Lake County Family Practice

9500 Mentor Ave. Suite 100 Mentor Ohio 44060 (440) 352-4880
www.lcfp.net

NOTICE OF PRIVACY PRACTICES

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

Lake County Family Practice (LCFP) is requíred by law to maintain the privacy of patients' personal health information and to provide patients with notice of LCFP legal duties and privacy practices with respect to your personal health information. LCFP is required to abide by the terms of the Notice of Privacy Practices as necessary and make the new Notice effective for all personal health information maintained by LCFP. You may receive a copy of any revised notices by mailing a request to Privacy Officer, Lake County Family Practice, 9500 Mentor Ave., Mentor, Ohio 44060.

USES AND DISCLOSURES OF PERSONAL HEALTH INFORMATION

Your Authorization. Except as outlined below, LCFP will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the disclosure. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Uses and Disclosures for Treatment. LCFP will make uses and disclosures for your personal health information as necessary for your treatment. For instance, doctors, nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, tests, ect. LCFP may also release your personal health information to another health care facility or professional who is or will be providing treatment to you. For instance, if you are going to receive home care or are being referred to a specialist for treatment, LCFP may release your personal health information to that facility so that a plan of treatment can be prepared for you.

Uses and Disclosure for Payment. LCFP will make uses and disclosures of your personal health information as necessary for payment purposes of those health professionals and facilities that have treated you or provided services to you. For instance, LCFP may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you, or LCFP may use your information to prepare a bill to send to you or the person responsible for your payment.

Family and Friends Involved in your Care. LCFP may, from time to time, disclose your personal health information to family, friends and others who are involved in your care or in payment of your care. If you are unavailable, incapacitated, or facing an emergency medical situation and it is determined that a limited disclosure may be in your best interest, limited personal health information may be shared with such individuals without your approval.

Appointments and Services. LCFP may contact you to provide appointment reminders or test results. You have the right to request, and LCFP will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, you may wish appointment reminders not to be left on voice mail or sent to a particular address. You may request such confidential communication in writing. Request forms may be obtained from registration at our office.

Health Products and Services. LCFP may from time to time use your personal health information to communicate with you about health products and services necessary for your treatment, to advise you of new products and services offered by LCFP and to provide general health and wellness information.

Other Uses and Disclosures. Federal laws and regulations do not protect any information about suspected child or elder abuse or neglect from being reported under State law to appropriate State or local authorities. LCFP is permitted or required by law to make certain other uses and disclosure of your personal health information without your consent or authorization:

- For any purpose required by law; for public health activities, such as required reporting of disease, injury, birth, death, and for required public health investigations.
- For suspected child/elder abuse or neglect; or if there is suspicion that you may be a victim of abuse, neglect or domestic violence.
- To the FDA to report adverse events, product defects, or to participate in product recalls.
- To your employer when LCFP has provided health care to you at the request of your employer to determine workplace-related illness or injury.
- To coroners and/or funeral directors consistent with the law.
- If necessary to arrange an organ or tissue donation from you or a transplant for you.
- If you are a member of the military as required by armed forces services; or if necessary for national security or intelligence activities.

LCFP may release your personal health information in accordance with any state laws that are more restrictive or limiting than federal privacy regulations. (Ohio law requires that we obtain a consent form from you before disclosing the Performance or results of an HIV test or diagnosis of AIDS or an AIDS-related condition.)

RIGHTS THAT YOU HAVE

Access to Your Personal Health Information. You have the right to inspect and/or copy much of the personal health information that LCFP retains on your behalf.
Amendments to Your Personal Health Information. You have the right to request in writing that personal health information maintained by LCFP be amended or corrected. LCFP is not obligated to make all requested amendments but will give each request careful consideration.
Accounting for Disclosures of your Personal Health Information. You have the right to receive an accounting of certain disclosures made by LCFP of your personal health information after April 14, 2003. The first accounting is free; you will then be charged a fee of $5.00 for each subsequent accounting.
Restrictions on Use and Disclosure of Your Personal Health Information. You have the right to request restrictions on certain of LCFP uses and disclosures of personal health information for treatment, payment, or health care operations. LCFP is not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate .

