NEW PATIENT INFORMATION

Name _____ Birth Date _____ S.S. # _____
Last First M.I.

Address _____ Apt. # _____ Sex M F Marital Status _____ Race _____

City/State/Zip _____ Home Phone _____

Employer _____ Work Phone _____

Email Address _____

Employer Address _____ City/State/Zip _____

Primary Care Giver Name _____ Relationship _____

Sibling _____ D.O.B _____ Sibling _____ D.O.B._____

Sibling _____ D.O.B. _____ Sibling _____ D.O.B. _____

RESPONSIBLE PARTY:

Name _____ Birth Date _____ S.S. # _____
Last First M.I.

Address _____ Apt. # _____ Sex M F Marital Status _____ Race _____

City/State/Zip _____ Home Phone _____

Employer _____ Work Phone _____

Employer Address _____ City/State/Zip_____

❑ Check here if the primary caregiver is NOT the "responsible party" financially.

EMERGENCY

Name _____ Phone _____ Relationship _____

Address _____ City/State/Zip _____

Nearest Relative _____ Phone _____ Relationship _____
(Not in household)

CONTACT INFORMATION

Because we value your right to privacy, we would like to determine how to best handle our telephone communications with you. We routinely call our patients for the following reasons: 1) results of various tests, 2) to confirm appointments, or 3) to respond to patient questions or concerns.

In the event that we attempt to contact you and you are not available, is there another person (or persons) that you would like us to leave your personal health information (such as, test results, appointments, responses to your inquiries)? (PLEASE LIST THESE BELOW).

Please list the person or persons **IN YOUR HOME** that can be given your personal **health** information when you are not available:

Last Name _____ First Name _____

Relationship _____ Phone _____

In the event we **"call your home"** cannot reach you directly, is there someone **OUTSIDE OF YOUR HOME** that you give us permission to give **your** personal health information?

Last Name _____ First Name _____

Relationship _____ Phone _____

May we fax your child(ren)'s personal health information **(such as shot records or required medical information)** to his/her school or **day care facility**, when requested?

Yes _____ No _____ Fax Number (if known) _____

Do you give us permission to leave personal health information **(such as normal lab results or answers to your questions/concerns)** on **your** answering machine?

Yes _____ No _____

PLEASE COMPLETE REVERSE SIDE

MEDICARE PATIENTS ONLY - PLEASE COMPLETE THIS SECTION

1. Are you currently working? Y N
   If yes, employer? _____
   No. of employees _____ Retired Y N Date of retirement _____
2. Do you have insurance through your employer? Y N
3. Is your spouse currently working? Y N
   If yes, employer? _____
4. Do you have insurance through your spouse's employer? Y N
   Do you have any other insurance responsible for this bill? Y N

If you have answered yes to any questions above, please provide insurance information to the staff.

CONSENT FOR TREATMENT AND FINANCIAL DISCLOSURE

CONSENT FOR TREATMENT

I, _____, consent to examination, diagnosis, and general treatment (including but not limited to the use of x-rays and other non-invasive procedures such as diagnostic tests) this includes treatment of minor (under age of 18) to be performed by GHA providers and his/her designated staff. If necessary, I also give my permission for the allied health professionals (counseling services and well-ness center, social services, nutritionist, physician assistant, nurse practitioner, etc.) to review my medical record for the purpose of evaluating my overall health needs. I realize that if a medical procedure or surgery is required, I will be given additional information.

RELEASE OF INFORMATION AND FINANCIAL AGREEMENT

I hereby permit my attending physician to furnish information from the patient's medical record to any health care provider whom my physician deems necessary to provide for the continuity of my medical care.

I hereby permit my attending physician to furnish information from the medical record to my insurer, compensation carrier or health care facility which may be providing financial assistance for my care.

I REALIZE THIS BILL IS MY RESPONSIBILITY. I ASSIGN AND AUTHORIZE PAYMENTS BE MADE DIRECTLY TO GROUP HEALTH ASSOCIATES OF ALL INSURANCE BENEFITS AND AGREE TO PAY ANY BALANCE DUE.

