Coordinated Health
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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** _____

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Patient Information Form

Why are we collecting this information?

According to the standards of the Center for Medicare Services, Meaningful Use is the act of using a Certified Electronic Health Record in a "meaningful way" over the course of 3 stages.

Meaningful Use means that an Eligible Professional must meet core and menu objectives within the EHR. By doing so, an organization will be able to improve quality, safety, and efficiency of patient care. The patient and their families will also have a greater role in the management of their healthcare.

Evidence shows that racial, ethnic, and language-based disparities persist in healthcare, leaving the most vulnerable populations at risk. We don't know why disparities occur, but these gaps in care are associated with higher mortality rates.

The collection of this information will be used to measure delivery of healthcare services; collecting accurate data is the basic foundation to identify differences and improve the quality of care. This information provides the practice with an accurate snapshot and trending of the patient population and the need for more care interventions, such as: interpreter services, translated patient healthcare information, improving rates of preventive services, and cultural competency training for staff.

The intention is that through the collection of this data, the disparities will be identified and care will be aligned regardless of these disparities so we can all benefit from the same quality of medical care.

Account Number:	
Name:	
Race: (Please select all that apply)	☐ American Indian or Alaskan Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Declined ☐ White
Ethnicity: (Please select one only)	☐ Declined ☐ Hispanic or Latino ☐ Non-Hispanic or Latino
Primary Language Spoken: (Please select all that apply)	☐ Amharic ☐ Arabic ☐ Armenian ☐ Bengali ☐ Cajun ☐ Chinese ☐ Croatian ☐ Czech ☐ Danish ☐ Declined ☐ Dutch ☐ English ☐ Finnish ☐ Formosan ☐ French ☐ French Creole ☐ German ☐ Greek ☐ Gujarathi ☐ Hebrew ☐ Hindi ☐ Hungarian ☐ Ilocano ☐ Italian ☐ Japanese ☐ Korean ☐ Kru ☐ Lithuanian ☐ Malayalam ☐ Mandarin ☐ Miao (Hmong) ☐ Moni-Khmer (Cambodian) ☐ Navaho ☐ Norwegian ☐ Panjabi ☐ Pennsylvania Dutch ☐ Persian ☐ Polish ☐ Portuguese ☐ Romanian ☐ Russian ☐ Samoan ☐ Serbocroatian ☐ Slovak ☐ Spanish ☐ Swedish ☐ Syriac ☐ Tagalog ☐ Thai (Laotian) ☐ Turkish ☐ Ukrainian ☐ Vietnamese ☐ Yiddish ☐ Other: _____

Patient Signature _____ **Date** _____

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IMPORTANT PATIENT POLICIES

A. FINANCIAL POLICY AND ASSIGNMENT: I, the undersigned, understand that, as a courtesy to its patients, CH Hospital of Allentown, L.L.C, Coordinated Health Orthopedic Hospital, L.L.C., and/or CHS Professional Practice, P.C. (hereinafter also collectively referenced as "CH") may seek reimbursement from an insurance company who may be responsible for medical services, devices and/or supplies provided to the below identified patient. I agree to: (a) provide CH with complete and accurate information concerning said insurance coverage; (b) assign any such benefits or rights to said insurance coverage to CH and authorize payment of benefits or rights related thereto to CH; (c) be financially responsible for all charges by CH that are not covered by and/or are not timely reimbursed by said insurance (in whole or in part), including (but not limited to) co-payments and deductibles for and/or coverage denials by said insurance; (d) be responsible for determining whether insurance coverage exists and the extent of said coverage in advance of the below identified patient being provided with medical services, devices and/or supplies by CH; (e) immediately, upon the request of CH, make any and all payments owed to CH for medical services, devices and/or supplies provided to or to be provided to the below identified patient; (f) reimburse CH for all reasonable collection service and/or attorney fees and for other reasonable costs incurred by CH related to its efforts to collect payments owed to CH for medical services, devices and/or supplies provided to the below identified patient and for any service fees or other charges assessed against CH related to a check issued for said payment of medical services, devices and/or supplies for the below identified patient; and (g) determine, in advance of the below identified patient's visit to CH, whether a referral is required by the insurance company I have identified as being responsible for payment.

