PLEASE PRINT YOUR INFORMATION IN THE WHITE SPACES BELOW

PATIENT INFORMATION

Print ABOVE: N AME	LAST	FIRST	MI	DATE OF BIRTH

Print ABOVE: STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE	U.S. MILITARY SERVICE: Circle One: ACTIVELY SERVING DISCHARGED NONE LOCATION
( ) --	( ) --	( ) --	

Sexual Orientation: Circle One
Choose not to disclose Straight or heterosexual
Bi- sexual Lesbian, gay or homosexual

Marital Status: (Circle One)
Single Married Widowed
Separated Divorced

--- ---

PATIENT'S SOCIAL SECURITY

Gender Identity: Please check which applies
[ ] Choose not to disclose [ ] Female [ ] Female-to-Male [ ] Genderqueer, neither male nor female [ ] Male [ ] Male – to –Female

Print ABOVE: EMERGENCY CONTACT NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT
	( ) --	

WHICH OF THE FOLLOWING GROUPS BEST DESCRIBES YOU: (Please complete BOTH 1 & 2) **1.Race** ☐ AMERICAN INDIAN / ALASKA NATIVE ☐ BLACK ☐ ASIAN ☐ WHITE ☐ NATIVE HAWAIIAN ☐ HISPANIC/ LATINO ☐ ASIAN PACIFIC ISLANDER ☐ OTHER PACIFIC ISLANDER ☐ UNKNOWN **(continued below)**
2. Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐Refused

COUNTY OF RESIDENCE	Primary Language spoken:	PATIENT'S RELATIONSHIP TO RESPONSIBLE PARTY : (Circle One) Self; Spouse; Natural Child; Step Child; Parent; Foster Child; Foster Parent

RESPONSIBLE PARTY INFORMATION (enter name of person financially responsible for your account.)

NAME LAST	FIRST	M.I.

STREET ADDRESS	CITY	STATE	ZIP	COUNTY

MAILING ADDRESS	CITY	STATE	ZIP	COUNTY

HOME PHONE	WORK PHONE	FAMILY INCOME	FAMILY SIZE
( ) --	( ) --	$ PER ☐ WEEK ☐ YEAR ☐ MONTH ☐ BI-MONTHLY	

EMPLOYER NAME	EMPLOYER ADDRESS		SEX	MARITAL STATUS (Circle One)
--- ---			☐ F ☐ M	SINGLE MARRIED DIVORCED SEPARATED WIDOWED

SECURITY NO SOCIAL.	DATE OF BIRTH

INSURANCE COMPANY

PRIMARY INSURANCE	ID#	GROUP #	INSURANCE COMPANY ADDRESS

RELATIONSHIP TO PATIENT (Circle One): Self; Spouse; Natural Child; Step Child; Parent; Foster Child; Foster Parent

NAME OF INSURED	DATE OF BIRTH	INSURED'S EMPLOYER

SECONDARY INSURANCE	ID#	GROUP #	INSURANCE COMPANY ADDRESS

RELATIONSHIP TO PATIENT (Circle One): Self; Spouse; Natural Child; Step Child; Parent; Foster Child; Foster Parent

NAME OF INSURED	DATE OF BIRTH	INSURED'S EMPLOYER

Assignment and Release: I authorize my insurance benefits to be paid directly to the Lisbon/East Liverpool Community Health/Dental Center. I understand that I may be responsible for non-covered charges. I also authorize the Lisbon/East Liverpool Community Health/ Dental Center to release any information required to process this claim.

SIGNATURE: **X** _____ DATE: _____

EMAIL ADDRESS _____ (This information is needed to access the Patient Portal)

CAA Health, Behavioral Health and Dental Centers

Medical/Dental - Did NOT Keep Appointment Policy

Your Medical, Behavioral Health or Dental Providers want to be sure that you and other area residents have access to high-quality care when you need it. In order to provide the best access to medical, behavioral health and dental services for all of our patients, please be aware of the following appointment policy:

Scheduled Appointments: Although we will make every effort to remind you of your upcoming appointment by phone, by email or by mail, it is your responsible to remember your appointment date and time.

Canceling Appointments: If you cannot make your scheduled appointment, you must call us at least 24 hours in advance to let us know so that we can offer your appointment to another patient. Failure to provide at least 24 hours notice counts as a missed appointment.

Missed Appointments: Your health is important to us. Missed appointments are taken very seriously as they affect your health.