All requests for Access, Amendments, Accounting for Disclosures, and Restrictions on Use and Disclosure must be in writing and signed by you or your representative. Forms can be obtained from an LCFP receptionist.

RECORDS
Charts that have been inactive for 10 years are destroyed except for the charts of children which are kept until the child is 18 years old.

COMPLAINTS
If you believe your privacy rights have been violated, you can file a complaint with the LCFP Privacy Officer by mail or by telephone. Please direct correspondence to Joyce Taylor, Administration Building, 7590 Auburn Road, Concord Township, Ohio 44077. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights.

FINANCIAL POLICY

In order to provide your health care at the most affordable cost, Lake Health Physician Group requires payment at the time of service.

IF YOU HAVE INSURANCE

Lake Health Physician Group participates with many health insurance carriers. As a service to our patients, we will submit an insurance claim provided we have that information on file. It is the patient's responsibility to ensure that Lake Health Physician Group has the most up-to-date, correct insurance information on file. If you have a copayment, this will be collected when you arrive for your appointment. In the event your health plan determines a service to be "non-covered", you will be responsible for the complete charge. A statement will be sent to you and payment is due upon receipt of that statement.
In the event we are not able to confirm eligibility of your insurance, your visit will be considered self-pay, please see below.

If Lake Health Physician Group does not have a participating agreement with your carrier or you have not provided the most up-to-date insurance information to Lake Health Physician Group, your visit will be considered self-pay. Please see below.

SELF-PAY

If you are without health insurance, we do offer a 25% discount off all services rendered in the Lake Health Physician Group office (does not include any charges for lab and/or radiology professional services by non-employed physicians) when payment in full is made on the service date. Information of the total charges for your visit is available upon check-out. If you are not able to pay for services the same day, a minimum of $150.00 is required per office visit, with the balance remaining due upon receipt of the first statement within 30 days. Failure to pay the outstanding balance could result in no further appointments being scheduled and/or dismissal from Lake Health Physician Group for non-payment in accordance with Lake Health Physician Group's policies.

COLLECTIONS POLICY

If any balance remains on your account; we will consider an outside collection agency or other means to pursue payment of your account. To avoid this, please contact our business office to discuss payment arrangements.

You may also be eligible for financial assistance under Lake Health Physician Group's current financial assistance programs. For more information on Lake Health Physician Group's financial assistance policies, please call 440-602-6682 or visit www.lakehealth.org/patients/financial-information/financial-aid-application for more information.

PATIENT ________________________________ **GUARANTOR** ______________________________

DATE ____________________ **WITNESS** ________________________________

GENERAL HEALTH HISTORY QUESTIONNAIRE (age 13 years or older)

DATE________________

Name:_____________________ __________________ ______ (LAST) (FIRST) (MI)

Date of birth :___________________

Male/Female _________ Race ___________________ Occupation _____________________

Religious Affiliation___________________ Referred by__________________________

SIGNIFICANT ILLNESSES

Do you or have you had: (please circle)

Diabetes	YES	NO
Cancer (type) *	YES	NO
Gout	YES	NO
High Blood Pressure	YES	NO
Heart Disease	YES	NO
Kidney Disease	YES	NO
Mental Illness	YES	NO
Abnormal Pap	YES	NO
Asthma	YES	NO
High Cholesterol	YES	NO

Other Illness not listed:__________________

____

*please list type ________________________

HOSPITALIZATIONS/SURGERIES

List all reasons you were hospitalized Year

1. ___________________________ _____
2. ___________________________ _____
3. ___________________________ _____
4. ___________________________ _____
5. ___________________________ _____

FAMILY MEDICAL HISTORY

Has any blood relative, including children, had any of the following:

			Relationship
Anemia	Y	N	_______________
Bleeding Tendency	Y	N	_______________
Cancer (type) *	Y	N	_______________
Diabetes	Y	N	_______________
Epilepsy	Y	N	_______________
Heart Disease	Y	N	_______________
High Cholesterol	Y	N	_______________
Stroke	Y	N	_______________
Tuberculosis	Y	N	_______________
Colon Polyps	Y	N	_______________
High Blood Pressure	Y	N	_______________

