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.
4822 Cleveland Ave. South, Canton, OH 44707
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
PAST 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

____ ____
____ ____
____ ____

(Continue on back if needed.)

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

ADVANCED DIRECTIVES: Do you have any of the following? Can we have a copy if not already given?
☐ Health Care Proxy/POA ☐ Living Will ☐ Power of Attorney ☐ DNR

MEDICAL HISTORY: (please check all that apply)

☐ Allergies - seasonal
☐ Allergies – perennial
☐ Anemia
☐ Asthma
☐ Blood Clots
☐ Cancer, ________________
☐ Diabetes, Type I or II
☐ Enlarged Prostate
☐ Fibromyalgia
☐ Gall Stones
☐ GERD/ Reflux
☐ Headaches, migraine/tension
☐ Heart Failure
☐ Heart Disease
☐ Heart Attack
☐ Hemophilia, A or B
☐ High Cholesterol
☐ High Blood Pressure
☐ History of Fracture _______
☐ Irregular Heart Rhythm
☐ Kidney Stones
☐ Lung Disease
☐ Osteoarthritis
☐ Osteoporosis
☐ Peptic Ulcer Disease
☐ Psychological Illnesses
☐ Rheumatoid Arthritis
☐ Stroke
☐ Thyroid Disease
☐ UTI, recurring
☐ Other: _________________
____
____

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

☐ Appendectomy
☐ Arthroscopy: ___________
☐ Back Surgery
☐ Biopsy: ________________
☐ Cataract Removal
☐ Colon Surgery
☐ D&C
☐ Fracture Repair, _________
☐ Gall Bladder Removal
☐ Heart Surgery, __________
☐ Hernia Repair
☐ Hysterectomy and ovaries
☐ Hysterectomy without ovary removal
☐ Joint Replacement, _______
☐ Mastectomy/Lumpectomy
☐ Mole Removal __________
☐ Orthopedic Surgery: ______
☐ Prostatectomy
☐ Stents (where): __________
☐ Tonsil/Adenoidectomy
☐ Tubal Ligation
☐ Tubes in Ears
☐ Urinary Surgery, _________
☐ Vasectomy
☐ Other: _________________
____
____

SUBSTANCE ABUSE HISTORY: ☐ None Other: ____

MENTAL HEALTH HISTORY: ☐ None Other: ____

COMMUNICABLE DISEASE HISTORY: ☐ None Other: ______________________________________

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:														
High Blood Pressure:														
High Cholesterol:														
Kidney Disease:__________														
Obesity:														
Osteoarthritis:														
Osteoporosis:														
Psychiatric Illness														
Rheumatoid Arthritis:														
Seizure Disorder:														
Stroke:														
Thyroid Disease:														
Other:__________________														

TOBACCO/ALCOHOL/SUPPLEMENTS: ☐ 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? ________

SOCIAL HISTORY:
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried Number of Children: ______
Who lives in your household with you? ____

JOB/EMPLOYMENT – if retired, please answer with what you did before retirement
Presently employed? Yes ________ No ______
☐ Full Time ☐ Part Time ☐ Unemployed ☐ Homemaker ☐ Student ☐ Retired ☐ Disabled

Where do/did you work: ____

What is/was your job: ____

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

ADDITIONAL COMMENTS, QUESTIONS, OR CONCERNS: ____________________________________

____

Date: __________________ Signature: ____

CANTON SOUTH FAMILY HEALTHCARE, LLC

Kerwin Joel A. Lupisan, M.D.

4822 Cleveland Ave S,
Canton, OH 44707

Tel. No. 330-484-1607
Fax. No. 330-484-2943

PRACTICE POLICY FOR OPIOD MEDICATIONS

OUR PRACTICE DOES NOT DO CHRONIC PAIN MANAGEMENT. YOU WILL BE REFERRED TO PAIN MANAGEMENT IF YOU HAVE CHRONIC PAIN.

IF YOU ARE TAKING OPIOID PAIN MEDICATIONS BEFORE, IT IS AT THE DOCTOR'S DISCRETION IF HE/SHE WILL PRESCRIBE THEM PRIOR TO SEEING PAIN MANAGEMENT. HOWEVER, PRESCRIPTIONS WILL ONLY BE TEMPORARY (MAXIMUM OF 3 MONTHS) UNTIL YOU ARE SEEN BY PAIN MANAGEMENT. THIS IS AFTER WE RECEIVE ALL RECORDS FROM PREVIOUS DOCTORS: IMAGING (X-RAYS, MRI, CT SCAN), LABS, SPECIALIST NOTES, ETC.

WE ARE REQUIRED TO DO A URINE DRUG SCREEN PRIOR TO GIVING OPIOID PRESCRIPTIONS. IF POSITIVE FOR ILLEGAL DRUGS OR INCONSISTENT WITH ANY CONTROLLED MEDICATIONS YOU ARE PRESCRIBED, THEN YOU WILL BE DISMISSED.

____

PATIENT'S SIGNATURE and DATE

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:** ___________________________

CANTON SOUTH FAMILY HEALTHCARE, LLC.
4822 Cleveland Ave. South, Canton, OH 44707
Tel. (330) 484-1607 Fax (330) 484-2943

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.
4822 Cleveland Ave. South, Canton, OH 44707
Tel. (330) 484-1607 Fax (330) 484-2943

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