Initials of Patient (or Parent/Guardian if Patient is a Minor) _____

B. AUTHORIZATION OF CARE/TREATMENT: I hereby authorize CH and its physicians, physician assistants, podiatrists, chiropractors, physical therapists and/or other employees and/or agents to provide such services, devices and/or supplies that they deem reasonable and appropriate for the below identified patient. I agree that any revocation of this authorization shall be done in a writing signed by me and personally delivered to CH. I understand that such a revocation shall not be effective as to a health care professional at CH until I personally serve that health care professional with said notice. I further understand that no guarantee of a cure or an outcome of care/treatment can be or is given by CH or its physicians, physician assistants, podiatrists, chiropractors, physical therapists and/or other employees and/or agents.

Initials of Patient (or Parent/Guardian if Patient is a Minor) _____

C. DISCLOSURE OF FINANCIAL INTEREST IN REFERRALS AND YOUR FREEDOM TO CHOOSE ALTERNATE PROVIDER: I UNDERSTAND THAT CH AND/OR ITS PHYSICIANS AND/OR ITS OTHER HEALTH CARE PROVIDERS MAY REFER THE BELOW IDENTIFIED PATIENT 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, I UNDERSTAND THAT I WILL ALWAYS HAVE THE FREEDOM TO CHOOSE AN ALTERNATE PROVIDER. I FURTHER UNDERSTAND THAT A LIST OF THE FACILITIES OR BUSINESSES IN WHICH ONE OR MORE OF OUR PHYSICIANS HAS A FINANCIAL INTEREST WILL BE PROVIDED TO ME UPON MY REQUEST.

Initials of Patient (or Parent/Guardian if Patient is a Minor) _____

D. 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, I acknowledge the following about the "Notice of Privacy Practices" of CH: (a) I was offered a copy of it on the below date; and (b) I 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. Further, I agree that the pharmacy for the below identified patient and CH may exchange information about my prescription history in accordance with said Notice of Privacy Practices.

Initials of Patient (or Parent/Guardian if Patient is a Minor) _____

E. ACKNOWLEDGEMENT OF PREVENTATIVE CARE COMMUNICATION OPTIONS: I understand that: (a) reminders for preventative/follow-up care may be sent to me by CH by any of the following communication methods: phone, mail and/or patient portal secure messaging; and (b) these reminders shall be sent to me via mail until I have completed registration with CH's patient portal (which shall then result in future reminders being communicated to me via patient portal secure messaging) or until I request a change in the method that these reminders for preventative/follow-up care are communicated to me. A change request (including a request to decline all such reminders for preventative/follow-up care) must be sent in writing to: Compliance Officer, Coordinated Health, 3435 Winchester Road, 4th Floor, Allentown, PA 18104.

Initials of Patient (or Parent/Guardian if Patient is a Minor) _____

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 Parent/Guardian (if Patient is a Minor)

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO EMPLOYER/PROSPECTIVE EMPLOYER AND/OR TO SCHOOL

I, the undersigned, authorize the doctors, physician assistants, physical therapists, nurses, case managers and/or other employees/agents of CHS Professional Practice, PC (CHS), Coordinated Health Orthopedic Hospital, LLC (CHOH), and CH Hospital of Allentown, LLC (CHHA) [hereinafter also collectively referenced as "CH"] to disclose the protected health information referenced in this Authorization to the following school and/or employer/prospective employer (and/or the officers, employees and/or agents designated by it/them to receive said protected health information):

_____.

Print Name of School and/or Employer/Prospective Employer

The protected health information to be disclosed is the entire designated record set and/or information contained therein, which may include (but is not limited to) historical, examination, drug/alcohol, mental health and/or HIV information and/or drug/alcohol testing results, except the following:

_____.

Print "None" if no exceptions apply

This protected health information is being disclosed at the request of the undersigned.