*please list type ________________________

HEALTH SCREENING

Have you had			Date of Last
Physical	Y	N	________
Pap	Y	N	________
Chest X-ray	Y	N	________
Tetanus Shot	Y	N	________
MMR shot	Y	N	________
TB test	Y	N	________
Mammogram	Y	N	________
EKG	Y	N	________
Colonoscopy	Y	N	________
Hepatitis Vaccine	Y	N	________
Pneumonia Shot	Y	N	________
Bone Density	Y	N	________
Shingles Vaccine	Y	N	________

SOCIAL HISTORY

Tobacco Use

Current Y N # yrs ____ #per day____

Former Y N # yrs ____ yr quit_____

Alcohol Y N Drinks per week _____

Caffeine Y N Cups/cans per week ___

Recreational Drugs Y N Times per week ______

Exercise Y N Times per week ______

Occupation _______________________

ALL ALLERGIES (MEDICATIONS/FOODS/ETC) REACTION

1. ____________________ ________________
2. ____________________ ________________
3. ____________________ ________________
4. ____________________ ________________
5. ____________________ ________________

SPECIALISTS SEEN

(List all specialists from whom you are currently receiving care)

1. ________________________ 2. ________________________

3. ________________________ 4. ________________________

5. ________________________ 6. ________________________

MEDICATIONS WITH DOSAGE & INSTRUCTIONS

(List all medication you take on a regular basis including over the counter medications)

1. ________________________ 6. ________________________
2. ________________________ 7. ________________________
3. ________________________ 8. ________________________
4. ________________________ 9. ________________________
5. ________________________ 10. ________________________

Your Pharmacy ________________________ Location ________________________
(example –CVS) (example – Bacon Rd)

Please answer the following:

Over the past 2 weeks, how often have You been bothered by any of the Following problems?	Not At all	Several Days	More than Half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Do you have any specific communication needs due to visual impairment, hearing impairment, or language spoken? YES _____ NO ______ If yes, please describe ________________________
____

Do you have any specific concerns today? YES ________ NO ______ If yes, please describe
____
____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Lake County Family Practice
9500 Mentor Ave • Suite 100 • Mentor, OH 44060
Telephone: 440-352-4880 • Fax: 440-352-3629

Patient Label

Part A:
☐ **Tripoint Medical Center** ☐ **Perry Walk-in** ☐ **Mentor Medical Campus** ☐ **Lake Health Physician Group**
☐ **West Medical Center** ☐ **Lake Health Diagnostic Centers** ☐ **Lake Health Sleep Center** ☐ **Mentor Physical Therapy**
Urgent Care Centers: ☐ **Willowick** ☐ **Tyler** ☐ **Madison** ☐ **Chardon** ☐ **Painesville**

Name of Patient: ____________________
Last First Maiden / AKA
Address: ____________________
Date of Birth: __________ Home Phone: __________ MR #: __________
Email Address: ____________________

INFORMATION TO BE:
☐ Released to: __________ ☐ Obtained from: __________
I hereby authorize Lake Health / Lake Health Physician Group to release to/or obtain from the following facility, the information as specified below:

Facility/Name: ____________________
Phone #: __________ Fax #: __________
Address: ____________________
Date(s) of Treatment: ____________________
Reason for Treatment: ____________________

INFORMATION TO BE RELEASED/OBTAINED: ☐ Pertinent Summary (Includes all * items):
☐ Demographic / Facesheet ☐ Pathology Report * ☐ Radiology Report * ☐ Drug / Alcohol Info
☐ History & Physical * ☐ Consultation Report * ☐ Radiology Films ☐ EKG Report *
☐ ER Report * ☐ Entire Record ☐ Lab Reports * ☐ Cardiac Cath Report *
☐ Discharge Summary * ☐ Physical Therapy ☐ Psychiatric Info ☐ HIV / AIDS Info
☐ Operative Note * ☐ Other: __________

PURPOSE OF DISCLOSURE: ☐ Continued Treatment ☐ Personal Use ☐ Legal ☐ Other Specific Use __________

To be completed by the Organization if this authorization is for marketing, fundraising, research, or sale of Protected Health Information:
The organization will receive compensation in exchange for using or disclosing the health information as described above: ☐ YES ☐ NO

Upon admission as an inpatient or to an LHPG office practice, you were asked to sign a Consent for Treatment in which you designated that Lake Health could utilize your health information for the purpose of treatment, payment, and other health care operations as defined by law. The above information you have requested to be disclosed requires you to sign an authorization because it is being released to a third party entity outside of Lake Health.

