Patient Information		**Please Make Changes Here**
Primary Care Physician		___________________________________
Patient Name		___________________________________
Patient Address 1		___________________________________
Patient Address 2		___________________________________
City, State Zip		___________________________________
County		___________________________________
Phone #		___________________________________
Marital Status		___________________________________
Date of Birth Sex		___________________________________
E-Mail Address		___________________________________
Primary Pharmacy Name		___________________________________
Primary Pharmacy Phone #		___________________________________
Race (circle one)	American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, Hispanic, Other, Refused	
Ethnicity (circle one)	Hispanic, Non-Hispanic, Refused	
Patient Employer		___________________________________
Employer Address		___________________________________
Primary Insurance		___________________________________
Group #		___________________________________
ID #		___________________________________
Policy Holder Name		___________________________________
DOB		___________________________________
Secondary Insurance		___________________________________
Group #		___________________________________
ID #		___________________________________
Guarantor Name		___________________________________
Guarantor Address		___________________________________
City, State Zip		___________________________________

All professional services rendered are charged to the patient, necessary forms will be completed to help expedite insurance carrier payments. If you are covered by a plan with a restrictive network, it is your responsibility as the insured/patient to seek professional care with a participating provider within your plan. The patient (or guardian) is responsible for all fees, regardless of insurance coverage.

I hereby give the physicians of UHN permission to treat me or my dependent(s), and I authorize UHN to furnish any medical information necessary for insurance claim submission and/or payment. I understand that I am responsible for any remaining fees not covered by insurance.

I further understand that some or all of the services rendered may be deemed “non-covered” by my insurance carrier and that I will be billed for such services.

I authorize payment of medical benefits to the physicians of UHN for services described herein. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees and services rendered.

Patient Signature: ____ Date: ____________________

Parent/Guardian Signature: ____ Date: ____________________

DISCLOSURE OF PERSONAL HEALTH INFORMATION

Unity Health Network has implemented an electronic medical record in order to improve the efficiency in our offices and provide the highest quality healthcare services to our patients.

Unity Health Network adheres to the standards as defined for privacy of individually identifiable health information; which is commonly referred to as the privacy rule. The Privacy Rule standards address the use and disclosure of individuals' health information better known as PHI (Protected Health Information). Also, Unity Health Network follows the regulations associated with the Health Insurance Portability and Accountability Act (HIPAA); a notice of our privacy practices is available to you upon request.

We need to obtain your permission to release or share your protected health information. Please complete this form in order for Unity Health Network to release your medical records.

Ohio Public Health Reporting

To keep track of Patients' adult and childhood immunizations and health information, your **Unity Health Network Providers** use the Ohio Department of Health secure, online system, called Impact Statewide Immunization Information System (ImpactSIIS). In addition to immunizations, body mass index, vision, lead, tuberculosis and hearing measures are reported to ImpactSIIS. The primary benefit of ImpactSIIS is that State of Ohio authorized users like schools, local health departments, immunization providers, and Women Infants and Children (WIC) program staff, may access your immunization and health information, even if you move. Please note that not all authorized entities use ImpactSIIS. If you have additional questions about ImpactSIIS, please call the Ohio Department of Health at 1-866-349-0002 or (614) 466-4643 or send an email message to "mailto:impact@odh.ohio.gov". If you do not want your immunization and health information included in ImpactSIIS, ask your Provider or the Ohio Department of Health for the ImpactSIIS Removal Request form.

We hope you recognize the importance of the steps we are taking in order to provide high quality, efficient, healthcare services. As always, our patients are our number one priority.

Health Information exchange (HIE)

Unity Health Network participates in one or more Health Information Exchange (HIE). As your healthcare provider, we may appropriately access your health information electronically, as well as securely share your health information with other health information exchange participants. For example, if you see a Unity physician and then visit a hospital that participates in the HIE, that hospital would be able to access your Unity Health Network medical chart information. This is a voluntary agreement. You may opt-out at any time by notifying our office.

Personal Health Information Release / Emergency Contacts:

Name: ______________________________________

Relationship: _________________________________

Home Phone #: _______________________________

Cell Phone #: _________________________________

Is this person able to receive your Personal Health Information (circle one)? Yes No

Name: ______________________________________

Relationship: _________________________________

Home Phone #: _______________________________

Cell Phone #: _________________________________

Is this person able to receive your Personal Health Information (circle one)? Yes No

Patient Signature: ____ Date: ___________________

Parent/Guardian Signature: ____ Date: ___________________

CONSENT AND COMMUNICATION

What is your preferred contact number for appointment reminders and messages?

Preferred Phone#: ____

If Cell is preferred, is text allowed (circle one)? Yes No

What is your preferred time of day for appointment reminders and messages?

