WELCOME TO CHAPMAN AND ASSOCIATES HEALTH CARE!

We want to make sure we are the right provider for you and that we are par with your insurance company. Please complete the following information.

Date_____

Patient Name_____ DOB_____

Patient Address _____

_____ Phone _____

Referral Source: Newspaper (if so, which?) _____ Radio_____

Friend/Family_____ Current patient_____ Other_____

Previous PCP_____

Other Specialists_____

SERVICES REQUESTED:

PRIMARY CARE: _____

MENTAL HEALTH: Medication Management _____ Therapy _____

Please be aware that we do not prescribe controlled substances. If you are expecting us to prescribe narcotic pain medicines or chronic use of benzodiazepines (Ativan, Klonopin, Valium, Xanax), we may not be right practice for you.

Information included in this packet:

- Cancellation and Missed Appointment Policy
- A Team Approach to Health Care
- Demographic/billing information
- HIPAA release form
- New patient history and physical
- Release of information forms to obtain records from your other provider(s)
- Permission to communicate with other health care providers involved in your care

Team Approach to Health Care

We believe that health care is truly a team approach – the patient and the health care team working together for the best health care possible! We want your care to go as smoothly as possible. Therefore, we request the following:

- Please bring your routine medicines to each visit. This includes prescription drugs, vitamins, herbal medications, and over the counter drugs.
- Please bring your current insurance card to **every** office visit.
- **Per your insurance company, copays, coinsurance and deductibles are due at the time of the appointment.**
- Please allow at least ***2 business days*** for medication refills. Please use the Patient Fusion portal to message your provider directly if you need refills in between visits. If you do not have internet access, you can call the prescription line at ***240-362-7489*** including evenings and weekends! Leave a message on our confidential refill line for medication refills. **We do not accept faxed refill requests from your pharmacy.**
- Please remember that your insurance may take 24-48 hours (or longer) to approve a referral or authorization. We will do our best to get these authorizations as quickly as possible for you but we have no control over your insurance company.
- When calling in to make an appointment, please tell the person scheduling the appointment exactly why you need to be seen. The amount of time we allot for each appointment is based on the information you provide us.
- Cell phones are to be set to vibrate or off when being seen by the provider.
- **For Behavioral Health patients**: We believe that therapy is an important and integral part of mental health care. All patients are required to see a therapist at CAHC for an intake prior to seeing the psychiatric nurse practitioner. Therapy services will continue until the patient and therapist agree that the therapy goals have been met. Failure to keep therapy appointments may result in dismissal of behavioral health services (therapy and psychiatric medication management) from CAHC.
- Foul language or inappropriate behavior towards staff is not tolerated and may be grounds for dismissal.

We understand the frustration of having a condition that causes chronic pain. However, narcotics and controlled substances are addictive and can cause potential problems with long term use. Therefore, **we do not prescribe narcotics or controlled substances.** We will recommend other treatment options for chronic pain such as non-addictive medications, physical therapy, or pain management. We use non-addictive medications for control of anxiety and encourage nonpharmaceutical approaches such as therapy.

Cancellation, Missed Appointment and Financial Policy

Your appointment is time set aside specifically for you to address your health care needs and concerns. If you cannot keep your appointment, please notify us as soon as possible so we can use this time to help another patient.

How to cancel an appointment

Please call us at 240-362-7294 at extension 101 or 102 during regular business hours to cancel your appointment. If we are busy, please leave this information in a message along with your name and telephone number so we can return your call and reschedule your appointment. Once you're an established patient, you'll have the ability to cancel appointments on your patient portal through Patient Fusion.

Missed appointments/No-Shows

Any appointment that is not kept or cancelled with less than 24-hour notice is considered a missed appointment. *If you do not keep an appointment or give less than a 24-hour notice, you may be charged a $35.00 missed appointment fee*.

Late for an appointment

If you arrive late for an appointment, you may be asked to reschedule your appointment. We try our best to stay on time. Patients that arrive late for appointments cause a disruption in the schedule and cause our providers to get behind. It is up to you to take into consideration weather, road construction, EMT or bus schedule, taxi and other factors when determining the amount of time it takes to travel from your home to our office.

Repeated missed appointments and late arrivals may result in your dismissal from the practice.

Account Balance

Some insurance policies have copays, coinsurance and/or deductibles that must be met before your office visit will be paid or processed. We have implemented CCOF (Credit Card on File) for your convenience. Your credit card information will be kept confidential and secure, and charges to your card are made after your health plan processes your claims (unless payment is due at time services are rendered). You have the option of selecting a date on which charges can be made to your card, and limiting the amount charged. Patient balances must be paid within 30 days of receipt of the statement.

NSF (Non-Sufficient Funds/returned check fee)

There will be a $35.00 fee for any checks that are returned. This must be paid in full within 48 hours and prior to scheduling another appointment or medication requests.