The consent to disclose information may be revoked by you in writing at any time - except those disclosures, made in good faith that have already occurred. This consent expires one year (1) from the date of signature and applies to all services provided and protected health information created by Lake Health prior to the date of this signature.

I certify that this Authorization has been made freely, voluntarily, and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I understand that redisclosure of my medical records by those receiving the above-authorized information may be accomplished without further written authorization and may no longer be protected. I attest that if such redisclosure is made, I will not hold Lake Health responsible.

X ____________________
Signature of Patient/Parent/Patient Representative/Physician/Other as Allowable by Law

__________ __________ __________
Relationship to Patient ☐ Patient Unable to Sign Date

If signature is other than patient's signature, a copy of all legal documents verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care.) For a deceased patient: A death certificate coupled with executor of administrator of estate paperwork must accompany authorization. Exception: parent signing for patient under the age of 18.

Part B: **LH USE ONLY**

Pulled and Verified by: __________ Date: __________
Verify Photo ID by: __________ Date: __________
Method of Disbursement: ☐ Mail ☐ In-person ☐ Faxed ☐ Electronic Disclosure ☐ Other: __________
Forms of Records: ☐ Paper ______ # of pages copied ______ Cost ☐ Electronic # Pages ______ , Cost ______ (Retrieval/Media Fee)
Films returned and verified by: __________ Date: __________
☐ No disclosure made (see Part C).

EX4846

Copies of Medical Records are <u>NOT</u> to be emailed directly to patients. Contact HIM DEPT: Healthport Copy Service to process this request for electronic disclosure.

LAKE HEALTH PHYSICIAN GROUP REGISTRATION

Patient Label

Date:	Primary Care Physician:

PATIENT

First Name	Middle Initial	Last Name
SSN	Race ______	☐ Single ☐ Married ☐ Divorced
Sex ☐ male ☐ female	Ethnicity ☐ Non Hispanic ☐ Hispanic	☐ Separated ☐ Widowed
	Language ______	

Date of Birth	Employer	Employer Telephone

Patient Mailing Address

Street Address	City	State	Zip

Primary Telephone Number	Alternate Telephone Number

RESPONSIBLE PARTY (Other Than Self)

First Name	Middle Initial	Last Name

SSN	Relationship to Patient	Sex ☐ male ☐ female

Date of Birth	Employer	☐ Full-time ☐ Part-time	Employer Telephone

Responsible Party Mailing Address (if different from patient)

Street Address	City	State	Zip

Primary Telephone Number	Alternate Telephone Number

EMERGENCY CONTACT

Name	Relationship to Patient

Primary Telephone Number	Alternate Telephone Number

For Office Use Only:

☐ Entered

______ Initials ______ Date

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LAKE HEALTH PHYSICIAN GROUP
OUTPATIENT CONSENT FORM – COMMUNICATION

Patient Name: ______________________________

Date of Birth: _____/_____/_____ Today's Date: _____/_____/_____

PRESCRIPTION HISTORY CONSENT

I authorize Lake Health Physician Group to obtain my prescription history from an external source.

X ______________________________ Date: __________ Time: __________
Patient or Legal Guardian Signature

CONSENT FOR COMMUNICATION REGARDING MY HEALTH (Adult Patients Only)

I hereby authorize Lake Health/Lake Health Physician Group to discuss protected health information with a family member, guardian or friend listed below. This includes information related to the care or changes to the care that I have received. ***This does not authorize requests for copies of medical records. An "Authorization for Disclosure of Health Information" must be completed when requesting copies of medical records.***

1. Name: ______________________________ Relationship: __________
   Phone Number: ______________________________
2. Name: ______________________________ Relationship: __________
   Phone Number: ______________________________

CONSENT FOR COMMUNICATION REGARDING A MINOR (Pediatric Patients Only)

This consent authorizes Lake Health/Lake Health Physician Group to discuss protected health information with a family member, guardian or friend listed below. This includes information related to the care or changes to the care that a minor has received. ***This does not authorize requests for copies of medical records. An "Authorization for Disclosure of Health Information" must be completed when requesting copies of medical records.***

1. Name: ______________________________ Relationship: __________
   Phone Number: ______________________________
2. Name: ______________________________ Relationship: __________
   Phone Number: ______________________________

THE FOLLOWING INDIVIDUAL(S) MAY BRING MY CHILD IN FOR TREATMENT IN MY ABSENCE

Note: This Authorization Does NOT Grant Access to Medical Records.

