PLEASE PRINT YOUR INFORMATION IN THE WHITE SPACES BELOW

PATIENT INFORMATION

Print ABOVE: NAME 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

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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
$ PER ☐ WEEK ☐ YEAR ☐ MONTH ☐ BI-MONTHLY

FAMILY SIZE

EMPLOYER NAME EMPLOYER ADDRESS

--- ---

SEX ☐ F ☐ M

MARITAL STATUS (Circle One)
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 of Columbiana County, Inc.
Medical, Behavioral Health, Dental and MAT program
Sliding Fee Scale

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

FAMILY SIZE	SLIDE A 0-100% Poverty Guidelines Medical-BH $20.00 Dental $35.00 MAT $10.00	SLIDE B 100%-125% Poverty Guidelines Medical-BH $35.00 Dental $45.00 MAT $15.00	SLIDE C 125%-150% Poverty Guidelines Medical-BH $50.00 Dental $55.00 MAT $25.00	SLIDE D 150%-175% Poverty Guidelines Medical-BH $65.00 Dental $65.00 MAT $35.00	SLIDE E 175%-200% Poverty Guidelines Medical-BH $80.00 Dental $75.00 MAT $40.00	0% Discount SLIDE F >200% Poverty Guidelines
1	0 – 14,580	14,581-18,225	18,226-21,870	21,871-25,515	25,516-29,160	>29,160
2	0 – 19,720	19,721-24,650	24,651-29,580	29,581-34,510	34,511-39,440	>39,440
3	0 – 24,860	24,861-31,075	31,076-37,290	37,291-43,505	43,506-49,720	>49,720
4	0 –30,000	30,001-37,500	37,501-45,000	45,001-52,500	52,501-60,000	>60,000
5	0 – 35,140	35,141-43,925	43,926-52,710	52,711-61,495	61,496-70,280	>70,280
6	0 – 40,280	40,281-50,350	50,351-60,420	60,421-70,490	70,491-80,560	>80,560
7	0 – 45,420	45,421– 56,775	56,776 – 68,130	68,131 – 79,485	79,486 – 90,840	>90,840
8	0 – 50,560	50,561 – 63,200	63,201 – 75,840	75,841 – 88,480	88,481 – 101,120	>101,120

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 = Medical and Behavioral Health $20.00, Dental $35, MAT $10

For family units with more than 8 members, add $5,140.00 for each additional member.

Based on revised poverty guidelines published in the federal register on January 12, 2023.

Services will not be denied due to inability to pay.

EFFECTIVE: April 1, 2023

Approved by CAA Board of Directors on March 30, 2023

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

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

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

Nominal Fee + Medication Cost (MC) per Prescription						
FAMILY SIZE	**$9.00+MC SLIDE A 0-100% Poverty Guidelines**	**$12.00+MC SLIDE B >100%-125% Poverty Guidelines**	**$15.00+MC SLIDE C >125%-150% Poverty Guidelines**	**$18.00+MC SLIDE D >150%-175% Poverty Guidelines**	**$21.00+MC SLIDE E >175%-200% Poverty Guidelines**	**$24.00+MC SLIDE F >200% Poverty Guidelines**
1	0 – 14,580	14,581 – 18,225	18,226– 21,870	21,871 – 25,515	25,516 – 29,160	>29,160
2	0 – 19,720	19,721 – 24,650	24,651 – 29,580	29,581 – 34,510	34,511 – 39,440	>39,440
3	0 – 24,860	24,861– 31,075	31,076 – 37,290	37,291 – 43,505	43,506 – 49,720	>49,720
4	0 – 30,000	30,001– 37,500	37,501 – 45,000	45,001 – 52,500	52,501 – 60,000	>60,000
5	0 – 35,140	35,141 – 43,925	43,926 – 52,710	52,711 – 61,495	61,496 – 70,280	>70,280
6	0 – 40,280	40,281 – 50,350	50,351 – 60,420	60,421– 70,490	70,491 – 80,560	>80,560
7	0 – 45,420	45,421 – 56,775	56,776 – 68,130	68,131 – 79,485	79,486 – 90,840	>90,840
8	0 – 50,560	50,561 – 63,200	63,201 – 75,840	75,841 – 88,480	88,481 – 101,120	>101,120

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.

For family units with more than 8 members, add $5,140.00 for each additional member.

Based on revised poverty guidelines published in the federal register on January 12, 2023.

Services will not be denied due to inability to pay.

EFFECTIVE: April 1, 2023

liApproved by the CAA Board of Directors March 30, 2023

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

CAA Health and Behavioral Health Centers

CAA Sliding Fee Scale Application

Valid from April 1, 2023 to March 31, 2024

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. Lab Fees are not included and will be additional cost.

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

- Lab Fees: For patients with a Slide A, Lab cost are included in nominal fee
- For patient with a Slide B - Slide F, Lab cost will be $40.00 and must be paid at time of visit (Lab 101).

☐ Application Denied – RESPONSIBLE FOR 100% OF BILL

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

_____ _____

Processed by: Date:

Last Revised 3/30/2023

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
- o Ok to leave message with detail information
- o Leave message with call back number only

☐ Cell Phone
- o Ok to leave message with detail information
- o 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):

- o My Spouse: _____
- o My child (ren): _____
- o My Parents: _____
- o 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

Relationship to Patient (if other than patient): _____

Witnessed by: _____

Print name – Practice Representative

Revised 8.2019 sg

CAA Health, Behavioral Health and Dental Centers
Informed Consent for Telehealth Services

Today's Date:

Patient's Name: _____ **Date of Birth:** _____

Purpose: CAA Health, Behavioral Health and Dental Centers and the health care provider assigned to you today will provide health care services through the use of audio (sound) and other computer-based service.

I understand that the electronic service allows Provider to obtain information about my health status though electronic communications of diagnosing and determining a treatment plan for certain non-emergency conditions.

I understand that the information provided or exchanged may be used for diagnosis; treatment plan development and review and may include any or all of the following electronic communication; patient medical record documentation, live two-way video and audio files and transmission of images and other data.

Possible Risks: As with any use of technology, there are potential risks associated with the use of the electronic care series. You understand that these risks include, but may not be limited to, the following risks:

- Delays or errors in medical evaluation and treatment
- Information transmitted may not be sufficient to allow for appropriate medical decision making
- Possible Security Threats

Patient Consent:

- I understand that the laws that protect privacy and confidentiality of medical information also apply to telehealth
- I understand that I have the right to withhold or withdraw this consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatments
- I understand that you do not have to use Telehealth Services; it is my choice to use electronic services.
- I understand that the Provider will document the services you receive today in CAA Health Center medical record.
- I understand that no results can be guaranteed or assured
- I understand that the Provider may terminate a Telehealth Visit if the provider determines that my condition requires immediate in person care, or otherwise determines that a Telehealth Visit is not appropriate to meet my health care needs.
- I understand that my medical information may be sent to other healthcare providers as part of coordination of care.
- I understand that Providers will not prescribe certain types of medicines, including controlled substances. You understand that any prescriptions you receive from an electronic visit will be used only by you, for your health care needs.

I have reviewed this document carefully and understand the risks and benefits of the electronic services and wish to obtain services through an electronic visit.

_____

Signature of Patient/Parent/Guardian Date