This Authorization shall be in effect for twenty-four (24) months from the below date.

I understand that I have the right to revoke this Authorization in writing at any time by sending written notification to: Privacy Officer, c/o Operations, Coordinated Health, 3435 Winchester Rd., Allentown, PA 18104. I understand that CH shall need a reasonable time to process my revocation. I agree that five (5) business days after CH receives said revocation is a reasonable period of time for CH to process my revocation. Consequently, I understand that my revocation will not be effective until five (5) business days after it is received by the Privacy Officer.

I understand that CH may condition my examination/evaluation on whether I execute this Authorization if the primary purpose of the creation of this protected health information is for disclosure to the aforesaid school or employer or prospective employer (e.g., a pre-employment physical or a physical to participate in athletics). Otherwise, CH shall not condition its medical care of the below identified patient on whether I execute this Authorization.

I understand that information used or disclosed pursuant to this Authorization may be used or disclosed by the recipient and may no longer be protected by Federal or State law.

I hereby release CH and/or their officers, representatives, employees and/or agents from any and all claims related to their use or disclosure of information pursuant to this Authorization. This release shall apply to my heirs, beneficiaries, successors and/or assignees.

By my signature below, I acknowledge that I have received a copy of this document.

_____ _____

Patient Account Number Patient Name

_____ _____

Date Signature of Patient or Legal Guardian

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Outpatient Department Coinsurance Notice & Frequently Asked Questions About Hospital Outpatient Department (or Provider Based) Billing for Office Visits

What is Provider (or Hospital) Based Status?

The Centers for Medicare and Medicaid Services (CMS) permit certain off-campus hospital outpatient department locations to charge a "facility fee" in addition to the provider's professional fee. This occurs when an off-campus hospital outpatient department (such as a physician office or imaging suite) is owned and operated as part of a hospital and must comply with quality and safety standards established by the Department of Health and Joint Commission for Accreditation of Hospitals.

Has Coordinated Health incurred costs to become Provider Based?

Yes. Satisfying the compliance requirements mentioned above has caused and will continue to cause significant equipment, construction and personnel expenses for Coordinated Health.

Why did these outpatient offices of Coordinated Health become part of a hospital?

To improve the experience of its patients. Being Provider Based has resulted in quality and safety improvements (e.g., from increased oversight and integration and from new equipment and facilities).

How does this affect billing?

CMS patients and patients of some commercial insurances who receive care in one of Coordinated Health's Provider Based (or outpatient) offices or clinics (such as a physician office) will receive two (2) charges for their visit (except for physical therapy[1]). One is the fee for the service rendered by the professional, and one is for the facility fee (i.e., the charge 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 office, including but not limited to office space, nursing staff, clerical support, and supplies. Your total liability resulting from these two (2) charges could be higher, lower or the same as if you received one charge. As always, it is your responsibility to determine whether insurance coverage exists and the extent of coverage for these two (2) charges in advance of services being rendered.

If I am a Medicare patient, what is my potential co-insurance liability for a visit to a Provider Based office?

In accordance with Medicare's laws and regulations, you will incur a co-insurance liability to CH Hospital of Allentown at a Provider Based office that you would not have otherwise incurred. In general, Medicare pays 80% of the "allowed" amount, and the remaining 20% is your co-insurance liability. Your actual co-insurance liability will depend upon the actual services furnished by the Provider Based office. For example, co-insurance balances for an average follow up visit for an established patient (99213) would be approximately $17.55 for the hospital (facility) charge and $10.12 for the physician charge. Please note that secondary coverage (if applicable) may pay these balances.

Which Coordinated Health outpatient offices or clinics are Provider Based?