1. Name: ______________________________ Relationship: __________
   Phone Number: ______________________________
2. Name: ______________________________ Relationship: __________
   Phone Number: ______________________________

MINORS (16-18 YEARS) PRESENTING WITHOUT A PARENT OR GUARDIAN

☐ I give permission to Lake Health/Lake Health Physician Group to provide medical care to my child (examinations, immunizations, laboratory tests, radiology tests, prescribe medications).

☐ I do not give permission to Lake Health/Lake Health Physician Group to provide medical care to my child (examinations, immunizations, laboratory tests, radiology tests, prescribe medications).

CONSENT FOR TELEPHONE, EMAIL, AND/OR TEXT MESSAGE COMMUNICATIONS

I hereby authorize Lake Health/Lake Health Physician Group to communicate the following protected health information contained in my medical record with me via the following forms of communication (check where applicable):

☐ Home Phone (_______) ________ - ____________
- ☐ I consent to receiving information at this number via voicemail.
- ☐ I consent to receiving information at this number via text message.

☐ Work Phone (_______) ________ - ____________
- ☐ I consent to receiving information at this number via voicemail.
- ☐ I consent to receiving information at this number via text message.

☐ Cell Phone (_______) ________ - ____________
- ☐ I consent to receiving information at this number via voicemail.
- ☐ I consent to receiving information at this number via text message.

☐ E-mail ______________________________ @ ____________________

I understand that voicemail, e-mail, and text messages are not a confidential method of communication. I further understand that there is a risk that voicemail, e-mail, and text communications between myself and Lake Health/Lake Health Physician Group regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I understand that Lake Health/Lake Health Physician Group is not responsible for e-mail or text messages that are lost due to technical failure during composition, transmission, and/or storage. I also understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail or text messaging.

This authorization shall be in force and effect for twelve (12) months from the date of signature. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may no longer be protected by federal or state law.

THESE CONSENTS AND AUTHORIZATIONS ARE VALID FOR TWELVE (12) MONTHS FROM THE DATE OF SIGNATURE BUT MAY BE REVOKED BY NOTIFYING LAKE HEALTH IN WRITING AT ANY TIME. I UNDERSTAND THE NATURE OF THIS CONSENT AND IT IS REVOCABLE AT ANY TIME.

Patient/Legal Guardian Signature: ______________________________ Date: __________ Time: __________

Relationship: ____

Witness Signature: ____

An employee of Lake Health may witness this consent; however, the employee is signing this Form as a witness and not as an employee or on behalf of Lake Health.

FOR OFFICE USE ONLY

☐ Entered

__________ ______________
Initials Date

LAKE HEALTH
PATIENT CONSENT FORM Page 1 of 2

Patient Label

REQUEST FOR GENERAL TREATMENT

I request and authorize Lake Health, its employees, my physician and other physicians or allied health professionals as are necessary to provide emergency, outpatient and/or general hospital treatment and care. Further, I authorize the hospital and my physician(s) to permit the presence of observers in my treatment as deemed necessary.

I, ____, understand and acknowledge that from time to time, medical
(Patient Name)

students, nursing students or students of other healthcare disciplines may be undergoing clinical education in various departments at the hospital. I hereby authorize and permit such students of any such health profession to participate in my care insofar as they are properly supervised at all times by a licensed and credentialed healthcare practitioner in that field of expertise. I acknowledge that I have a right to ask questions of any physician or nurse regarding the use of students in my care at any time.

I also understand that some physicians and healthcare providers, including, but not limited to anesthesia, pathology, radiology, surgery, and emergency department providers are independent practitioners ("Independent Practitioners") and are not employees or agents of Lake Health. They are independent contractors acting as my (patient's) agent. Lake Health is not responsible for the acts or omissions of such Independent Practitioners.

