Welcome to West Ohio Family Physicians.
We respect your time and would like to make your visit as efficient as possible.

Please arrive 15 minutes before your scheduled appointment time.

To avoid delays when you arrive, please complete the following forms in advance then mail them to:
West Ohio Family Physicians
735 S Shoop Ave, Wauseon, OH 43567,
fax them to 419-335-3222
or bring them with you to our office.

Please note: we reserve the right to reschedule
your appointment if the paperwork is not completed in advance.

FCHC Medical Care - PATIENT REGISTRATION FORM

PLEASE COMPLETE IN BLACK INK

TODAY'S DATE | PAGE 1

LAST NAME	LEGAL FIRST NAME	MI	PREFERRED NAME if different than Legal Name
MAILING ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER	DATE OF BIRTH	MARITAL STATUS	EMAIL ADDRESS

FCHC Medical Care, LLC is asking you to complete the next section to meet the requirements of Section 1557 of the Affordable Care Act. This is not specific to FCHC Medical Care, LLC, all healthcare facilities must comply.

LEGAL SEX:
❒ Female
❒ Male

WHAT IS YOUR GENDER IDENTITY?
❒ Female
❒ Male
❒ Trans Male (Female to Male)
❒ Trans Female (Male to Female)
❒ Other
❒ Decline to Answer

WHAT IS YOUR SEXUAL ORIENTATION?
❒ Bisexual
❒ Heterosexual or Straight
❒ Lesbian, Gay or Homosexual
❒ Something Else
❒ Decline to Answer
❒ Don't Know

PREFERRED FORM OF COMMUNICATION FOR APPOINTMENT REMINDERS? ❒ Home Phone ❒ Cell Phone ❒ Text Message
PREFERRED TIME TO CALL FOR APPOINTMENT REMINDERS? ❒ Morning ❒ Afternoon ❒ Evening

PHONE: HOME	MAY WE CONTACT YOU AT HOME? MAY WE LEAVE A DETAILED MESSAGE?	YES YES	NO NO
PHONE: CELL	MAY WE CONTACT YOU ON YOUR CELL PHONE? MAY WE LEAVE A DETAILED MESSAGE?	YES YES	NO NO
PHONE: WORK	MAY WE CONTACT YOU AT WORK? MAY WE LEAVE A NAME & CALL BACK NUMBER?	YES YES	NO NO

WHOM WE ARE ALLOWED TO DISCUSS AND/OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION?

Information in your medical record is confidential and is protected under HIPAA/Ohio Laws. By completing this section and signing the Patient Registration Form consent, you are allowing our office to disclose your protected health information with the following:

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE

ETHNICITY (PLEASE CHECK ONE OF THE FOLLOWING)
❑ HISPANIC OR LATINO
❑ NOT HISPANIC OR LATINO
❑ DECLINE TO ANSWER

RACE (PLEASE CHECK ALL THAT APPLY)
❑ AMERICAN INDIAN OR ALASKA NATIVE
❑ BLACK OR AFRICAN AMERICAN
❑ OTHER PACIFIC ISLANDER
❑ DECLINE TO ANSWER
❑ ASIAN
❑ HISPANIC
❑ NATIVE HAWAIIAN
❑ WHITE

PRIMARY LANGUAGE
❑ ENGLISH
❑ SPANISH
❑ ASL
❑ OTHER

EMPLOYER NAME		OCCUPATION	
EMPLOYER ADDRESS	CITY	STATE	ZIP

IF PATIENT IS MARRIED PLEASE COMPLETE THE FOLLOWING INFORMATION

SPOUSE'S INFORMATION

LAST NAME	LEGAL FIRST NAME	MI	
MAILING ADDRESS	CITY	STATE	ZIP
SS#	DATE OF BIRTH	OCCUPATION	
EMPLOYER NAME	EMPLOYER ADDRESS		

IF PATIENT IS A MINOR CHILD PLEASE COMPLETE THE FOLLOWING INFORMATION

PARENT/GUARDIAN'S INFORMATION

LAST NAME	LEGAL FIRST NAME	MI	
MAILING ADDRESS	CITY	STATE	ZIP
SS#	DATE OF BIRTH	OCCUPATION/	
EMPLOYER NAME	EMPLOYER ADDRESS		

