance):	
Subscriber's Relationship (Primary Group Health Insurance):	
Subscriber's name (Secondary Group Health Insurance):	
Subscriber's Date of Birth (Secondary Group Health Insurance):	
Subscriber's Relationship (Secondary Group Health Insurance):	
Maiden Name:	
Referred By:	

Patient Signature _____ **Date** _____

Coordinated Health

Patient Information Form

Account Number:	
Name:	
Race: (Please select one only)	☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Declined ☐ Native Hawaiian or Other Pacific Islander ☐ Not Reported ☐ Unknown ☐ White
Ethnicity: (Please select one only)	☐ Declined ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Not Reported ☐ Unknown
Primary Language Spoken: (Please select one only)	☐ Amharic ☐ Arabic ☐ Armenian ☐ Bengali ☐ Cajun ☐ Chinese ☐ Croatian ☐ Czech ☐ Danish ☐ Declined ☐ Dutch ☐ English ☐ Finnish ☐ Formosan ☐ French ☐ French Creole ☐ German ☐ Greek ☐ Gujarathi ☐ Hebrew ☐ Hindi (Urdu) ☐ Hungarian ☐ Ilocano ☐ Italian ☐ Japanese ☐ Korean ☐ Kru ☐ Lithuanian ☐ Malayalam ☐ Mandarin ☐ Miao (Hmong) ☐ Moni-Khmer (Cambodian) ☐ Navaho ☐ Norwegian ☐ Not Reported ☐ Panjabi ☐ Pennsylvania Dutch ☐ Persian ☐ Polish ☐ Portuguese ☐ Romanian ☐ Russian ☐ Samoan ☐ Serbocroatian ☐ Slovak ☐ Spanish ☐ Swedish ☐ Syriac ☐ Tagalog ☐ Thai (Laotian) ☐ Turkish ☐ Ukrainian ☐ Unknown ☐ Vietnamese ☐ Yiddish

Patient Signature _____ **Date** _____

Coordinated Health

IMPORTANT PATIENT POLICIES

A. FINANCIAL POLICY AND ASSIGNMENT

While the filing of your insurance claims is a courtesy that we extend to our patients, we must emphasize that our relationship is with the undersigned and not with your insurance company. Because you have the relationship with your insurance company, if you are uncertain as to whether your insurance company will cover services rendered and/or supplies provided by CH, then you should contact your insurance company prior to incurring the expenses for such supplies and/or services.

Unless otherwise agreed by CH, payment for services is due at the time the services are rendered and/or supplies are provided. Some insurance companies may require referrals for services. It is your responsibility to obtain the referral prior to the time of service. If a referral is not presented before the service, the undersigned will be legally responsible for payment.

The undersigned hereby agrees to assign to CH all payments and benefits to which the below identified patient may be entitled for services rendered and/or supplies provided by CH and to be legally responsible to reimburse CH within thirty (30) days after receipt of a bill from CH for any amount that is not covered by the insurance companies, health maintenance or preferred provider organizations and/or other third parties that have been identified as being responsible for payment of the services rendered and/or supplies provided by CH to the below identified patient. Any bill from CH that is not paid by the undersigned within 90 days past shall be sent to collections. In that event, the undersigned will be legally responsible to reimburse CH for all reasonable collection and/or attorney fees and/or costs incurred by CH.

Patient's Initials _____

B. AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

I hereby authorize CH Hospital of Allentown, L.L.C and CHS Professional Practice, P.C. (CH) and its physicians, physician assistants, podiatrists, chiropractors, physical therapists and/or other employees and/or agents to furnish and/or to receive any & all information relating to the medical condition, care, treatment and/or history of the below identified patient to and/or from the following: all insurance companies, health maintenance or preferred provider organizations and/or other third parties that may be responsible for payment of the services rendered and/or supplies provided by CH; other health care providers and/or pharmacies of the below identified patient; any third party payors that are or have been responsible for pharmacy benefits of the below identified patient; and/or to all employers and/or schools of the below identified patient.

Patient's Initials _____

C. NO GUARANTEE OF CURE OR OUTCOME

I understand that no guarantee of a cure or an outcome of care/treatment can be or is given.

