Lower Lights
Christian Health Center

Dear Patient,

Welcome! It is our pleasure to have you as a part of Lower Lights Christian Health Center – to have you as both a patient receiving medical treatment and also as a partner in making this a better organization. It is our privilege to serve you. Our providers and staff want to serve you with the highest level of care. To help us do this we ask the following from you:

1. Bring the following to EVERY visit:
    a. Proof of income
    b. Photo ID
    c. Insurance Card
    d. All medications you are currently taking or a list that includes all medications (both from LLCHC providers and other providers you might see/have seen)

    **This is important so we can accurately enter this into our EMR system and issue prescriptions electronically*

2. Come prepared with your co-pay each visit. Co-pays are required for each provider services at LLCHC; i.e. separate co-pay is required for medical visit vs. counseling or psychiatric vs. dietitian.

3. Actively participate in your care by asking questions and following treatment plans.

Following these expectations will allow our staff to enhance the quality of care. Again we are excited and privileged to partner with you in your health care. We look forward to seeing you soon.

Sincerely,

Lower Lights Christian Health Center Providers and Staff

Lower Lights
Christian Health Center

Controlled Substance Medications

Welcome to Lower Lights Christian Health Center!

We are a primary care health center and we evaluate and treat a large range of conditions. We perform a comprehensive assessment of all patients before deciding to continue or change prescription medications. Many medications commonly used to treat chronic pain and anxiety are highly regulated (called "controlled-substance prescriptions) and providers must follow specific regulations to be able to prescribe these medications safely because these medications pose additional risks to your health and to the community if prescribed incorrectly or not taken as recommended. Common control-substance medications include:

Opioid Pain Medications, including:

- Codeine products such as Tylenol #3 and #4
- Hydrocodone products such as Vicodin, Lortab, and Norco
- Oxycodone products such as Percocet, Roxicet, Tylox, and OxyContin
- Morphine products such as Roxanol, Kadian, and MSContin
- Methadone and fentanyl/Durgesic, among others
- Tramadol

Anxiety and Insomnia Medications, including:

- Benzodiazepines such as diazepam (Valium), lorazepam (Ativan), alprazolam (Xanax), clonazepam (Klonopin); also Ambien, Zolpidem, Restoril, among others

ADHD Medications, including:

- Ritalin and Adderall

If you have a history of requiring controlled-substance prescriptions, our health center team will perform an assessment of your case to determine if it is in your best interest and safe to continue to prescribe these medications before writing any prescriptions for these medications.

Before our providers will consider prescribing these medications, we will review your history, physical exam, medical records, pharmacy records, and test results. To expedite your evaluation, you must provide your medical and pharmacy records from previous providers.

Because controlled-substance medications are highly regulated, all providers have access to state records of controlled-substance prescriptions filled. Sometimes we need to verify record details by talking with your pharmacist. Please provide the name and phone number of your pharmacy.

In order to help you obtain records from your previous doctors, we will provide you a Release of Information form to have your medical records sent to our office for review.

It is your responsibility to sign the release of records form.

Before you are eligible to receive any controlled-substance medications, our medical record must contain:

1. Medical records from your previous physicians documenting previous test and consults performed to evaluate the condition that is being treated with a controlled-substance medication.
2. Medical records from the physician who previously prescribed the controlled-substance medications.
3. Name and phone number of the pharmacy where you have most recently filled these prescriptions.
4. Results of laboratory tests as your physician deems appropriate for the type of medications you are taking.
5. If asked by your new provider, you must bring your most recent prescription bottles, including remaining pills or patches to your next health center appointment.
6. You must agree to the terms and conditions that allow our providers to safely prescribe these medications and monitor for side effects and complications by reading and signing the Controlled-Substance Medication Management Agreement.

You will not likely be prescribed controlled substances on the first several visits to the health center or as you see new providers at the health center, because our providers will need time to review records and test results and perform an assessment of your case. After the assessment is complete, our providers will determine whether it is in your best interest and is safe to prescribe scheduled medications. There is no guarantee that you will receive these medications.

We value your health and look forward to a productive doctor-patient relationship.

The LLCHC Provider Team

Lower Lights
Christian Health Center

Privacy Practices – Patient Consent

I have read and understand the Privacy Practices given to me and give my permission for LLCHC to use my protected health information (PHI) for the following purposes:

Consent for treatment: I give my permission for LLCHC physicians and employee working under the direction of the physician to provide medical care for me or to the patient for which I am a legal guardian. This may include services and supplies related to my health and may include (but not limited to) preventive, diagnostic, therapeutic, maintenance, palliative care, counseling, assessment or review of physical or mental status/function, and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals. I understand that LLCHC participates in one or more Health Information Exchanges and may use this to search for and access health information to provide better quality care. I understand that by signing this form I agree that LLCHC, and other health care providers, may search for, access and share my health information.