Outcome of Not Keeping Appointments -

1. If you miss your appointment, you will be documented as having missed an appointment. The front desk staff will attempt to contact you to reschedule and remind you of our Did Not Keep Appointment Policy (DNKA). If you cannot be reached by phone we will send a letter to remind you of your missed appointment and the DNKA policy.

2. If you continue to not keep or cancel appointments, three (3) times in a 12-month period, or five (5) times in a 12-month period for children under 18 years of age, a warning letter will be mailed to you informing you of the policy and potential outcome of any future missed appointments.

3. After warning letter, you fail to keep future appointments you will only be allowed to schedule Same Day appointments (SDA) only.

4. If Same Day Appointments are missed, potential discharge or walk in appointments only will be recommended.

5. After one year if you have not missed any appointments, patient may request to be able to schedule future appointments again.

Please talk to any of the Health, Behavioral Health or Dental Centers Staff if you have questions about our Did Not Keep Appointment Policy.

I understand and agree to abide by this Did Not Keep Policy.

_____ _____ _____

Patient Signature DOB Date

_____ _____

Parent/Guardian Signature (For Patients Under 18) Date

4/14/2019

CAA Health, Behavioral Health and Dental Centers

Consent/Authorization for Medical Health Exam and Treatment

I hereby consent to, and request and authorize the staff of the CAA Health Center to perform those procedures normally necessary. I understand that if indicated and within the scope of clinical program practice, services will be done by the CAA Health Center provider. If not within the scope of the program's clinical practice I will be referred out of the CAA Health Center to another provider. The patient or guardian retains the right to refuse any and/or all treatment/tests deemed necessary after consultation with the provider.

I am entitled to ask and to have my questions answered to my satisfaction, regarding any treatment or proposed treatment. I should always ask my provider if there is any aspect of my care or treatment that I do not understand.

I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks. I acknowledge that no guarantees have been made to me about the results of examination or treatment in this office.

I give permission to the CAA Health Center to release pertinent medical information concerning me to my insurance companies, if applicable, and authorize my insurance companies to pay all benefits due, if any, directly to the CAA Health Center or supplier for services rendered. Payment by the insurance companies to CAA Health Center or supplier for services previously paid for by the patient or guardian at the time of service will be refunded to the patient or guardian.

(Note: Insurance claims are filed as a courtesy to you without charge. However, CAA Health Center cannot accept the responsibility for collecting for your claim, or negotiate a settlement on a disputed claim.) Even though an insurance claim has been filed, all charges are the responsibility of the patient.

I realize that there may be medical personnel in this office who are still in training. I understand that they may be present during my care unless I request them not to be present.

This form has been fully explained to me and I am satisfied that I understand its content and significance. This consent is valid until the patient, parent, or guardian revokes it.

CAA Health, Behavioral Health and Dental Centers attempts to confirm all appointments with telephone/patient portal reminders. I consent to receive phone messages regarding my appointment time and date.

Patient Name (Please Print):_____ Date of Birth:_____

Date:_____ Signature:_____
(guardian or parent if patient is a minor)

CAA Health, Behavioral Health and Dental Centers

Notice of Privacy Practices Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to receive a copy of our Notice before signing this Acknowledgement. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you acknowledge that you have had the opportunity to receive our Notice of Privacy Practices. The Practice provides this from to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices, and I have the opportunity to review and receive a paper copy of this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- I have the right to request restrictions to the uses of my information. The Practice does not have to agree to those restrictions, but if we do, we will honor these restrictions.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone
- Ok to leave message with detail information
- Leave message with call back number only

☐ Cell Phone
- Ok to leave message with detail information
- Leave message with call back number only

☐ Electronic Communications
- ☐ Ok to email message with detail information
- ☐ Ok to email with call back number only

Email Address: _____

I authorize this office to disclose information regarding my medical condition/treatment to (please check and print names for all that apply):

- My Spouse: _____
- My child (ren): _____
- My Parents: _____
- Other (ie., family member or friend who may be involved in my medical care); _____

I understand that if I provide the Practice with a secondary contact, the Practice may contact that person with information regarding my appointments.