Bethlehem: 2775 Schoenersville Road, 2300 Highland Avenue, 2030 Highland Avenue, 3100 Emrick Avenue	**Allentown**: 1621 North Cedar Crest, 1503 North Cedar Crest, 1405 North Cedar Crest, 250 Cetronia Road
Wind Gap: 1411 Jacobsburg Road	**Brodheadsville**: 111 Switzgable Drive
Lehighton: 239 North First Street	**Hazleton**: 1097B North Church Street
East Stroudsburg: 505 Independence Road, 511 VNA Road	

If you have any questions regarding your bill, please contact our Central Billing Office at 610- 861-8080 or 1-877-247-8080 and follow the prompts.

_____ _____

Patient Account Number Patient Name

_____ _____

Date Signature of Patient or Legal Guardian

_____

[1] Physical therapy has only 1 bill, and it is from CH Hospital of Allentown LLC.

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Review of Systems

Patient Name: MRN: DOB: Today's Date:

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

In the past 6 months have you had **ANY** *of the following?*

General:
1. Recent unexplained changes in weight ☐ N ☐ Y
2. Unexplained Fevers ☐ N ☐ Y
3. Night sweats ☐ N ☐ Y
4. Weakness or fatigue ☐ N ☐ Y
5. Loss of appetite ☐ N ☐ Y
6. Immune deficiencies ☐ N ☐ Y
7. Trouble sleeping ☐ N ☐ Y
8. Daytime sleepiness ☐ N ☐ Y

Musculo-skeletal:
9. Joint pain ☐ N ☐ Y
10. Joint swelling ☐ N ☐ Y
11. Muscle pain ☐ N ☐ Y
12. Muscle cramps ☐ N ☐ Y
13. History of back pain ☐ N ☐ Y
14. Trouble walking ☐ N ☐ Y

Skin:
15. Rashes ☐ N ☐ Y
16. Changes in skin ☐ N ☐ Y
17. Changes in nails ☐ N ☐ Y
18. Changes in hair (e.g.-dryness) ☐ N ☐ Y
19. Non-healing sores ☐ N ☐ Y

Head:
20. Frequent headaches ☐ N ☐ Y

Eyes: ☐ N ☐ Y
21. Eye pain(discomfort) ☐ N ☐ Y
22. Double vision ☐ N ☐ Y
23. Blurred vision ☐ N ☐ Y

Ears, Nose & Throat: ☐ N ☐ Y
24. Ringing in the ears ☐ N ☐ Y
25. Ear pain ☐ N ☐ Y
26. Nasal discharge ☐ N ☐ Y
27. Nasal bleeding ☐ N ☐ Y
28. Sinus pain ☐ N ☐ Y
29. Soreness ☐ N ☐ Y
30. Hoarseness ☐ N ☐ Y
31. Difficulty swallowing ☐ N ☐ Y
32. Dry mouth ☐ N ☐ Y
33. Snoring ☐ N ☐ Y

Respiratory:
34. Chest Pain ☐ N ☐ Y
35. Wheezing ☐ N ☐ Y
36. Coughing ☐ productive ☐ dry ☐ N ☐ Y
37. History of tuberculosis ☐ N ☐ Y
38. History of smoking ☐ N ☐ Y
39. Shortness of breath/difficulty breathing ☐ N ☐ Y
40. History of pneumonia ☐ N ☐ Y

Hematological/Lymphatic:
41. Swollen glands ☐ N ☐ Y
42. Bruise easily ☐ N ☐ Y

Neurological:
43. Fainting ☐ N ☐ Y
44. History of seizures ☐ N ☐ Y
45. Memory loss ☐ N ☐ Y
46. Numbness ☐ N ☐ Y
47. Tingling ☐ N ☐ Y
48. Loss of bladder control ☐ N ☐ Y
49. Loss of bowel control ☐ N ☐ Y
50. Mood swings ☐ N ☐ Y
51. Depression ☐ N ☐ Y
52. Anxiety ☐ N ☐ Y

