Canton South Family Healthcare, LLC.

Kerwin Joel A. Lupisan, M.D.

4822 Cleveland Ave. S, Canton, OH 44707

Tel. 330.484.1607/ Fax. 330.484.2943

Welcome to Canton Family Healthcare!

We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

We will do our best to provide you with same-day office visits and accept walk-ins for first available slots for all sick visits. You will need to bring your **insurance card and a photo ID** with you for each appointment. Please let our staff know if you have had any information changes since your last appointment. If you are unable to provide us with your insurance card, your appointment will need to be rescheduled. You will be asked to fill out new registration forms annually so we may update your information.

All co-pays and past due balances are expected at time of service, unless a prior agreement has been made with our billing department.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

Please bring all of your prescription and over-the-counter medications with you at each visit.

Our office policy for a missed appointment is:

- If it is an appointment for a new patient, the appointment will be rescheduled once according to our earliest available schedule;
- Two (2) no-show appointments may result in dismissal from the practice.

We understand that appointments sometime need to be changed, so we ask that you call in advance if you cannot keep your scheduled appointment (at least a 24 hour notice).

Providing the highest quality of professional care to our patients is very important to us. Therefore, the following guidelines for dispensing medications in our office have been established:

1. ***Canton South Family Healthcare does not offer chronic pain management and will not dispense chronic pain medication*** (for example, chronic daily narcotics). We will provide you with a referral to a pain management center if you need this specialized form of care after evaluation by our physician.
2. If you are on a medication that requires refills for a chronic disease (for example, high blood pressure or diabetes), you will be given ample refills for 30 or 90 days at a time during your office visit.

a. When you are down to a 30 day supply of medication, we ask that you call and schedule your follow-up office visit in order to be evaluated and have your medications adjusted or refilled. We ask that you allow enough time for us to make an appointment so you're not without your medication.

3. For the safety and well-being of our patients,

    a. Requests for new medications (including antibiotics) and medication refills will not be taken over the phone or over the Internet during office hours without an appointment and evaluation by the physician.

    b. No new medications (including antibiotics) will be called in over the phone after office hours by the on-call physician.

    c. We understand that unexpected situations arise, thus a small refill of a chronic medication will be granted for one or two days after office hours on an as-needed basis determined by the on-call physician. This allows patients to be seen and evaluated by the physician during office hours for all their medication refills.

If you need to reach the physician after hours, you can reach our answering service at Our office hours for patient care are Monday, Thursday, Friday 8:30am -5 pm, Tuesday 8:30am - 6 pm, Wednesday 8:30am - 12 nn. Telephone hours Monday, Thursday, Friday 9am – 12nn, 1:30 pm - 4:30 pm, Tuesday 9am – 12 nn, 1:30 pm - 5:30 pm and Wednesday 9am - 12 nn.

Canton South Family Healthcare has a website (www.cantonsouthfh.com) where you can access health records/appointment request/messages through **PATIENT PORTAL via ATHENAHEALTH**.

Welcome to our practice and thank you for choosing Canton South Family Healthcare, LLC. for all your health care needs.

Your appointment is scheduled on _____ at _____.

Sincerely yours,

Canton South Family Healthcare, LLC.

CANTON SOUTH FAMILY HEALTHCARE, LLC.
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Tel. (330) 484-1607 Fax (330) 484-2943

Patient Information Sheet

Today's Date: _____

Patient Name: _____ Birthdate: _____ Age: _____ M or F (Circle)

Address: _____ City: _____ State: _____ Zip: _____

Marital Status: Single __ Married __ Widowed __ Divorced __ **e-mail:** _____

Ethnicity: African American __ Caucasian __ Asian __Hispanic __ Other : _____

Telephone: Home _____ Work _____ **Cell** _____

Your Social Security #: _____ Spouse's Social Security #: _____

Employer Name: _____ Occupation: _____

Spouse's Employer: _____ Occupation: _____

Language/Communication Barrier: None __ Educational Level: _____

Deaf __ Blind __ Cannot read __ Preferred Language if not English: _____

In case of Emergency Contact: _____ Relationship: _____

Phone: _____

Insurance Information

Primary: Name_____ Address:_____

Policy #_____ Group #_____ Ins Phone # _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Secondary: Name _____ Address:_____