PARENT/GUARDIAN'S INFORMATION

LAST NAME	LEGAL FIRST NAME	MI	
MAILING ADDRESS	CITY	STATE	ZIP
SS#	DATE OF BIRTH	OCCUPATION	
EMPLOYER NAME	EMPLOYER ADDRESS		

FCHC Medical Care - PATIENT REGISTRATION FORM

PLEASE COMPLETE IN BLACK INK

TODAY'S DATE

LAST NAME	LEGAL FIRST NAME	MI	

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE NUMBER

MAILING ADDRESS	CITY	STATE	ZIP

PRIMARY PHARMACY

NAME	PHONE NUMBER

ADDRESS	CITY	STATE	ZIP

IT IS THE PATIENT/GUARANTOR'S RESPONSIBILITY TO COMPLETE THE INSURANCE INFORMATION BELOW AND TO PROVIDE INSURANCE CARD(S) SO FCHC MEDICAL CARE, LCC CAN BILL YOUR INSURANCE APPROPRIATELY.

PRIMARY INSURANCE COVERAGE – IF NO COVERAGE, PLEASE CHECK HERE ❑

INSURANCE COMPANY NAME	GROUP NAME (EMPLOYER)

I.D. NUMBER	GROUP NUMBER

POLICY HOLDER NAME	RELATIONSHIP

POLICY HOLDER'S SOCIAL SECURITY NUMBER	POLICY HOLDER'S DATE OF BIRTH

INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP

INSURANCE COMPANY PHONE NUMBER	EFFECTIVE DATE	PRESCRIPTION CARD? YES NO	COPAY

SECONDARY INSURANCE COVERAGE

INSURANCE COMPANY NAME	GROUP NAME (EMPLOYER)

I.D. NUMBER	GROUP NUMBER

POLICY HOLDER NAME	RELATIONSHIP

POLICY HOLDER'S SOCIAL SECURITY NUMBER	POLICY HOLDER'S DATE OF BIRTH

INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP

INSURANCE COMPANY PHONE NUMBER	EFFECTIVE DATE	PRESCRIPTION CARD? YES NO	COPAY

CONSENT TO RELEASE MEDICAL INFORMATION/ASSIGNMENT OF BENEFITS

I hereby consent to the use and disclosure by FCHC Medical Care, LLC of medical information to carry out medical treatment. Payment and health care operations as defined by applicable law. MEDICAL TREATMENT includes the provision, coordination and management of my health care and related services, including treatment by other health services and/or their agents to whom I may be referred (and any referring and primary care/family physician which have been or may be involved in my care and treatment). PAYMENT includes all activities relating to the determination of coverage and reimbursement for the provision of health care services and related claims management and review activities. HEALTH CARE OPERATIONS include activities of FCHC Medical Care, LLC relating to medical care and treatment and related assessment, quality improvement and management activities.

I authorize the disclosure of my clinical health information for the duration of my care unless revoked in writing to those listed under **WHOM WE ARE ALLOWED TO DISCUSS AND/OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION?**

I authorize my insurance benefit to be paid directly to FCHC Medical Care, LLC realizing that I am ultimately responsible for any allowable portion of the charge not covered by my insurance plans.

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE	DATE
X	

If signed by patient's authorized representative, describe representative's authority:

□ Patient is a minor; I am the patient's parent and natural guardian.
□ Patient is a minor; I am the patient's guardian, appointed by the _____County Juvenile Court.
□ Patient is a ward; I am the patient's guardian, appointed by the _____ County Probate Court.
□ I am the patient's attorney in fact, as designated in the patient's durable power of attorney for health care.

WITNESS SIGNATURE	DATE

FCHC Medical Care - PATIENT HEALTH HISTORY FORM

PLEASE COMPLETE IN BLACK INK

TODAY'S DATE | PAGE 1

LAST NAME	LEGAL FIRST NAME	MI	DATE OF BIRTH

YOUR HEALTH HISTORY

Check all items either No or Yes	No	Yes, Now	Yes, Past
ALLERGY			
Drug Allergies			
Hay Fever			
Latex Allergy			
CARDIOVASCULAR			
Chest Pain			
Heart Defects			
Heart Murmur			
High Blood Pressure			
Low Blood Pressure			
Palpitations			
Varicose Veins			
CONSTITUTIONAL			
Chills			
Fatigue or Weakness			
Fever			
Headache (Frequent)			
Weight Gain			
Weight Loss			
EAR/NOSE/THROAT			
Difficulty Hearing			
Ear Infections			
Ringing Ears			
Sinus Trouble			
Sore Throat			
ENDOCRINE			
Cold Intolerance			
Excessive Thirst			
Heat Intolerance			
Thyroid Trouble			
Tired/Sluggish			