Patient Best Contact Number: ______________________________ X (Signature) ______________________________________

AUTHORIZATION TO RELEASE INFORMATION

I authorize Lake Health, Anesthesia Associates, Community Hospitalists, Inc., Drs. Hill & Thomas, Drs. Hill & Chapnick, EKG Associates, US Acute Care Solutions, and other interpreting physicians involved in my care to release any medical records or medical information necessary to file an insurance claim, to perform quality and utilization assessments, and to release any medical information which may be requested by my insurance carrier or agencies on their behalf. I authorize the release to other health organizations and/or professionals such medical information deemed necessary to ensure continuity and quality of care to my routine health care provider (Primary Care Physician) or in the event of my transfer to another institution. Further, I authorize release of medical information to a quality assurance of peer review committee or organization, compliance audits, research, marketing, Department of Health, federal and/or state agencies.

ELECTRONIC COMMUNICATIONS

I understand that Lake Health may utilize, or make available to the healthcare professionals involved in my care, various technologies that are secure, confidential, and meet federal and state privacy and security requirements to allow providers involved in my care to communicate with each other and facilitate clinical decision-making regarding my care. Examples include, but are not limited to: secured texting, taking and sending photographs via secure technology, and other electronic communications.

ASSIGNMENT OF BENEFITS

In consideration of medical services to be received for this admission, I assign to Lake Health or any Hospital-Based Physician, as applicable, all, including Title XVIII of Social Security Administration, other benefits herein specified. This assignment shall be irrevocable.

GUARANTEE OF ACCOUNT

I guarantee payment of any and all hospital or Independent Practitioner charges not covered by insurance of this assignment, including court costs, if appropriate.

AUTHORIZATION TO PARTICIPATE IN HEALTH INFORMATION EXCHANGES (HIE)

Lake Health participates in one or more HIEs. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying in writing the Lake Health, Health Information Management Dept. at 36000 Euclid Avenue Willoughby, Ohio 44094.

AUTHORIZATION TO BE INCLUDED IN DIRECTORY

Lake Health maintains a directory of individuals in its facility that includes the individual's: 1) name; 2) location at Lake Health's facility; 3) condition, which is described in general terms and does not communicate any specific medical information about the individual; and 4) religious affiliation. This information may be provided to members of the clergy or, except for religious affiliation, to any person who asks for the me by name. I wish to have my information listed in the directory. ☐ Yes ☐ No

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LAKE HEALTH
PATIENT CONSENT FORM Page 2 of 2

Patient Label

AUTHORIZATION TO BE CONTACTED FOR FUND RAISING

From time to time, Lake Health may use certain information (e.g., patient ID, name, address, telephone number, dates of service, age, and gender) to contact you to raise funds for the benefit of Lake Health's charitable mission. I wish to receive fundraising communications in the future. ☐ Yes (I understand that I may opt-out of fundraising communications at any time.) ☐ No

YOUR CONSENT FOR CALLS AND / OR TEXT MESSAGES TO YOUR CELLULAR PHONE

I expressly consent to you using my cellular phone number for you, your affiliates or any third party acting on your behalf including collection agencies, calls or text messages, for collection purposes or other account related purposes. Further, I expressly consent to receiving phone calls made by an auto dialer and/or any automatic telephone dialing system from you, your affiliates or any third party acting on your behalf, including collection agencies, telephone calls for collection purposes or for other account related purposes to any cell phone number obtained from me, from any other source, or as a result of a receiving a cellular phone call from me. ☐ Yes ☐ No

ACKNOWLEDGEMENT OF RECEIPT OF MEDICARE/CHAMPUS INFORMATION

I acknowledge that if I am a Medicare and/or CHAMPUS beneficiary, I have been provided with a notice from Medicare and/or CHAMPUS, regarding my rights as a Medicare and/or CHAMPUS hospital patient.