This Acknowledgement was signed by: _____ Date: _____

Patient or Representative

_____ DOB: _____

Printed Name – Patient or Representative

Relationship to Patient (if other than patient): _____

Witnessed by: _____

Print name – Practice Representative

Revised 8.2019 sg

Community Action Agency of Columbiana County, Inc.
Health, Behavioral Health and Dental Centers Privacy Notice:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses/Disclosures:

Medical information including but not limited to diagnosis, medical history, description of symptoms, medications and treatment methods, and other protected health information may be shared with other providers including but not limited to physicians, hospitals, labs, etc., to help with the treatment of your medical condition. Such information may be given orally, in writing, by fax, by telephone or in any other way that seems reasonable to the provider. *For example, your typed office notes [including past medical history, medicines, symptoms, treatments, diagnosis and any other information listed on your health record] may be faxed or otherwise sent to the office of another provider who is taking care of you.*

Medical information may also be given to your insurance company in order for us to be paid. Information about each visit to our office, including but not limited to services provided, diagnosis and symptoms, treatment given, etc., may be sent to your insurance company in order to receive payment. *For example, we will provide to your insurance company or other payer all information necessary to receive payment for all services given to you, including but not limited to diagnosis information, treatment details, dates of service, medications and services provided, or any other information required by or requested from your insurance company or other payer.*

Medical information about you may also be used for other health care operations. *For example, providers and/or staff members may use for staff training or for evaluating quality performance your entire medical record or parts of your medical record.*

Medical information may be provided to business associates of the health center. These business associates may use that information to provide services for the health center. *For example, if we send your blood to an outside lab, that lab will function as a business associate of the health center in testing your blood.*

In addition to disclosing the patient's protected health information for purposes of treatment, payment and other healthcare operations, the health/dental centers may disclose information when required by law to do so. CAA may also make the following uses/disclosures of protected health information without written authorization from the patient:

*medical information may be given to other departments of the Community Action Agency (CAA) of Columbiana County who provide services that may be helpful for our patients

*appointment reminders
*fundraising activities of the health center
*special events such as health fairs or other community outreach efforts
*special contacts regarding products/services that may be of value to some of our patients (for example, information regarding new testing equipment for our diabetic patients)
*reporting required by our state and/or federal funding sources

We will communicate directly with your employer or the employers' designated representative for services provided to you if such services were filed under workers' compensation, requested by or paid for by your employer, or provided under an employer's pre-employment testing program, drug and alcohol testing program or other employer authority.

Other than the uses listed above, we will not disclose your protected health information to anyone unless you have given us specific, written permission to do so. You may revoke such permission at any time. Such changes in permission must be done in writing by the patient to the privacy officer of the health center.

Individual Rights of our patients:

You have the right to request restrictions on certain uses/disclosures of your protected health information. These restrictions must be requested by the patient in writing to the privacy officer of the health center. The health center is not required to agree to such restrictions. The privacy officer will answer your request for restriction in writing.

You have the right to ask for information from the health center to be sent to you in ways other than your usual address, phone number, etc. These requests must be given to the privacy officer in writing. If you are requesting that we contact you in a way OTHER THAN your commonly known address/phone number, etc., you must prove that using this alternative address/phone number, etc., will not keep us from getting paid for services provided to you.

You have the right to see and receive a copy of your protected health information. If you want to see your records or get copies of your records, you must ask the privacy officer in writing. The privacy officer will talk to you to arrange a time and place that are acceptable to you and to the health center for you to review or get copies of your records. If there is a reason that you can't see or copy your records, the privacy officer will follow the privacy rule as required by HIPAA law in explaining those reasons to you.

You have the right to request an amendment (change) to your protected health information. Such request for amendment must be made to the privacy officer by the patient in writing. Asking for changes to your health record must include an explanation of why you are asking for the changes. The privacy officer will grant or deny the amendment request as required by the HIPAA privacy rule. If your request is denied, the privacy officer will explain to you the reasons for this denial according to the HIPAA rule.

You have the right to receive a list of disclosures of your protected health information made by the health center. (A "disclosure" means giving your private information to someone else.) We will keep a list of any of your information that we give to someone else when that information is given for reasons OTHER THAN treatment, payment, or health care operations. If you want a list of such disclosures, you must send a written request to the privacy officer. The privacy officer will follow the HIPAA rule in giving this list to you.

You have the right to receive a written copy of this privacy notice. Patients must prove that they have received the privacy notice by signing an acknowledgement form. The health center reserves the right to change or revise its privacy notice at any time without prior notice to patients. Such changes or revisions will become effective immediately and will govern all protected health information from the time of the revision. A current privacy notice will always be prominently displayed at all health center locations and will be available to patients upon request.