Consent for release of information for payment/operations and assignment of benefits: I also agree to allow LLCHC to send my information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services rendered. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by payor sources, as required by my contract with my insurance plan and state regulations. It is my responsibility to obtain all information from my health plan about coverage for services and if I seek care outside of the contract I am responsible for all charges incurred. I understand that my information may also be used for any operational needs as described in the Notice of Privacy Practices.

Consent for the Privacy Practice Notice: I agree that during my registration process I had the chance to read the Privacy Practices Notice. I understand these terms may change and that at any time I may request a copy of these practices by phone or in writing. I understand I have the right to know how my information is used and can also restrict how my information is shared. LLCHC is not required to agree to my restrictions but if an agreement is met then LLCHC is bound to the agreement.

I understand that LLCHC may refuse to provide services if I do not agree to these conditions. I may revoke this consent in writing at any time, but LLCHC may then refuse to provide services. If I choose to revoke this consent, it will take effect once LLCHC receives it in writing.

Patient/Guardian _____ Date _____

Printed Name _____ Relationship (if not patient) _____

Patient unable to sign due to _____

REVOCATION OF CONSENT: I hereby revoke the consent given above.

Patient/Guardian _____ Date _____

Printed Name _____ Relationship (if not patient) _____

Lower Lights
Christian Health Center

(614) 274-1455

Lower Lights Health Center
1160 West Broad Street
Columbus, OH 43222

Lower Lights Nursing Center
777 West State Street, Suite 201
Columbus, OH 43222

Lower Lights East 5th Avenue
171 East 5th Avenue
Columbus, OH 43201

Lower Lights German Village
1560 South High Street
Columbus, OH 43207

Lower Lights Cooper Road
6000 Cooper Road
Westerville, OH 43081

Lower Lights UnionStar
773 Walnut Street
Marysville, OH 43040

Lower Lights Shared Services
1251 West Broad Street
Columbus, OH 43222

Patient Registration Form

PATIENT INFORMATION

Last Name: _____First Name: _____Middle Initial:_____

Address: _____ DOB: _____ SSN: _____

City/State/Zip Code: _____County: _____

Home Phone Number: _____ Marital Status: Single Married Other

Work Phone Number: _____ Employment Status: Employed PT Student FT Student

Name of Employer: _____ Occupation: _____ Veteran: Y N

Email Address _____

RESPONSIBILITY/ GUARANTOR (IF DIFFERENT FROM PATIENT)

Guarantor Name: _____

Address: _____ DOB: _____ SSN:_____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Marital Status: Single Married Other

Work Phone Number: _____ Employment Status: Employed PT Student FT Student

Name of Employer: _____

Relationship to Patient: Self Spouse Child Foster-Parent Parent Grandparent Other

EMERGENCY CONTACT/RELATIVE

Last Name: _____First Name: _____ Middle Initial:_____

Address: _____ Phone Number: _____

May we leave messages at your home with other residents? Y N

May we leave messages on your voice mail or answering machine? Y N

Patient Signature _____ Date_____

Patient Name _____

INSURANCE INFORMATION

INSURANCE – MEDICAL

Policy Holder Name: _____

Policy Holder's DOB: _____ SSN: _____

Name of Primary Insurance: _____ Insured ID#: _____ Group# _____

Name of Secondary Insurance: _____ Insured ID#: _____ Group#: _____

Accident: Y N if yes, what type: Auto Home Sports Work Other Date of Accident: _____

INSURANCE – DENTAL

Policy Holder Name: _____

Policy Holder's DOB: _____ SSN: _____

Name of Primary Insurance: _____ Insured ID#: _____ Group# _____

Name of Secondary Insurance: _____ Insured ID#: _____ Group#: _____

Accident: Y N if yes, what type: Auto Home Sports Work Other Date of Accident: _____

INSURANCE – VISION

Policy Holder Name: _____

Policy Holder's DOB: _____ SSN: _____

Name of Primary Insurance: _____ Insured ID#: _____ Group# _____

Name of Secondary Insurance: _____ Insured ID#: _____ Group#: _____

Accident: Y N if yes, what type: Auto Home Sports Work Other Date of Accident: _____

Patient Name _____

Because Lower Lights Christian Health Center is a Federally Qualified Health Center (FQHC), we are required to track and report demographic data of our patient base. All information is kept strictly confidential, so please complete this page in its entirety. Thank you!

