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**
( ) --	( ) --	( ) --	**U.S. MILITARY SERVICE: Circle One:** ACTIVELY SERVING DISCHARGED NONE **LOCATION**	
HOME PHONE	**WORK PHONE**	**CELL PHONE**		
SEX ☐ F ☐ M ☐ Transgender	**Marital Status: (Circle One)** Single Married Widowed Separated Divorced		--- ---	
			PATIENT'S SOCIAL SECURITY	
	( ) --			
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**
( ) --	( ) --	**FAMILY INCOME** $ PER ☐ WEEK ☐ YEAR ☐ MONTH ☐ BI-MONTHLY		
HOME PHONE	**WORK PHONE**			**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 and Behavioral Health Centers

Sliding Fee Scale Application

Valid from April 1, 2016 to March 31, 2017

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 Stub

_____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

_____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

_____Railroad Retirement Board Records

I have completed this application for sliding fee eligibility and confirm that all information is correct to the best of my knowledge. **I also understand that a minimum payment of $20 will be requested at the time of each medical or behavioral health 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 A Nominal Fee ($20)

Slide B $35

Slide C $50

Slide D $65

Slide E $80

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

_____ _____

Processed by: **Date:**

CAA of Columbiana County, Inc.
Health and Behavioral Health Centers
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
1	0 – 11,880	11,881-14,850	14,851-17,820	17,821-20,790	20,791-23,760	>23,760
2	0 – 16,020	16,021-20,025	20,026-24,030	24,031-28,035	28,036-32,040	>32,040
3	0 – 20,160	20,161-25,200	25,201-30,240	30,241-35,280	35,281-40,320	>40,320
4	0 – 24,300	24,301-30,375	30,376-36,450	36,451-42,525	42,526-48,600	>48,600
5	0 – 28,440	28,441-35,550	35,551-42,660	42,661-49,770	49,771-56,880	>56,880
6	0 – 32,580	32,581-40,725	40,726-48,870	48,871-57,015	57,016-65,160	>65,160
7	0 – 36,730	36,731-45,913	45,914-55,095	55,096-64,278	64,279-73,460	>73,460
8	0 – 40,890	40,891-51,113	51,114-61,335	61,336-71,558	71,559-81,780	>81,780

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 = $20.00

For family units with more than 8 members, add $4,160.00 for each additional member.

Based on revised poverty guidelines published in the federal register on January 25, 2016.

Services will not be denied due to inability to pay.

EFFECTIVE: April 1, 2016

_____ _____ _____

Signature of Patient or Guardian | Date | Patients Date of Birth

CAA Dental Centers

Sliding Fee Scale Application

Valid from April 1, 2016 to March 31, 2017

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 Stub

_____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

_____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

_____Railroad Retirement Board Records

I have completed this application for sliding fee eligibility and confirm that all information is correct to the best of my knowledge. **I also understand that a nominal payment will be requested at the time of each dental office visit based upon income level.**

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 A Nominal Fee ($35)

Slide B $45

Slide C $55

Slide D $65

Slide E $75

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

_____ _____

Processed by: **Date:**

CAA of Columbiana County, Inc.
Dental Centers
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 – 11,880	11,881-14,850	14,851-17,820	17,821-20,790	20,791-23,760	>23,760
2	0 – 16,020	16,021-20,025	20,026-24,030	24,031-28,035	28,036-32,040	>32,040
3	0 – 20,160	20,161-25,200	25,201-30,240	30,241-35,280	35,281-40,320	>40,320
4	0 – 24,300	24,301-30,375	30,376-36,450	36,451-42,525	42,526-48,600	>48,600
5	0 – 28,440	28,441-35,550	35,551-42,660	42,661-49,770	49,771-56,880	>56,880
6	0 – 32,580	32,581-40,725	40,726-48,870	48,871-57,015	57,016-65,160	>65,160
7	0 – 36,730	36,731-45,913	45,914-55,095	55,096-64,278	64,279-73,460	>73,460
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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 $4,160.00 for each additional member.

Based on revised poverty guidelines published in the federal register on January 25, 2016.

Services will not be denied due to inability to pay.

EFFECTIVE: April 1, 2016

_____ _____ _____

Signature of Patient or Guardian | Date | Patients Date of Birth

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
*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 maryann.pettibon@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.**

Acknowledgement of Receipt of the Privacy Notice for Community Action Agency of Columbiana County, Inc. Health, Behavioral Health and Dental Centers

I,_____, hereby acknowledge that I have received the privacy notice of the CAA Health, Behavioral Health and Dental Centers. I accept the provisions of the privacy notice without any requested restrictions.

For children under 18, I verify that I am signing this acknowledgement for my child to be treated each time the child is brought by a parent to CAA's Health, Behavioral Health and Dental Centers from this date forward until I produce written revocation of the right to treat or until my child reaches 18 years of age, whichever comes first.

Patient Signature/**Parent Signature** Date

Witness Date

Acknowledgement of Receipt of the Privacy Notice for
Community Action Agency of Columbiana County, Inc.
Health, Behavioral Health and Dental Centers

WITH A REQUESTED RESTRICTION

Patient: _____ DOB: _____

Relationship to patient (completing this form): _____

I, _____, hereby acknowledge that I have received the privacy notice of the CAA Health, Behavioral Health and Dental Centers. I accept the provisions of the privacy notice with the following requests for restriction of information:

_____

_____

_____

_____

_____ _____

Patient Signature/Parent Signature Date

_____ _____

Witness Date

Disposition of request: ___GRANTED ___DENIED

_____ _____

Employee Signature of Disposition **Date**

CAA Health Center No Show Policy

_____ _____

Patient Name (print) DOB

Your Medical Providers want to make sure that you and other area residents have access to high-quality medical care when you need it. To ensure maximum access to medical 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, you are ultimately responsible for remembering 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: Because of the critical lack of access to medical services in our area, missed appointments are taken very seriously. If you miss one appointment, you will be documented as having missed an appointment. If you miss a second appointment without proper notice within the same calendar year, you will be placed on "no show status." In order to continue receiving care from our program, you will be required to write a letter to the Medical Director *(Dr. Maria Ryhal, 7880 Lincole Place, Lisbon, OH 44432*) stating the following: 1) why you missed the last appointment; 2) why you feel you need another appointment; and 3) that you understand that another no-show visit will result in your discharge from the practice. Failure to write this letter will result in your discharge from the practice.

Please talk to any of the Health Center Staff if you have questions about our No-Show Policy.

I understand and agree to abide by this No Show Policy.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature (For Patients Under 18) Date