The health center is required by law to keep your information private and to give you this notice that tells you how your information will be used. The health center is committed to providing excellent patient care within the current government rules. As part of that excellent patient care, we will handle your protected health information as outlined in this privacy notice.

If you believe that your patient rights as described above have been violated by the health center, you may register a complaint to the privacy officer at the health center or to the secretary of Health and Human Services. To file a complaint with the health center's privacy officer, you may either telephone the privacy officer at (330) 424-7221 or mail a complaint to the privacy officer at 7880 Lincole Place, Lisbon, OH 44432. The privacy officer is also available at email address jenna.wonner@caaofcc.org. The health center will not retaliate in any form against any patient who files such a complaint.

For more information about this privacy notice, contact the Privacy Officer by the address or phone number listed above. **This privacy policy is in effect beginning April 14, 2003.**

CAA Health and Behavioral Health Centers

CAA Sliding Fee Scale Application

Valid from April 1, 2022 to March 31, 2023

Please fill out the application completely and attach all income information

PERSONAL INFORMATION

Last name:_____ First Name:_____

Date of Birth :_____ Social Security Number:_____

Home Address:_____ Phone number:_____ Cell:_____

_____

HOUSEHOLD INFORMATION

Name of Spouse:_____ Date of Birth_____ SS #_____

List dependents under the age of 18

Name:_____ Date of Birth_____ Relationship_____

Name:_____ Date of Birth_____ Relationship_____

Name:_____ Date of Birth_____ Relationship_____

Name:_____ Date of Birth_____ Relationship_____

Name:_____ Date of Birth_____ Relationship_____

Acceptable Forms of Income

_____Pay Stubs, 2 most recent

_____W-2 Tax Form

_____Wage Tax Receipt

_____State or Federal Income Tax Return

_____Self-employment bookkeeping records

_____Sales and Expenditure Records

_____Statement from Employer

_____Cert. from Employment Services Office

_____Cert. from the State Income Tax Bureau

_____Railroad Retirement Board Record

_____Social Security Award Letter

_____Benefit Payment Check

_____Unemployment Award Letter

_____Pension Award Notice

_____Veteran's Administration Award Notice

_____Income Tax Records

_____Railroad Retirement Award Letter

_____Court papers for Alimony/Child Support

_____Social Security Form SSA-1610

_____Social Security District Office Files

_____Bureau of Employ. Serv. Cert.

_____Unemployment Certification

_____Union Records

_____Workers Compensation Records

_____Veterans Administration Records

_____Insurance Company Records

_____Tax Records

I have completed this application for sliding fee eligibility and confirm that all information is correct to the best of my knowledge.

I understand that a nominal fee will be requested at the time of each medical, behavioral health or dental visit.

I certify that the information in this application is, to the best of my knowledge, a true, accurate and complete disclosure of the requested information. I understand that I may be held civilly and criminally liable under federal and state laws for knowingly making false or fraudulent statements.

X Sign Here_____ **Date**_____

Eligibility Information – For Office Use Only

Annual Gross Income $_____ Number of Dependents_____

☐ **Application Approved**

(Circle One Slide Level)

	Medical/BH	**MAT**	**Dental**	**Pharmacy (Base fee + Medication Cost [MC])**
Slide A (nominal fee)	$20	$10	$35	$9+MC
Slide B	$35	$15	$45	$12+MC
Slide C	$50	$25	$55	$15+MC
Slide D	$65	$35	$65	$18+MC
Slide E	$80	$40	$75	$21+MC