Policy #_____ Group #_____ Ins. Phone # _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Do you have a prescription plan? Y ____ N _____ Preferred Pharmacy: _____

Pharmacy Tel. no. _____

Immediate Family Members

Name Relationship

1. _____
2. _____
3. _____
4. _____

Previous Doctor:
Name:_____ Last seen: _____Reason for Change: _____

Who referred you to this office? _____

CANTON SOUTH FAMILY HEALTHCARE, LLC
PEDIATRIC (0-17) - FAMILY, MEDICAL, & SOCIAL HISTORY (two pages)

NAME _____ DOB _____

ALLERGIES ☐ None (please list allergies **and what happens to you when you take it**)
Drug Allergies: _____
_____
Food Allergies: _____

CURRENT MEDICATIONS ☐ None
_____ _____
_____ _____

OTHER MEDICAL PROVIDERS: (Please list all of your healthcare providers)
Specialists: _____
Others: _____

CHILD'S MEDICAL HISTORY: (please check all that apply)

☐ Allergies - seasonal	☐ Headaches, migraine/tension	☐ UTI, recurring
☐ Allergies – perennial	☐ Hemophilia, A or B	☐ Weight issues (gain or loss)
☐ Anemia	☐ History of Fracture _____	☐ Other: _____
☐ Asthma	☐ Irregular Heart Rhythm	_____
☐ Cancer, _____	☐ Kidney Stones	_____
☐ Diabetes, Type I or II	☐ Psychological Illnesses	
☐ GERD/ Reflux	☐ Thyroid Disease	

CHILD'S SURGICAL HISTORY: (Please indicate date & details if possible)

☐ Appendectomy	☐ Hernia Repair	☐ Tubes in Ears
☐ Arthroscopy: _____	☐ Mole Removal _____	☐ Other: _____
☐ Biopsy: _____	☐ Orthopedic Surgery: _____	_____
☐ Fracture Repair, _____	☐ Tonsil/Adenoidectomy	_____

SUBSTANCE ABUSE HISTORY: ☐ None Other: _____

MENTAL HEALTH HISTORY: ☐ None Other: _____

COMMUNICABLE DISEASE HISTORY: ☐ None Other: _____

TOBACCO/ALCOHOL/SUPPLEMENTS:
(Tobacco and Alcohol for adolescent and older, **Caffeine, Vitamin, and Tobacco Exposure for all ages**)
☐ Tobacco use presently ☐ Previous use ☐ Never smoked
If present or previous use: ☐ Cigarettes ☐ Cigars ☐ Smokeless tobacco
How many/day? _____ How long have you/did you used tobacco? _____ Quit when? _____

Do you use **Alcohol**? ☐ None ☐ Beer ☐ Wine ☐ Liquor How much? _____ How often? _____

Caffeine intake: ☐ Coffee ☐ Tea ☐ Soda ☐ Chocolate How much? _____ How often? _____

Vitamin or Diet Supplements: Type: _____ How often? _____

Child's Tobacco/Smoke Exposure: Who smokes in the house with child? _____
_____

SOCIAL HISTORY:
Parent's marital status:
☐ Single, live together ☐ Single, live apart ☐ Married ☐ Divorced ☐ Widowed ☐ Remarried

Number of Siblings: _____ Other Living Arrangements: ☐ Adopted ☐ Foster Care
Who lives in your household with child? _____

Parents - JOB/EMPLOYMENT:
Father employed? ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Homemaker ☐ Student ☐ Disabled

Mother employed? ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Homemaker ☐ Student ☐ Disabled

Where do/did you work: Father_____ Mother_____

What is/was your job: Father_____ Mother_____

SCHOOL/DAYCARE: ☐ Daycare ☐ Pre-K ☐ Kindergarten ☐ Grade in school: _____

CHILD'S WORK HISTORY: _____

Religion: (any needs or concerns affecting your healthcare) _____

FAMILY HISTORY: Indicate which family member with an **x** in the column
Mat GM/GF = maternal grandmother/grandfather Pat GM/GF = paternal grandmother/grandfather