Check all items either No or Yes	No	Yes, Now	Yes, Past
EYES			
Blurred Vision			
Double Vision			
Eye Pain			
Failing Vision			
Vision Loss			
GASTROINTESTINAL			
Abdominal Pain			
Appetite Loss			
Blood in Stool			
Constipation			
Diarrhea			
GI Bleed			
Indigestion/Heartburn			
Nausea/Vomiting			
Ulcers/Reflux/GERD			
GENITOURINARY			
Bladder Leakage			
Blood in Urine			
Painful Urination			
Urinary Frequency			
Urine Retention			
HEMATOLOGIC/LYMPHATIC			
Abnormal Bleeding			
Bleeding Disorders			
Blood Clotting Problems			
Swollen Glands			

Check all items either No or Yes	No	Yes, Now	Yes, Past
INTEGUMENTARY/SKIN			
Boils/Lesions			
Persistent Itch			
Skin Rash			
MUSCULOSKELETAL			
Back Pain			
History of Falls			
History of Fractures			
Joint Pain			
Neck Pain			
NEUROLOGICAL			
Dizzy Spells			
Memory Loss			
Numbness/Tingling			
Seizures			
Stroke			
Tremors			
PSYCHIATRIC			
Anxiety			
Depression			
Difficulty Sleeping			
RESPIRATORY			
Difficulty Breathing			
Frequent Cough			
History/Exposure TB			
Shortness of Breath			
Wheezing			

HABITS/SOCIAL HISTORY

Do you:	No	Yes	If Yes, how much?
Smoke Tobacco			Packs/Day
Chew Tobacco			Tins or Bags/Day
Did you Smoke?			Year Quit
How many years did you smoke?			Packs/Day
Drink Alcohol or Wine			Drinks/Day
Drink Beer			Cans/Day
Drink Caffeine			Cups/Day
Use Recreational Drugs			
Exercise			
Live Alone			
History of Falls			
History of Fractures			

MEDICATIONS

Please list all medications you are now taking, including those you buy without a doctor's prescription (over-the-counter, supplements, herbals, etc.)

What pharmacy do you use?

Medication	Dosage	How many times a day?

IMMUNIZATIONS

	No	Yes	Date
Flu Shot			
Hepatitis B			
MMR			
Pertussis (Whooping Cough)			
Pneumonia			
Tetanus			
Zoster (Shingles)			

ALLERGIES

	No	Yes	Reaction
Aspirin			
Banana			
Bee Sting			
Codeine			
Latex			
Peanuts			
Penicillin			
Shellfish			
Sulfa			
Other			

FCHC Medical Care - PATIENT HEALTH HISTORY FORM

PLEASE COMPLETE IN BLACK INK

TODAY'S DATE | PAGE 2

LAST NAME	LEGAL FIRST NAME	MI	DATE OF BIRTH

Are you being treated by other Healthcare Professionals? No Yes **If yes, please list doctors & reasons for treatment.**

Physician/Specialist
Dentist
Chiropractor

HOSPITALIZATIONS (NOT INCLUDING NORMAL PREGNANCIES)		SERIOUS ILLNESS (NOT REQUIRING HOSPITALIZATION)	
	Year		Year
	Year		Year
	Year		Year
	Year		Year

PAST SURGERIES		PAST ACCIDENTS	
	Year		Year
	Year		Year
	Year		Year
	Year		Year

FAMILY HISTORY

	Living	**Deceased**	Year of Birth	Age	Hypertension	Diabetes	Heart Disease	Stroke	Mental Illness	Cancer: List Type	Other Health Issue: List
Father											
Mother											
Father's Grandfather											
Father's Grandmother											
Mother's Grandfather											
Mother's Grandmother											
Son(s)											
Daughter(s)											
Siblings:											
Spouse											