Sexual Orientation: Lesbian or Gay, Straight (not Lesbian or Gay), Bisexual, Something Else, Don't know, Choose Not to Disclose

Gender Identity: Male, Female, Transgender Male/Female to Male, Transgender Female/Male to Female, Other, Choose Not to Disclose

Preferred Language: _____

Race: Black/African-American White/Caucasian Native Hawaiian Asian Native-American Other

Pacific Islander American Indian/Alaska Native More than 1 race

Ethnicity (Pick One): Hispanic or Latino All Other

Homeless: Y N

If Homeless where are you staying? Doubling Up Shelter Streets Transitional Unknown

Migrant Worker: Y N Seasonal Worker: Y N

Education (completed): High School HS/GED Some-College College-Grad Post-Grad

Religious Preference: _____

Are you an Armed Services Veteran? Y N

INCOME INFORMATION (MUST BE COMPLETED BY ALL PATIENTS REGARDLESS OF INCOME OR INSURANCE)

Income Before Taxes: $ _____ per Hour Week Bi-week Month Year

Other Income: $ _____

Income Type: Job Retirement Disability Medicaid/ADC SSI None Exp. Date_____

Family Size (# in Household): _____

Ages of Dependents: _____ _____ _____ _____

How did you hear about Lower Lights Christian Health Center? Please check one:
□ Referred by family/friend □ Referred by hospital or healthcare provider □ Walk in □ Internet search
□ Other (please list how you heard about us) _____

ATTENTION Sliding Fee Scale Patients:

For all uninsured patients, there is minimum $10.00 co-pay for each visit regardless of sliding fee scale status.

Failure to submit all requested documents within 60 days of initial visit will result in a denial of the sliding fee scale discount and you will be responsible for the entire cost of each visit and service. The documentation is evaluated on a yearly basis. Each year you will be expected to submit your financial status for sliding fee scale eligibility per federal regulation.

SIGNATURE: _____ **DATE:**_____

Lower Lights
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Health Questionnaire

To be completed by patient, please print.

Today's Date _____

Name _____ **Date of birth** _____

Height _____ **Weight** _____

Drug allergies _____

Please list in order of importance, the present health concerns, symptoms, or problems you are experiencing:

_____

Have you had a diagnosis of the following Circle Yes or No for each; leave blank if uncertain.

AIDS OR HIV	Y	N	Heart Valvular Disease	Y	N	Osteoporosis	Y	N
Anemia	Y	N	Hepatitis	Y	N	Gall Bladder Disease	Y	N
Angina	Y	N	List Type _____			Glaucoma	Y	N
Atrial Fibrillation	Y	N	Hypertension	Y	N	Epilepsy	Y	N
Asthma	Y	N	High Cholesterol	Y	N	Stroke	Y	N
Blood Clots	Y	N	Inflam. Bowel Disease	Y	N	Thyroid Disease	Y	N
Coronary Artery	Y	N	Irritable Bowel Disease	Y	N	Cancer	Y	N
COPD	Y	N	Kidney Disease	Y	N	List Type _____		
Diabetes	Y	N	Liver Disease	Y	N			
Heart Disease	Y	N	Migraines	Y	N			

Please list any other health problems you have had: _____

_____

Surgical History

Have you ever had the following surgeries? Please circle the surgery and list the year.

Disease	Year	Disease	Year	Disease	Year
Appendectomy		Gastric Bypass		Hysterectomy	
Angioplasty		Hernia Repair		Mastectomy	
Heart Stent		Hip Replacement		Gall Bladder Surgery	
Arthroscopy		Knee Replacement		Ovary Removal	
Back Surgery		LASIK		Breast Surgery	
Blood Transfusion		Liver Biopsy		Bowel Resection	
Carpal Tunnel Release		Pacemaker		Tubal Ligation	
Coronary Bypass		Thyroid Surgery		Fibroid Surgery	
Cataract Extraction		Tonsillectomy		ORIF	
Colectomy		C-Section		Colostomy	
D and C					

Other: _____

_____

Patient Name: _____ **DOB:** _____

Hospitalization: If you have been in the hospital overnight, other than the surgeries listed above, please list the illness and the year. Do not include normal pregnancies. _____

_____

Family History

Has any blood relative had any of the following? (Circle Yes or No; leave blank if unsure)

Disease	Relationship	Disease	Relationship
ADD/ADHD		Irritable Bowel	
Alcohol Abuse		Learning Disability	
Allergies		Peripheral Vascular Disease	
Alzheimer's		Kidney Disease	
Asthma		Migraines	
Blood Disorder		Mental Illness	
Depression		Obesity	
Eczema		Osteoporosis	
High Cholesterol		Epilepsy	
Hypertension		Thyroid Disorder	
Developmental Delay		Genetic Disease	
Cancer (List Type and Relationship)			