☐ Morning ☐ Afternoon ☐ Evening

Would you like to be web-enabled for our patient portal (check box)? ☐ Yes ☐ No ☐ I already have access

If yes, please provide your email address ____

On occasion, we may need to call you and leave information regarding the results of any treatments or tests that you have had. May we leave this information on your voicemail (check box)? ☐ Yes ☐ No

If yes **please circle** preference:

Home Phone or Cell Phone

Brief or Extended

By providing my telephone number and e-mail address to Unity Health Network, I agree to receive automated calls, prerecorded voice and text messages, and/or e-mail messages related to my health care from Unity Health Network and its affiliates. I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing which must be provided to my clinic. I acknowledge and accept that communications may be sent unencrypted and there is some risk of disclosure or interception of the contents of these communications.

Text Messages: By providing my telephone number to Unity Health Network: (1) I agree to receive text messages related to my health care from Unity Health Network and its affiliates; (2) I acknowledge and agree that these text messages, which may contain Protected Health Information (PHI), will be sent via unencrypted means and there is some risk of disclosure or interception of the messages; (3) I agree that message & data rates may apply, terms and privacy information are available at https://www.optumcare.com/texting.html and that these messages will recurring and vary based on Unity Health Network with me. To stop receiving text messages at any time, I may reply "STOP".

Email: I acknowledge and agree that email messages, which may contain Protected Health Information (PHI), will be sent via unencrypted means and there is risk of disclosure or interception of the emails. To stop receiving e-mails at any time, I may click "unsubscribe" at the bottom of the e-mail.

In order for us to service our account or to collect any amounts you may owe, we, as well as any agency contracted by us, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We, as well as any agency contracted by us, may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I do hereby acknowledge notification of the Notice of Privacy Practices, Policies, and Procedures.

Patient Signature: ____ Date: ____________________

Parent/Guardian Signature: ____ Date: ____________________

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a summary of our Financial Policies which we require you to read and sign prior to initial treatment. We welcome the opportunity to discuss any aspect of our financial policies with our patients. Please feel free to contact our billing office at 330-923-6606 - Monday thru Friday 7:00 a.m. to 5:00 p.m.

INSURANCE CARD

It is very important that we receive the correct insurance information. Please present all current insurance card(s) at the time of service. Due to the many changes that occur in insurance coverage, you will be asked to present this card(s) at each visit. We will make every effort to bill your insurance company based on accurate, current information presented to us at the time of service.

CO-PAYMENT

Our contracts with insurance companies require that we collect the entire co-payment at the time of service.

INSURANCE PARTICIPATION

Unity Health Network makes every effort to participate with insurance plans for the convenience of our patients; however, you are responsible for knowing your insurance coverage. Please verify your physician's participation, referral, and pre-cert requirements with your insurance company prior to your appointment. Unity Health Network assumes no liability for non-coverage due to insurance participation and/or plan design. You will be responsible for any balance that results as out-of-network benefits or non-participating provider. We do not accept UCR from non-participating insurance companies.

APPOINTMENT CANCELLATION

There will be a $25.00 fee for all office appointments and a $100.00 fee for MRI, Neurodiagnostic, and NeuroPsych testing appointments that are not attended and not canceled at least 24 hours prior to the scheduled time. This charge is not covered by insurance companies. After three (3) no-shows or failed appointments, you may be dismissed from the practice.

PRESCRIPTION REFILLS

Please remember to obtain your prescription refills during your office visit. There is a $10.00 charge for calling or faxing a prescription into your pharmacy outside of a scheduled visit.

INSURANCE PAYMENT/PATIENT RESPONSIBILITY

After receiving payment from your insurance company, we will send you a statement for any additional patient responsibility. All balances billed are due within 30 days of the first statement. Unpaid balances greater than 90 days are subject to our collections process.

SELF-PAY DISCOUNTS

We offer a self-pay discount to patients that do not have any type of insurance. This discount is only available if charges are paid in full at the time of service. Our physicians will code the service to the level of specification appropriate for the service rendered, which has a corresponding self-pay charge. PLEASE NOTE: If you are uninsured or a self-pay patient, you have the right to request a good faith estimate of expected charges prior to receiving services.

All services provided for an MVA or Personal Injury claim will be billed to your medical insurance as long as we are "in-network" with your insurance carrier. You are responsible for all copayments, coinsurance, deductibles, and non-covered services. We do not bill "out-of-network" insurance carriers for conditions related to MVA or Personal Injury claims. We do not bill auto, home, or other non-medical insurance. Patients presenting with conditions covered by these types of policies will be considered self-pay and payment in full is required at the time of service. We do not offer self-pay discounts for MVA or Personal Injury claims.

NON-COVERED SERVICES

All services deemed non-covered services by your insurance company are the responsibility of the patient or the patient's guarantor.
I have read the Financial Policy. I understand and agree to this Financial Policy. I verify the billing information provided is accurate and authorize the release of any medical information necessary to process claims. I request payments be sent directly to the physician of the services provided when the physician accepts the assignment of my insurance benefits.
I further understand and agree that my failure to follow this Financial Policy may result in Unity Health Network terminating my patient-physician relationship

Patient Signature: ____ Date: ________________

Parent/Guardian Signature: ____________________________________ Date: ________________