MEDICAL INFORMATION, IF APPLICABLE

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I permit any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediates or carriers any information needed for this or a related Medicare claim. I request that payment of allowable benefits be made on my behalf. I assign the benefits payable for covered Medicare services to the physicians or organization furnishing the services or authorize such physicians or organizations to submit a claim to Medicare for payment to me.

By signing below you grant permission to give private health information to the persons or entities that you listed above. Also, by signing this form, you acknowledge that it is your responsibility to notify us in writing if any of the information you provided above should change.

I have read the above, I understand and accept these terms. If I refuse treatment or leave the facility, I hereby release the physician and his/her designate of all responsibility for my action. This consent shall remain in effect until notice of revocation is received by Cincinnati Group Health Associates, Inc.

I have received GHA's Notice of Privacy Practices.

_____ _____

Signature of Patient (or authorized representative) Witness

_____

Date ADMIN./LEGAL

Group Health Associates
Physicians & Surgeons

MEDICAL HISTORY

DATE: _____

NAME: _____ DATE OF BIRTH: _____ SEX: _____
Last First Middle

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____ NATIONALITY: _____

NAME AND RELATIONSHIP OF NEXT OF KIN: _____ PHONE: _____

ADDRESS: _____

SOCIAL HISTORY

MARITAL STATUS: SINGLE _____ MARRIED _____ SEPARATED _____ DIVORCED _____ WIDOWED _____

DO YOU USE TOBACCO? YES ☐ NO ☐ HOW MUCH? _____ FORM OF USE: _____

DO YOU USE ALCOHOL? YES ☐ NO ☐ HOW MUCH? _____ FORM OF USE: _____

DO YOU EXERCISE? YES ☐ NO ☐ HOW OFTEN? _____ WHAT KIND? _____

ARE YOU UNDER ANY UNUSUAL STRESS? YES ☐ NO ☐ EXPLAIN: _____

OCCUPATION: _____ AGES OF CHILDREN: _____

PAST MEDICAL HISTORY

LIST ALL SURGERIES AND THE YEAR PERFORMED: _____

_____

LIST ANY OTHER HOSPITALIZATIONS AND THE YEAR: _____

_____

LIST ANY OTHER SERIOUS ILLNESSES OR ACCIDENTS: _____

_____

LIST ANY ALLERGIES TO MEDICATIONS: _____

LIST ANY OTHER ALLERGIES: _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

HAVE YOU EVER HAD X-RAY TREATMENTS TO YOUR HEAD OR NECK FOR ACNE OR TONSILLITIS? YES ☐ NO

FAMILY HISTORY

PLEASE INDICATE IF ANY OF YOUR BLOOD RELATIVES HAVE HAD ANY OF THE FOLLOWING:

CHECK EACH ITEM	YES	NO	RELATIONSHIP	CHECK EACH ITEM	YES	NO	RELATIONSHIP
CANCER				STROKE			
DIABETES				GLAUCOMA			
HIGH BLOOD PRESSURE				EPILEPSY/CONVULSIONS			
HEART DISEASE				NERVOUS/MENTAL DISORDER			
LUNG DISEASE				ALCOHOL/SUBSTANCE ABUSE			

HOW MANY LIVING BROTHERS: _____ SISTERS: _____ PARENTS: _____

LIST RELATIONSHIP, AGE AND CAUSE OF DEATH FOR ANY DECEASED PARENTS, BROTHERS, OR SISTERS:

_____

_____

IMMUNIZATIONS

TETANUS: YES ☐ NO ☐ YEAR _____ PNEUMOCOCCAL VACCINE: YES ☐ NO ☐ YEAR _____

WOMEN ANSWER THE FOLLOWING:

DATE: _____

NAME: _____ DATE OF BIRTH: _____
Last First Middle

AGE AT ONSET OF PERIODS: _____ OR AGE OF MENOPAUSE: _____

PERIODS OCCUR EVERY ____ DAYS. FLOW LASTS FOR ____ DAYS. PAIN/CRAMPS: YES ☐ NO ☐ SOMETIMES ☐

FLOW IS: _____ LIGHT _____ MODERATE _____ HEAVY

BLEEDING BETWEEN PERIODS: YES ☐ NO ☐ HOW MUCH? _____ HOW OFTEN? _____

DATE OF LAST MENSTRUAL PERIOD: _____ IF NOT NORMAL, DESCRIBE: _____

DATE OF LAST PAP SMEAR: _____ IF NOT NORMAL, DESCRIBE: _____

DATE OF LAST MAMMOGRAM: _____ I DO BREAST SELF-EXAMS: YES ☐ NO ☐ HOW OFTEN? _____

NUMBER OF PREGNANCIES: _____ NUMBER OF LIVING CHILDREN: _____

NUMBER OF ABORTIONS (ELECTIVE OR SPONTANEOUS): _____

CONTRACEPTIVES USED: ____ NONE ____ PILLS ____ IUD ____ DIAPHRAGM OTHER: _____

Billing & Insurance FAQ

ANSWERS TO FREQUENTLY ASKED QUESTIONS ABOUT GROUP HEALTH ASSOCIATES

Patient Registration

- ✓ To every appointment, bring your insurance card(s) – including Medicare/Medicaid, prescriptions – and a photo ID, such as a driver's license, state-issued ID or student ID. Without an insurance card, you may have to pay for your visit that day.
- ✓ Insurance co-payments and all out-of-pocket expenses are due on the day of your visit. A billing fee of $20 will be charged when co-payment or out-of-pocket expenses are not paid the day of your visit.

Insurance Coverage

- ✓ GHA accepts all major insurance plans.
- ✓ Contact your insurance company, visit www.cgha.com or call 513.841.3588 to see if GHA participates in your plan.
- ✓ If you have completed all insurance paperwork, we will bill your primary and secondary insurance companies. If your insurance does not pay your claim, you will be billed for the balance.
- ✓ GHA will assist you in the appeals process if your insurance company denies payment. Any questions regarding coverage or benefits should be discussed directly with your insurance company.
- ✓ Contact our central registration at 513.841.3588 immediately with any changes to your insurance coverage, such as plan number changes, co-payment changes and name changes.

Balances after Insurance

- ✓ GHA will send a bill for services not covered by your insurance and for any out-of-pocket expenses or deductibles. These balances are due in full within 30 days.

Appointment Cancellations

- ✓ It is important to remember to cancel any scheduled appointment at least 24 hours in advance or you may be charged $50 for the missed appointment. To cancel an appointment, call 513.872.2000.

(continued on the back)

Group Health Associates℠
Physicians & Surgeons
Affiliated with TriHealth

(continued from the front)

Radiology & Pathology

- ✓ You may receive separate bills for reading of x-rays or for some lab services performed in a GHA facility. These charges are from providers that your doctor has asked to review your results – such as a pathologist or radiologist.

Claims Coding

- ✓ We cannot change codes so your insurance will cover the visit. Procedure and diagnosis codes are numbers assigned to services provided by medical professionals. We take great care to ensure accurate, ethical coding based upon your diagnosis and the procedures provided.
- ✓ It is important that you understand your insurance coverage. You are encouraged to contact your insurance company to find out what services are considered cosmetic and/or are not covered.

Auto Accidents

- ✓ Medical expenses resulting from a motor vehicle accident are your personal responsibility.
- ✓ GHA can provide claim forms upon request. Please call our billing department at 513.841.5240.

Paying Your Bill

- ✓ GHA accepts cash, checks, American Express, Discover, MasterCard and Visa.
- ✓ You may use a credit card to pay your bill by completing the credit card section on the bill or by calling 513.841.5240.
- ✓ If you don't have insurance, you will receive a 20-percent discount off your GHA charges if you pay in full at the time of service.

Billing Questions

- ✓ Our patient accounts department representatives are happy to help clarify any billing issues or questions. Please feel free to call a representative at 513.841.5240 during our regular business hours – 9 a.m. to 5 p.m., Monday through Friday.

Thank you for choosing Group Health Associates as your health care provider.

