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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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 #3 then prompt #1.

_____ _____

Patient Account Number Patient Name

_____ _____

Date Signature of Patient or Legal Guardian

Coordinated Health
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Rehabilitation Treatment Agreement

Account Number:

Name:

As part of my rehabilitation treatment by physical and/or occupational therapy, I agree as follows:

1. **I will inspect the facilities and equipment before each usage.**
2. **I will immediately advise my therapist of a potentially unsafe condition and may decline to participate in any activity involving a potentially unsafe condition.**
3. **I will follow the advice and instructions of my therapist, which includes (but is not limited to) refraining from using electronic devices (e.g., cell phones, iphones or other texting devices) during usage of the facilities and equipment.**
4. **I am aware that stretching and strengthening associated with my therapy may result in temporary mild-to-moderate discomfort and/or pain.**
5. **I will immediately report any unusual, significant, severe or persistent changes in my symptoms/condition to my therapist.**
6. **I am aware that therapy carries a risk of permanent or temporary injury.**
7. **I understand that my therapy involves manual (hands-on) evaluation and treatment and that I should immediately communicate any touching that makes me uncomfortable to my therapist and to his/her supervisor.**
8. **I am free to choose a provider other than Coordinated Health for my therapy.**
9. **I will check the status of my co-pay/deductible and future appointments at the front desk at each therapy visit.**
10. **I understand that it is important to attend my scheduled therapy appointments and that failure to be punctual or a recurrence of no-shows or cancellations may result in me being discharged from therapy.**
11. **If I need to cancel my appointment, I agree to provide at least 24 hours notice.**
12. **In the event of three or more cancellations or no-shows without sufficient notice, I understand that I may be discharged from therapy..**

_____	_____	_____
Signature	Print Name	Date

If the person participating in therapy is not yet 18 years old: As parent or legal guardian of the above named child, I verify that I fully agree to, understand, and accept all provisions of this Agreement.

_____	_____	_____
Signature	Print Name	Date