OTHER INFORMATION			No	Yes
Last Colonoscopy?		Abnormal?		
Last Sigmoidoscopy		Abnormal?		
Last Hema-Chek?		Abnormal?		
Wake in the night to go to the bathroom?				
Are you currently sexually active?				
Sexual Problems or concerns?				
Do you feel safe in your home?				
Do you have a Living Will?				
If Yes, where is it?				
If No, would you like information on Living Wills?				
Have you ever been treated for alcohol abuse?				
Have you ever been treated for drug abuse?				
Do you currently abuse any substances?				
Are you under a lot of pressure/stress at work?				
Are you under a lot of pressure/stress at home?				
Have you ever had anesthesia?				
If Yes, did you have any problems?				
Are you on a special diet?				
Are you on any food restrictions?				
If Yes, specify				
Have you had a blood transfusion in the past 6 months?				

WOMEN ONLY				No	Yes
Last Pap Smear?		Abnormal?			
Last Mammogram?		Abnormal?			
Age Periods Started?		Problems?			
Ovarian Cysts?					
Vaginal itching, burning or discharge?					
Breast lumps, disease or nipple discharge?					
Pregnant Now?					
Planning a Pregnancy?					
Nursing a Child?					
Pregnancies	#	Births	#		
Miscarriages	#	Abortions	#		
Birth Control Method					

MEN ONLY				No	Yes
Last PSA?		Abnormal?			
Last Prostate Exam?		Abnormal?			
Pain or lump(s) in testicles?					
Penile (penis) itching, burning or discharge?					
Prostate Disease or problems?					
Problems starting or stopping your urine stream?					

The information on this Patient Health History Form is correct to the best of my knowledge.

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE DATE

REVIEWED BY PROVIDER DATE

FINANCIAL POLICY

Thank you for choosing West Ohio Family Physicians, a division of FCHC Medical Care, LLC, as your health care provider. We are committed to your treatment. Please understand that payment of your bill is considered a part of your treatment. All patients must complete the required forms and are required to read and sign this Financial Policy prior to any treatment.

Remitting Payment: Please remit payment to FCHC Medical Care, LLC at 735 S. Shoop Ave. Wauseon, OH 43567. For your convenience we accept cash, check, Visa, MasterCard, American Express and Discover.

Insurance Companies: We have contracts with most commonly used insurance companies. Please check to see if we accept your insurance. If we do not accept your insurance policy, as a courtesy, we will bill your company. Your insurance policy is a contract between you and your insurance company. We are not a party of that contract. If we bill your insurance company and they have not paid your account in full within 45 days, the balance may be billed directly to you. Any subsequent visits must be paid in full at the time the services are rendered. Please be aware that some insurance companies, including Medicare, may determine treatment to be non-covered or find it not to be reasonable or necessary. If such a determination is made, you will be responsible for such services. Such services will be billed and payment is due upon receipt of bill.

Injury/Accidents: If you are being seen for an injury, please advise the office at the time of scheduling your appointment. You insurance may require additional information.

Regarding insurance plans where we are a participating provider: All co-pays and deductibles are due at the time of treatment. If there are any additional procedures performed, they may be subject to an additional **Co-Payment, Deductible or Co-Insurance.** Please refer to your HealthCare Plan for additional information. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.

Usual and customary rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of what constitutes a usual and customary rate.

Minor patients: The adults accompanying a minor and the parents (or guardians of the minor) are responsible for payment. Unaccompanied minors presenting for non-emergency treatment will be denied if there is no authorization or consent to treat.

Missed appointment: If appointments are missed we will move you to the next available opening. Please help us serve you by keeping scheduled appointments.

Late arrival: To help the providers stay on time and to cut back your wait time we have a 10 minute late appointment policy. If arrive more than 10 minutes after your appointment time you will be asked to reschedule. You will be placed at the next available opening. If you have 3 missed appointments in a 1 year time frame you may be terminated from the practice. A warning letter will be mailed to you to prior to termination.

Co-pays and Balances: Co-pays are due at the time of service. You will also be asked to pay any outstanding patient balance at the time of an appointment.

Disability Form Fees: You may be charged a fee for completion of forms. Please complete the Patient portion of the form before submitting it to the office staff.

Insufficient Fund Fee: Checks that are returned will be charged a $30.00 insufficient funds fee.

Please let us know if you have any questions or concerns.

I have read the *Financial Policy* and I understand and agree to its provisions.