For more information about other medical services provided by Group Health Associates, please visit www.trustthegroup.com.

PATIENT PRIVACY ACKNOWLEDGMENT AND FAMILY BILLING FORM

Please Print Patient's Name: _____

Date of Birth: _____ Medical Record Number: _____

Please complete and sign both boxes below.

Acknowledgment of Receipt of Notice of Privacy Policies

I, _____, received a copy of TriHealth G, LLC, d.b.a. Group Health Associates ("GHA"), Notice of Privacy Practices.

Patient / Guardian Signature: **X** _____ _____

Signature Relationship to Patient

Staff: If the patient did not acknowledge receipt of Notice above, you must document below your efforts to obtain the patient's acknowledgement and the reason why it was not obtained:

_____

_____

Family Billing – Designation of Individual Involved in My Medical Care

GHA provides family billing to its patients so that the charges for health care services provided to all members of the same family are sent on the same billing statement for the family's convenience. The billing statement will be addressed to the individual you designate below as the "Responsible Party".

I, _____ [INSERT NAME OF PATIENT] acknowledge that the individual listed below ("Responsible Party") is involved in my care and the payment for my health care:

Name of Responsible Party: _____

Address: _____

Telephone number: _____ Relationship to Patient: _____

I authorize GHA to disclose my protected health information that is relevant to my care or payment for that care to the Responsible Party including disclosure of all billing and account information related to the medical care I received from GHA.

I understand that GHA may send a bill to the Responsible Party that contains both my protected health information and the protected health information of other GHA patients who have identified the Responsible Party as involved in their care and payment of their medical care.

I further agree to the release of information to the Responsible Party concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological condition and/or psychiatric/mental health treatment and/or HIV related conditions.

I agree that if at any time, I no longer want GHA to communicate with the Responsible Party above and/or if I want to request the involvement of a different individual in my care or the payment for my medical care, I will immediately notify GHA in writing by sending a letter to the address of 4600 Wesley Avenue, Suite N, Cincinnati, Ohio 45212, addressed to the attention of Central Registration.

I also understand and agree that nothing in this form intended in any way to limit or alter GHA's ability to disclose my protected health information to individuals/entities not listed on this form in accordance with applicable law and professional judgment.

X_____ Date: _____ ____, 200__

Signature of Patient/Guardian

Effective Date: March 1, 2009

NOTICE OF PRIVACY PRACTICES

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.

This Notice will tell you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations that we have regarding the use and disclosure of your medical information.

TriHealth G LLC, doing business as **Group Health Associates,** (the "Practice") is covered by regulations pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and is required by law to maintain the privacy of your health information, give you notice of our privacy practices with respect to your medical information, and follow the terms of this Notice. This Notice applies to all of the records of your care generated and maintained by the Practice. The Practice will share your medical information as necessary in order to carry out your treatment, obtain payment for the services provided to you or operate its health care facilities.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that we may use and disclose your medical information. These are examples and, therefore, not every permitted use and disclosure is listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students and other trainees, or other personnel who are involved in taking care of you at a Practice location. Different areas of the Practice may share medical information about you in order to coordinate the different services you need, such as prescriptions, lab work and x-rays. We may also disclose medical information about you to people outside the Practice who may be involved in your medical care after you leave a Practice location, such as other physicians involved in your care, family members, or other health care related entities such as skilled nursing care facilities with whom you seek treatment.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at a Practice location may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health insurance company information about a procedure you received at a Practice location so your health insurance company will pay us or reimburse you for the procedure. We may also tell your health insurance company about a treatment that you are going to receive in order to obtain prior approval or to determine whether your health insurance company will cover the treatment. We may also disclose your medical information to other healthcare providers so that they can bill for health care services that they provided to you, such as ambulance services.

For Health Care Operations. We may use and disclose medical information about you in order to operate the Practice. These uses and disclosures are necessary to run the Practice and make sure

that our patients receive quality health care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also disclose medical information to doctors, nurses, technicians, medical and nursing students, and other personnel for review and learning purposes. We may also provide medical information to other healthcare providers who have a relationship with you and need the information for their own healthcare operations.