PATIENT RIGHTS

I acknowledge that I have received a copy of "Patients Rights and Responsibilities." ☐ Yes ☐ No

PATIENT PRIVACY

I acknowledge that I have received a copy of "The Notice of Privacy Practices." ☐ Yes ☐ No

PERSONAL CHOICES

I have an Advance Directive - Living Will ☐ Yes ☐ No
I have a Durable Power of Attorney for Health Care ☐ Yes ☐ No
I am an Organ Donor ☐ Yes ☐ No
I wish to receive information about other Lake Health programs ☐ Yes ☐ No
I wish to be included in the clergy census ☐ Yes ☐ No

OBSTETRICS

This consent covers this visit/admission and any subsequent visit/admission relating to this pregnancy.

SERIES

This consent covers this visit and any subsequent visit related to this encounter.

NON-COVERED SERVICES OR EQUIPMENT

Check Insurance Type: ☐ Medicare ☐ Kaiser ☐ Other ______________________

I understand that the service(s) or equipment checked below are considered to be non-covered by my insurance carrier including Medicare. Because this service/equipment is non-covered, I realize that I will be personally responsible for payment.

Check appropriate service:

☐ Cardiac Rehab Phase III ☐ Durable Medical Equipment
☐ Pulmonary Rehab Phase III ☐ Mammograms (beyond limitations of coverage)

PATIENT BELONGINGS

Patients are responsible for all money and valuables during their Lake Health admission or outpatient visit. Lake Health is not responsible and accepts no liability for lost, misplaced, stolen or retained belongings including but not limited to money, jewelry, dentures, hearing aids, eye glasses, or other prosthetic devices.

I HAVE REVIEWED AND CONSENT TO ALL APPLICABLE CLAUSES BY SIGNING BELOW. I UNDERSTAND THE NATURE OF THIS CONSENT AND IT IS REVOCABLE AT ANY TIME.

Signature X ______________________ Relationship to Patient: ______________________

Witness to the above signature: ______________________ Date: ____/____/____ Time: ____________

An employee of Lake Health may witness this consent; however, the employee is signing this Form as a witness and not as an employee or on behalf of Lake Health.

Grievance Process: Should you experience dissatisfaction with your care or services while you are a patient you may call (440) 953-6265 or ext. 6265 to report your concerns. You will be contacted and followup on your concerns will occur.

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The Role of the Patient Centered Medical Home

Welcome to the Lake County Family Practice Patient Centered Medical Home!!

In the Lake Health System we are embracing and transitioning to a new health care delivery system that seeks to provide care for you and your family that is comprehensive, coordinated and of the highest quality.

Your personally chosen Primary Care Provider and their team will coordinate your care or any treatment that you may need. Treatment may include outpatient care in our office during regular hours* as well as access to a designated on call physician after hours and on weekends. Both your Primary Care Providers and their delegates will have access to a wide and comprehensive array of specialists for you as well as Urgent Care Centers and Emergency Room and Hospital Care settings when necessary.

Your care will also include regular contact from our talented team of Medical Assistants at Lake County Family Practice as well as future involvement when needed with a Care Manager who is a Registered Nurse. As your medical home, we will include in our records information supplied by you the patient including but not limited to medications, visits to specialists, medical history, self-care information, dates of and reasons for hospitalizations, specialty care and/or ER and Urgent Care visits. We will help you receive and understand any of your results from our office in a timely manner and we will help you to implement your evidence based plan of care and support for your self-management to keep you in good health.

We also promise to secure your care when needed, with an array of professionals including Health Coaches, Mental Health teams, teams of Home Care nurses and coaches, Skilled Nursing Care and Hospice and Palliative Care facilities should they be necessary. Our goal, of course, is to PREVENT illness conditions for you and your family and to reduce unnecessary and costly Emergency Room and Hospital admissions.

In summary, we hope you will enjoy this transition to total care coordination for you by our Lake Health-Lake County Family Practice Patient Centered Medical Home team. Our responsibility is to continue to provide for your total care and to make your experience as pleasant and successful as possible.

Web Links:
http ://www.pcpcc.net/ - Patient Centered Primary Care Collaborative
http ://www.emmisolutions.com/medicalhome/pcpcc/ - Introductory PCMH Video

We offer same day sick appointments by calling our office at 440-352-4880

*Office hours Monday-Thursday 8:00am to 5:00pm Friday 8:00am to 5:00pm (3:00pm on Friday's Memorial Day to Labor Day)
Saturday's 9:00am -11:30 am for same day sick appointments