Patient's Initials _____

D. DISCLOSURE OF FINANCIAL INTEREST IN REFERRALS AND YOUR FREEDOM TO CHOOSE ALTERNATE PROVIDER

WE ARE REQUIRED TO NOTIFY YOU THAT CH AND/OR ITS PHYSICIANS AND/OR ITS OTHER HEALTH CARE PROVIDERS MAY REFER YOU FOR A MEDICAL SERVICE, PRODUCT OR DEVICE OR TO A FACILITY OR BUSINESS IN WHICH ONE OR MORE OF OUR PHYSICIANS HAS A FINANCIAL INTEREST. IF THAT HAPPENS, BE ADVISED THAT YOU WILL ALWAYS HAVE THE FREEDOM TO CHOOSE AN ALTERNATE PROVIDER. FURTHER, BE ADVISED THAT A LIST OF THE FACILITIES OR BUSINESSES IN WHICH ONE OR MORE OF OUR PHYSICIANS HAS A FINANCIAL INTEREST WILL BE PROVIDED TO YOU UPON YOUR REQUEST.

Patient's Initials _____

E. ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

CH has a detailed document called "Notice of Privacy Practices". It contains information about the policies and practices of CH regarding patient privacy. By signing below, the undersigned acknowledges the following about the "Notice of Privacy Practices" of CH: (a) you were offered a copy of it on the below date; and (b) you may review a copy of it on the Internet by going to www.coordinatedhealth.com and/or by requesting it at the front desk of any office of CH.

Patient's Initials _____

I HAVE REVIEWED THE ABOVE AND AGREE WITH ANY TERMS AND/OR CONDITIONS SET FORTH THEREIN.

_____ _____

Patient Account Number Patient Name

_____ _____

Date Signature of Patient or Legal Guardian

Coordinated Health

Coordinated Health Transition to Hospital Network – Provider Based Status
Patient Frequently Asked Questions

Due to the many changes of health care reform, organizations are moving towards integrating the delivery of healthcare with specific focus on receiving provider-based status as part of a Hospital Network. Coordinated Health is making just that transition. The government is supportive of the hospitals nationwide that have taken this step because it promotes a higher quality of care, equal to that required for hospital care. Care is delivered to patients in hospital and outpatient facility settings. Aligning all of our outpatient facilities with the hospital allows us to establish enhanced quality and safety standards, provide even more consistency in the delivery of care, continue to attract and retain high quality physicians, as well as maintain the state of the art facilities that you have become accustomed to at Coordinated Health.

What is Provider Based Status?
Provider Based Status refers to facilities that are owned and operated by the main provider but off campus from the actual hospital site. These offsite clinics are subject to the same standards as the main hospital. To achieve Provider Based Status our clinics underwent a rigorous inspection by the Department of Health to determine if they meet hospital standards for quality and safety. We passed that inspection with an effective date of July 1st, 2011. Through this change, all of our office locations will become provider based clinics of our hospital.

Why did my physician practice become a part of the hospital?
As part of a hospital network, you benefit by becoming a patient of an integrated delivery system which offers high-quality healthcare services and a continuity of care. As outpatient departments of the CH Allentown Hospital, your physician's clinic is required to function within the same regulatory standards as the hospital. This means that our outpatient physician clinics will be held to the same high standards as our hospitals. These standards are determined and upheld by two hospital regulatory agencies, the Department of Health and the Joint Commission. Typical physician offices do not have to comply with these standards.

Why am I receiving two bills?
By law, provider based clinics are required to bill separately for services. These bills are mailed separately and may not be received at the same time. One bill will be for the professional or doctor fees from the visit the other bill will be for the facility fee. Your total liability resulting from this split could be higher, lower or the same as if you received one bill.

Professional Fees will be billed by your physician and come from CHS Professional Practice, PC. This fee covers the time your physician has spent with you, along with the consultation, and any medical advice provided during your visit.

Facility Fees will be billed by CH Hospital of Allentown, LLC. This facility fee is the charge for administrative and other costs that are required to support the hospital-based clinic, including but not limited to office space, nursing staff, clerical support, and supplies.

If you have any questions regarding your bill, please contact our Central Billing Office at (610) 861-8080 or 1-877-247-8080 press prompt #4 then prompt #8.

Patient Initials: _____