Business Associates. We may disclose medical information about you to our business associates who need that information in order to provide a service to us or on behalf of us. A business associate is a person who is not part of the Practice's workforce, a company or other entity which uses or has access to protected health information in order to perform a function on behalf of the Practice. For example, business associates of the Practice may include billing companies, copying companies, document shredding companies, consultants, accountants and attorneys.

Appointment Reminders. We may use and disclose your medical information to contact you as a reminder that you have an appointment for treatment or medical care at a Practice location.

Treatment Alternatives. We may use and disclose your medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose your medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved With or Concerned About Your Care. We may release information about your condition or treatment to a friend or family member relevant to his/her involvement in your care or payment for your care. We may also disclose your location and condition to assist or notify a family member or personal representative who is involved in your care. We may also disclose your information in a disaster relief effort so that your family can be notified about your condition and location.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. Research projects are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information.

As Required by Law. We will disclose medical information about you when required to do so by federal, state or local law. For example, Ohio law requires hospitals and other health care providers to report cases of cancer to a registry called the Ohio Cancer Incidence Surveillance System.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation. We may release medical information about you for worker's compensation or similar programs which provide benefits for work-related injuries or illness.

Public Health Activities. We may disclose medical information about you for public health activities such as the prevention or control of disease, injury or disability; reporting of births and deaths; reporting of child abuse or neglect; and, reporting of reactions to medications or problems with products and to fulfill requirements of the U.S. Food and Drug Administration.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities allowed by law such as audits, investigations, inspections and licensure or disciplinary actions.

Lawsuits and Disputes. We may disclose medical information about you in response to a Court Order, Administrative Order or certain subpoenas.

Law Enforcement. We may release medical information to a law enforcement official about a death we believe may be the result of criminal conduct; about criminal conduct at a Practice location; and, in emergency circumstances, to report a crime, the location of a crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information to funeral directors as necessary to carry out their duties.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or the law enforcement official.

OTHER USES OF YOUR MEDICAL INFORMATION: Other uses and disclosures of your medical information not covered by this Notice or required by the laws that apply to the Practice, will be made only with your written permission (your written permission is referred to as an Authorization). If you provide your permission to use or disclose medical information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons indicated in your written Authorization. You understand that we are unable to take back any disclosures that we made before we received your written notice revoking your Authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU: You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and obtain a copy of your medical information. This includes your medical and billing records but does not include psychotherapy notes. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

To inspect or obtain a copy of your medical information, you must submit your request in writing to the Medical Records Department at the address of the office location where you were treated.

We may deny your request in certain circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Practice will review your request and the denial. The person conducting the review will not be the same person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long the information is kept by or for the Practice.

To request an amendment to your medical information, you must submit your request in writing to the Practice Administrator at the address of the office location where you were treated.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the Practice;
- Is not part of the information which you would be permitted to inspect and copy; or,
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of your medical information. This list will not include disclosures that we made for purposes of treatment, payment and health care operations. We are also not required to include in this list the disclosures we made by acting upon your written authorizations.

To request an accounting of disclosures, you must submit your request in writing to the attention of the Privacy Officer, TriHealth, Inc., 619 Oak Street, Cincinnati, Ohio 45206.

Your request must state a time period which may not be longer than six (6) years and may not include dates before April 14, 2003. The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work.

We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice. You have a right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. You may also obtain a copy of this Notice at our website, www.cgha.com.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the Practice locations. The Notice will contain on the first page, in the top right-hand corner, the effective date.

FOR FURTHER INFORMATION: For further information about the matters covered by this Notice, you may contact the Office Manager of the Practice location where you received treatment.

COMPLAINTS: If you believe your **privacy rights** have been violated, you may file a complaint with the Practice or with the Secretary of the U. S. Department of Health and Human Services. To file a complaint with the Practice, you must submit your complaint in writing to the attention of the Privacy Officer, TriHealth, Inc., Corporate Administration Department, 619 Oak Street, Cincinnati, Ohio 45206**.**

You will not be penalized for filing a complaint.