_____ Date_____

Signature of patient or responsible party

Notice of Privacy Practices

FCHC Medical Care, LLC

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.

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

• We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

• We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.

• We are not required to agree to your request, and we may say "no" if it would affect your care.

• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.

• We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

• We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

• You can complain if you feel we have violated your rights by contacting us using the information on the back page.

• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

• We will not retaliate against you for filing a complaint

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

• We can use your health information and share it with other professionals who are treating you.

Example: *A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

• We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: *We use health information about you to manage your treatment and services.*

Bill for your services

• We can use and share your health information to bill and get payment from health plans or other entities.

Example: *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

• We can share health information about you for certain situations such as:
• Preventing disease
• Helping with product recalls
• Reporting adverse reactions to medications
• Reporting suspected abuse, neglect, or domestic violence
• Preventing or reducing a serious threat to anyone's health or safety

Do research

• We can use or share your information for health research.

Comply with the law

• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

• We can use or share health information about you:
• For workers' compensation claims
• For law enforcement purposes or with a law enforcement official
• With health oversight agencies for activities authorized by law
• For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Your Rights

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

• Share information with your family, close friends, or others involved in your care
• Share information in a disaster relief situation
• Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

• Marketing purposes
• Sale of your information
• Most sharing of psychotherapy notes

In the case of fundraising:

• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Privacy Officer: Chad Peter • 419-330-2684 • cpeter@fulhealth.org

I, _____; hereby acknowledge receipt of this policy.

_____

Patient/Authorized Representative Signature Date

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that West Ohio Family Physicians can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. Understanding all of the above, I hereby provide informed consent to West Ohio Family Physicians to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____

Patient Name Patient DOB

_____

Signature of Patient or Guardian Date

_____

Relationship to Patient

Patient Portal Policy

DO NOT use Portal to communicate if there is an emergency.

Proper subject matter:
• Prescriptions refills, medical questions, lab results, appointment reminders, routine follow-up questions, etc.
• Sensitive subject matter (HIV, Hepatitis panels etc) are not permitted
• We do not refill controlled substance medications drugs on the patient portal. An appointment is required for a narcotic prescription refill.
• Please be concise when typing a message.

Current functionality of Patient Portal:
- Email and secure messaging for non-urgent needs.
- Viewing of lab results that have been sent to you.
- Viewing and printing of visit summaries
- Viewing and updating health information.
- List of future and past appointments
- Updating your demographic information (address, phone#, etc) and updating insurance information.

All communication via portal will be included in your chart.
Privacy:
• All messages sent to you will be encrypted.
• Messages from you to the staff should be through this portal or they will not be secure.
• We will keep all email lists confidential and will not share this with other parties.
• Any member of our staff may read your messages or reply in order to help the Physician that has been e-mailed. This is similar to how a phone message is handled.
• Our system will check when messages are viewed, so you do not need to reply that you have read it.

Response Time:
• We will normally respond to non-urgent message inquires within a timely manner. Please contact the office if you need an immediate response.

Patient and Family Request for Patient Portal
I hereby request access to the Patient Portal maintained by West Ohio Family Physicians for the patient named below. I understand that West Ohio Family Physicians takes seriously its responsibility to safeguard the privacy of its patients and protect the confidentiality of their protected health information. Therefore, I will only access the patient portal in a matter consistent with these terms. I will keep safe the sign-on and password that I am assigned and will not share my log-in information with anyone else. I agree that West Ohio Family Physicians will not be liable for any disclosure of information due to unauthorized use of my sign-on and password. If I feel my username and password combination has been compromised, I will contact West Ohio Family Physicians immediately or go to the portal and request a new password.

I understand that the Patient Portal will only allow me to view my records for the patient. If I accidently gain access to another patient's information, I will cease to view it and notify West Ohio Family Physicians immediately. In no event will I deliberately attempt to access information for any person other than myself. I represent to West Ohio Family Physicians that I am a personal representative of the Patient with the right to access the Patient's health information, or that the patient has expressly authorized me to have access. If my status as personal representative changes so that I no longer have such rights, or if the Patients authorization expires or is revoked, I will immediately cease using the Patient Portal to access the Patient's information and will notify West Ohio Family Physicians.

Patient Name (print):_____ DOB: _____

Email Address: _____

Patient/Guardian Signature: _____