Cardiovascular:
53. History of heart problems ☐ N ☐ Y
54. High blood pressure ☐ N ☐ Y
55. Low blood pressure ☐ N ☐ Y
56. Chest pains or palpitations ☐ N ☐ Y
If yes: What causes it? _____
How long does it last? _____
What makes it better? _____
What make it worse? _____
Where is it? _____
What does it feel like? _____
57. Shortness of breath w/normal activities ☐ N ☐ Y
58. Dizziness ☐ N ☐ Y
59. Loss of Consciousness ☐ N ☐ Y
60. Leg swelling ☐ N ☐ Y
61. Lightheadedness ☐ N ☐ Y

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62. Abdominal pain ☐ N ☐ Y
63. Frequent diarrhea ☐ N ☐ Y
64. Constipation ☐ N ☐ Y
65. Heart burn ☐ N ☐ Y
66. Unexplained nausea or vomiting ☐ N ☐ Y
67. History of hepatitis ☐ N ☐ Y
68. Ulcers ☐ N ☐ Y
69. Change in appetite ☐ N ☐ Y
70. Dark or bloody stool ☐ N ☐ Y

Urinary:

71. Frequent urination ☐ N ☐ Y
72. Painful urination ☐ N ☐ Y
73. Urinary infections ☐ N ☐ Y
74. Urinary urgency ☐ N ☐ Y
75. Blood in urine ☐ N ☐ Y
76. Urinary incontinence ☐ N ☐ Y
77. Get up at night to urinate ☐ N ☐ Y

Endocrine:

78. History of thyroid problems ☐ N ☐ Y
79. Heat intolerance ☐ N ☐ Y
80. Cold intolerance ☐ N ☐ Y
81. Excessive sweating ☐ N ☐ Y
82. Recent increased thirst ☐ N ☐ Y
83. Recent increased appetite ☐ N ☐ Y
84. Tremors ☐ N ☐ Y

Integumentary/Breasts:

85. Nodules ☐ N ☐ Y
86. Change in moles or freckles ☐ N ☐ Y

Integumentary/Breasts (cont.)

87. Change in hair growth, loss, texture ☐ N ☐ Y
88. Breast or nipple discharge ☐ N ☐ Y
89. Breast pain ☐ N ☐ Y

Mobility Matters:

90. Do you have any problems with bathing, dressing or eating ☐ N ☐ Y
91. Do you have any problem with light household tasks (e.g. cooking, cleaning or doing laundry? ☐ N ☐ Y
92. Do you have difficulty climbing stairs? ☐ N ☐ Y
93. Do you get shortness of breath doing any of the above mentioned tasks? ☐ N ☐ Y
94. Have you fallen in the last 6 months? ☐ N ☐ Y
95. Do you use an assistive device to walk? (cane or walker) ☐ N ☐ Y
96. Do you feel unsteady on your feet? ☐ N ☐ Y

FOR MEN ONLY

97. History of prostate problems ☐ N ☐ Y

FOR WOMEN ONLY

98. Personal history of breast disease ☐ N ☐ Y
99. Family history of breast cancer ☐ N ☐ Y
100. Have you ever been pregnant? ☐ N ☐ Y
If YES, how many times? _____
101. Personal history of ovarian cancer ☐ N ☐ Y
102. Bleeding or pain during intercourse ☐ N ☐ Y
103. Unusual vaginal itching or burning ☐ N ☐ Y
104. Vulvar or vaginal itching or burning ☐ N ☐ Y
105. Pelvic Pain ☐ N ☐ Y
106. Date of last menstrual period _____
107. Age during first menstrual period _____

SPECIAL NEEDS (*check all that apply*) ☐ None
☐ Religious ☐ Cultural ☐ Emotional ☐ Communication ☐ Physical ☐ Medical

Specify _____

_____

ALLERGIES (*Medications, metals, x-ray dyes or other substances*) ☐ Yes ☐ No

If yes, please list names or allergen and type of reactions:

_____

_____

Have you ever experienced a reaction to anesthesia? ☐ Yes ☐ No

If yes, please explain:

_____

Patient Signature _____