☐ **Application Denied – RESPONSIBLE FOR 100% OF BILL**

Pharmacy: Slide F (Unassigned) = $24 + Medication Cost

_____ _____

Processed by: **Date:**

CAA of Columbiana County, Inc.
Dental
Sliding Fee Scale

Please circle the appropriate square that indicates your family's income

FAMILY SIZE	Nominal Fee $35.00 SLIDE A 0-100% Poverty Guidelines	$45.00 SLIDE B >100%-125% Poverty Guidelines	$55.00 SLIDE C >125%-150% Poverty Guidelines	$65.00 SLIDE D >150%-175% Poverty Guidelines	$75.00 SLIDE E >175%-200% Poverty Guidelines	0% Discount SLIDE F >200% Poverty Guidelines
1	0 – 13,590	13,591 – 16,988	16,989– 20,385	20,386 – 23,783	23,784 – 27,180	>27,180
2	0 – 18,310	18,311 – 22,888	22,889 – 27,465	26,466 – 32,043	32,044 – 36,620	>36,620
3	0 – 23,030	23,031– 28,788	28,789 – 34,545	34,546 – 40,303	40,304 – 46,060	>46,060
4	0 – 27,750	27,751– 34,688	34,689 – 41,625	41,626 – 48,563	48,564 – 55,500	>55,500
5	0 – 32,470	32,471 – 40,588	40,589 – 48,705	48,706 – 56,823	56,824 – 64,940	>64,940
6	0 – 37,190	37,191 – 46,488	46,489 – 55,785	55,786– 65,083	65,084 – 74,380	>74,380
7	0 – 41,910	41,911 – 52,388	52,389 – 62,865	62,866 – 73,343	73,344 – 83,820	>83,820
8	0 – 46,630	46,631 – 58,288	58,289 – 69,945	69,946 – 81,603	81,604 – 93,260	>93,260

Definitions:

Income – Total cash receipts before taxes from all sources including wages, unemployment, workers comp, and public assistance, etc.

Family Size – All persons related by birth, marriage, or adoption who live together in the same housing unit (house, apartment, etc.) **and** are claimed as a dependent under IRS rules and regulations.

Nominal Fee = $35.00

For family units with more than 8 members, add $4,720.00 for each additional member.

Based on revised poverty guidelines published in the federal register on January 12, 2022.

Services will not be denied due to inability to pay.

EFFECTIVE: April 1, 2022

_____ _____ _____

Signature of Patient or Guardian | Date | Patient's Date of Birth

CAA of Columbiana County, Inc.
MAT Sliding Fee Scale
Sliding Fee Scale

Please circle the appropriate square that indicates your family's income

FAMILY SIZE	Nominal Fee $10.00 SLIDE A 0-100% Poverty Guidelines	$15.00 SLIDE B >100%-125% Poverty Guidelines	$25.00 SLIDE C >125%-150% Poverty Guidelines	$35.00 SLIDE D >150%-175% Poverty Guidelines	$40.00 SLIDE E >175%-200% Poverty Guidelines	0% Discount SLIDE F >200% Poverty Guidelines
1	0 – 13,590	13,591 – 16,988	16,989– 20,385	20,386 – 23,783	23,784 – 27,180	>27,180
2	0 – 18,310	18,311 – 22,888	22,889 – 27,465	26,466 – 32,043	32,044 – 36,620	>36,620
3	0 – 23,030	23,031– 28,788	28,789 – 34,545	34,546 – 40,303	40,304 – 46,060	>46,060
4	0 – 27,750	27,751– 34,688	34,689 – 41,625	41,626 – 48,563	48,564 – 55,500	>55,500
5	0 – 32,470	32,471 – 40,588	40,589 – 48,705	48,706 – 56,823	56,824 – 64,940	>64,940
6	0 – 37,190	37,191 – 46,488	46,489 – 55,785	55,786– 65,083	65,084 – 74,380	>74,380
7	0 – 41,910	41,911 – 52,388	52,389 – 62,865	62,866 – 73,343	73,344 – 83,820	>83,820
8	0 – 46,630	46,631 – 58,288	58,289 – 69,945	69,946 – 81,603	81,604 – 93,260	>93,260

Definitions:

Income – Total cash receipts before taxes from all sources including wages, unemployment, workers comp, and public assistance, etc.

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EFFECTIVE: April 1, 2022

_____ _____ _____

Signature of Patient or Guardian | Date | Patient's Date of Birth

CAA of Columbiana County, Inc.
Medical and Behavioral Health
Sliding Fee Scale

Please circle the appropriate square that indicates your family's income

FAMILY SIZE	Nominal Fee $20.00 SLIDE A 0-100% Poverty Guidelines	$35.00 SLIDE B >100%-125% Poverty Guidelines	$50.00 SLIDE C >125%-150% Poverty Guidelines	$65.00 SLIDE D >150%-175% Poverty Guidelines	$80.00 SLIDE E >175%-200% Poverty Guidelines	0% Discount SLIDE F >200% Poverty Guidelines
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5	0 – 32,470	32,471 – 40,588	40,589 – 48,705	48,706 – 56,823	56,824 – 64,940	>64,940
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EFFECTIVE: April 1, 2022

_____ _____ _____

Signature of Patient or Guardian | Date | Patient's Date of Birth