Demographic and Billing Information

NAME: LAST_____FIRST_____MI_____

ADDRESS: _____DOB: _____/_____/_____

CITY: _____STATE_____ ZIP_____

CELL# _____HOME#_____ M_____ F_____

RACE_____ETHNICITY_____ LANGUAGE_____ Marital Status_____

SS#_____/_____/_____ EMAIL: _____

Employer: _____**Phone #:** _____

Preferred Pharmacy: _____**CITY:** _____

Emergency Contact: _____**Relationship:** _____

Emergency Contact Phone #_____

Primary Insurance: _____ **Policy #**_____

Policy Holder (if different from SELF) _____ **Policy Holders DOB:** ____/____/____

Relationship to Patient: _____

Secondary Insurance:_____**Policy #**_____

Policy Holder:_____**Policy Holders DOB:** _____/_____/_____

Relationship to Patient: _____

Medical Information Release Form
HIPAA Release Form

Name:_____ Date of birth:____/____/_____

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

_____ Spouse _____
Name Phone #

_____ Child(ren) _____
Name(s) Phone #

_____ Other _____
Name Phone #

_____ **INFORMATION IS NOT TO BE RELEASED TO ANYONE.**

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call: my home phone _____ my work phone _____ my cell (mobile) phone _____

Appointment reminders: home phone _____ cell message _____ call text _____ email ____

If unable to reach me: ____ you may leave a detailed message on my phone

____ please leave a message asking me to return your call

____ _____
(Specific instructions for phone calls)

For Patients 18 yrs and younger

_____ I give permission for my child to be seen without a parent present.
_____ **I DO NOT** give permission for my child to be seen without a parent present.

_____ Date: ____/____/_____
(Signature of parent/legal guardian)

Chapman and Associates Health Care

Medical History

Patient Name_____ Today's Date_____

Date of Birth_____ Place of Birth_____

Hospitalizations, surgeries, major events such as accidents, injuries, childbirth

Illness	Date	Hospital (if hospitalized)

Please list any allergies and what your allergy symptoms are: _____

_____

Ongoing medical problems such as diabetes, hypertension, asthma, etc.

Medical Problem	Date of onset

Please tell us about your family medical history.

	Alive Y/N	Age	Health issues	Cause of Death
Mother				
Father				
Brother(s)				
Sister(s)				
children				
m. grandmother				
m. grandfather				
p. grandmother				
p. grandfather				

Preventative Health Care:

When was your last:

Pap smear_____ Mammogram_____ PSA_____

Colonoscopy_____ Tetanus _____ Influenza_____ Meningitis_____

Hepatitis A_____ Hepatitis B_____ Pneumovax_____ Varicella_____

Personal History:

Occupation_____ Previous occupations_____

Marital status_____ History of domestic violence_____

Who lives in your household?_____

Alcohol use_____ Tobacco use_____ Caffeine use_____

Recreational drug use_____ Have you every been treated for a STD?_____

Do you follow any special dietary? _____

What is the highest grade or degree that you obtained?_____

Current Pharmacy: _____

Please list your current medications. Include herbal and nonprescription medications.

Name of medication	Dosage	Frequency

Is there any additional information that you think we should know about you?

_____

_____

_____

_____ _____

Signature Date

CAHC Provider Information Form

Patient Name: _____ DOB: ____/____/____

PRIMARY CARE PROVIDER

☐ I have a primary care provider. Name: _____
☐ I ***do not*** have a primary care provider.
☐ I give permission to communicate and exchange information with my primary care provider.
☐ I ***do not*** give permission to communicate and exchange information with my primary care provider.

THERAPIST

☐ I have a therapist. Name: _____
☐ I ***do not*** have a therapist.
☐ I give permission to communicate and exchange information with my therapist.
☐ I ***do not*** give permission to communicate and exchange information with my therapist.

PSYCHIATRIC PROVIDER

☐ I have a psychiatric provider. Name: _____
☐ I ***do not*** have a psychiatric provider.
☐ I give permission to communicate and exchange information with my psychiatric provider.
☐ I ***do not*** give permission to communicate and exchange information with my psychiatric provider.

OTHER
☐ Name: _____
☐ I give permission to communicate and exchange information

Name:_____

Date of Birth:_____

Authorization to Bill/Pay Insurance Benefits

I hereby authorize Chapman and Associates Health Care to bill my medical insurance, not to exceed the balance due of the provider's charge for services rendered by the provider. I also authorize insurance benefit payment to be assigned/payable to Chapman and Associates Healthcare. I understand that I am financially responsible for any balance not paid by my insurance company.

Missed appointment, cancellation fee

I understand that I must give Chapman and Associates Healthcare a 24 hr notice upon having to cancel or reschedule any appointment. I also understand that I may be billed and responsible to pay any fees that apply to a missed appointment, no show or cancelled same -day appointment.

Authorization to Release Information

I hereby authorize Chapman and Associates Healthcare to release information about me which may be necessary to process claims that are payable, under medical insurance plans to which I am potentially entitled.

HIPAA Notice of Privacy Practices

*I have been offered a copy of CAHC Notice of Privacy Practices. I **DO/DO NOT** (please circle one) want a copy of this policy.*

ACKNOWLEDGEMENT

*I have read, understand and agree with the above policy procedures. I understand this authorization will be in effect for **12 months** from the date of signature unless cancelled by me or legal representative in writing.*

PATIENT SIGNATURE* _____ **DATE:** _____

*Patients 18 years of age and older must sign for themselves

If other than patient, please state relationship: _____

(legal documentation required is other than parent)

CAHC OFFICE STAFF: _____ **DATE:** _____