	Mother	Father	Brother	Sister	Son	Daughter	Mat GM	Mat GF	Pat GM	Pat GF	Mat Uncle	Mat Aunt	Pat Uncle	Pat Aunt
Alcoholism/Drug Abuse														
Alzheimer's Disease:														
Asthma/Bronchitis/Emphysema														
Bleeding Tendency:														
Cancer, _____														
Diabetes, Type I or II:														
Enlarged Prostate:														
Gall Stones:														
Heart Disease:														
Heart problem **under age 40**														
High Blood Pressure:														
High Cholesterol:														
Kidney Disease:_____														
Marfan Syndrome														
Obesity:														
Osteoarthritis:														
Osteoporosis:														
Psychiatric Illness														
Rheumatoid Arthritis:														
Seizure Disorder:														
Stroke:														
Sudden death **under age 40**														
Thyroid Disease:														
Other:_____														

ADDITIONAL COMMENTS, QUESTIONS, OR CONCERNS: _____

_____

Date: _____ Signature: _____

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HIPAA Privacy and Release of Information Authorization

Patient Name: _____
Patient ID: _____
Patient DOB: _____

I, _____ hereby authorize **CANTON SOUTH FAMILY HEALTHCARE, LLC.** and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____ _____
Patient Printed Name Date

_____
Patient Signature

CANTON SOUTH FAMILY HEALTHCARE, LLC.

DISCLOSURES AND CONSENTS

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of my insurance benefits to ***Canton South Family Healthcare, LLC.*** for the services rendered to my dependents or me. I understand that it is my responsibility to know the insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that ***Canton South Family Healthcare, LLC***. is unable to collect from my insurance carrier for whatever reason.

INSURANCE BENEFITS

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to ***Canton South Family Healthcare, LLC.*** or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC/PERSONAL INFORMATION

I certify that I have received a copy of the ***Canton South Family Healthcare, LLC***. ***Patient Information Privacy Policy*****.** I hereby authorize **Canton South Family Healthcare, LLC**. or the physician individually to release any of my or my dependent's medical or incidental non-public information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL/CALL/ E-MAIL

I certify that I understand the privacy risks of mail, phone calls, and e-mail. I hereby authorize ***Canton South Family Healthcare, LLC.*** or my physician to mail, or e-mail me with communications regarding my healthcare, Including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying **Canton South Family Healthcare, LLC.** to that effect in writing.

LAB/XRAY/DIAGNOSTIC SERVICES

I understand that I may receive a separate bill if my medical care includes lab, X-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT

I hereby consent to evaluation, testing, and treatment as directed by ***Canton South Family Healthcare, LLC.*** and or their designee.

Patient Signature: _____ Date: _____

Guarantor Signature: _____ Date: _____

Guarantor Name: _____ Date: _____

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Authorization to Release Protected Health Information

Patient Name _____
Date of Birth _____ Social Security # _____

I, the undersigned, hereby authorize _____

To Provide _____
(Healthcare facility or person requesting records)

_____
(Address)

With the following information:
_____Complete Medical Record (Past two years)
_____Recent labs (Please Specify Dates) _____
_____ Immunization Record
_____Other (Please Specify) _____

Purpose of Disclosure:
___ Relocation
___ Referral/Specialist
___ Changed Insurances
___ New Physician
___ Second Opinion
___ Other _____

I understand and acknowledge that the medical record may contain information regarding psychiatric disorders. Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS related conditions, alcohol and/or drug dependence/abuse.

This authorization shall be in force and in effect for **90 days** from the date of signature at which time this authorization to use or to disclose this protected health information expires.

I understand that I have the right to revoke this authorization at any time by sending written notification to **Canton South Family Healthcare, LLC**. I understand that a revocation is not effective to the extent that **Canton South Family Healthcare, LLC** has relied on the use or disclosure of the protected health information. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Canton South Family Healthcare, LLC will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights). I understand that I have the right to refuse .to sign this authorization. The use or disclosure requested under this authorization will result in direct or indirect remuneration to **Canton South Family Healthcare, LLC** from a third party.

_____ _____
Signature of Patient or Representative Date

_____ _____
Name of Patient (Please print) Relationship to Patient