For the following diseases, list the relationship and the age of onset, or whether it was the cause of death:

Disease	Age	Relationship	Cause of Death?	Yes	No
Diabetes					
Stroke					
Heart Attack					
Coronary Artery Disease					

List your medications:

Times/Day _____

Social History

Tobacco Y N Packs Per Day: _____ for _____ year's

Alcohol Y N Drinks Per Week: _____ Type: _____

Caffeine Y N Cups Per Day: _____ Type: _____

Illegal Drugs Y N Type: _____

Vaccine(s)

The last time you had a (list year):

Flu Vaccine _____ Tetanus Vaccine _____ Hepatitis Vaccine _____

Pneumonia Vaccine _____ TB Test _____ Rubella Vaccine _____

Stool Blood Test _____ Mammogram _____ Colonoscopy _____

Eye Exam _____ PAP _____

For Women Only

Age of first menstrual period: _____ Date of Last Menstrual Period: _____

Use of Birth Control: Y N Type: _____

Number of Pregnancies? _____ Number of Live Births? _____ Number of premature? _____

Number of Full Term? _____ Number of Abortions? _____ Number of Miscarriages? _____

Lower Lights
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Financial Assistance Form

Date:

Patient Name:	**Social Security #:**	**Date of Birth:**
Address:	**Phone Number:**	

Marital Status: Single Married (Date: _____) Divorced Widowed Separated

Sex: M/F

Ohio Resident? YES NO **Are you a US Citizen?** YES NO **Pregnant?** NO NOT APPLICABLE YES (Due Date: _____

Household Information

Please complete the information below regarding your household number and income. Please note:
ALL household income must be reported to qualify for Medicaid or Sliding Fee programs.

Name of Household Member (claim on taxes)	Date of Birth	SSN	Source of Income (wages, SSI, disability, unemployment, child support, etc.)	Monthly Income Amount	How often paid?	Hours worked per week?	Currently receiving Medicaid?	Has been in foster care?	In school?

_____ _____

Signature Date

***MEDICAID/MARKETPLACE APPLICATION: If you are uninsured and you would like our staff to assist you in applying for Medicaid or through the health insurance Marketplace, please read the below statement and sign at the bottom.**

I authorize Lower Lights Christian Health Center to apply for Medicaid/Marketplace on my behalf.
I have voluntarily provided the above information, which is complete and truthful to the best of my knowledge.

_____ _____

Signature Date

Lower Lights
Christian Health Center

OB Questionnaire

Name: _____ Date: _____

Father of the Baby: _____ Emergency Phone Number: _____

Date of Last Menstrual Period: _____

Are you sure of the Date? Yes/ No Was this a normal period for you? Yes/ No

Have you had a pregnancy test? Yes/ No If Yes, when and where?_____

Weight before Pregnancy: _____

Are you enrolled in WIC? Yes/ No

Would you like to breast or bottle feed your baby? Breast / Bottle

Do you know your blood type? Yes/ No If so, what type? _____

Would you accept a blood transfusión if it was necessary to save your life? Yes/ No

Do you care for any pet cats? Yes/ No

Do you wear your seat belt? Yes/ No

Please complete the following pregnancy history. Use back of the form if you need additional space.

Number of pregnancies	Delivery Date	Full term? If pre-term, how many weeks?	Hours in Labor	Type of Delivery – vaginal or c-section?	Sex of Baby	Weight of Baby	Complications

*Complications include pre-term labor, pre-eclampsia or high blood pressure, bleeding, infection, bad tears/laceratio, and postpartum depression.

Have you ever had any of these medical problems?

Autoimmune disorder Varicose Veins Breast Problems

Urinary tract or kidney infection Trauma / Violence History of abnormal pap smear

Depression or postpartum depression History of blood transfusion

Complications due to Anesthesia Latex Allergy Infertility

Revised 03/29/2018

Have you ever had or been exposed to the following infections?
(Have you ever had or been exposed to the following infections?)

Tuberculosis	Chlamydia	Hepatitis B
Genital herpes or warts	Syphillis	Hepatitis C
Gonorrea	Other sexually transmitted diseases	HIV

Does the mother, the father, or any relatives of the baby have a history of genetic problems?

Thalassemia	Familial Dysautonomia	Mental Retardation
Neural Tube Defect	Sickle Cell Disease or Trait	Autism
Congenital Heart Defect	Hemophilia or other blood disorder	Recurrent pregnancy loss or stillbirth
Down's Syndrome	Muscular Dystrophy	Other inherited/genetic disorders
Tay-Sachs Disease	Cystic Fibrosis	
Canavan Disease		
Huntington Chorea		

Who will be the baby's peditrician? _____

Medications: _____

_____

_____