SHAWNEE CHRISTIAN HEALTHCARE CENTER
"Serving God - Serving People" Matthew 25:40

234 Amy Avenue
Louisville, Kentucky 40212
502-778-0001 - Office
502-776-1133 - Fax
www.shawneechristianhealth.org

PATIENT RESPONSIBILITIES

- Be sure we have your correct name: Name, Address, Birthday, Phone number, Pharmacy and insurance.
- Arrive early or on time for your appointment. You will only have a fifteen minute grace period before we have to reschedule your appointment.
- Give us 24 hours' notice if you cannot make it to your appointment.
- Come prepared to ask questions about your healthcare needs.
- Ask questions if you do not understand the plan of care for you.
- Follow the advice the Providers give you.
- Bring all medicine bottles with you to your appointment.
- If you are referred to a specialist, you are responsible for keeping all appointments or rescheduling them on your own.
- Be courteous to the staff and other visitors at the center.
- No smoking on the property.

FOR AFTER HOURS CARE:

- If you have an emergency, call 911 or go to the nearest emergency room.
- If you need to reach the doctor on call and the issue cannot wait until the next business day leave a message. Your call will be returned.
- If you are calling for a refill, have your pharmacy send us a refill request electronically.
- If you need an appointment, please call during normal business hours.
- For anything else, leave a message and your call will be returned.

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It is our honor to partner with residents of this community to promote healthy living through Christ centered care.

We are committed to providing superior care to our patients by ensuring access for our patients to see the provider, completing each visit in a timely manner, communicating test results and providing a plan of care for each patient. In order to do this, we must create a partnership with our patients where we can collectively manage the care for you and your family. We have established the following policies to help us to be a successful healthcare center and fulfill our commitment to the community.

- **Walk In Visits:** Visits are available Monday from 11am-1pm and 3pm-5pm as well as Tuesdays-Fridays from 9am-11am and 1pm-3pm *WITH THE STIPULATION* that if all of the scheduled appointments come in we may have to turn walk-in appointments away until the next available walk in time. These can be for **one problem** only and new patient walk-in visits will be decided based on the provider and the issue.
- **Prescription Refills:** All prescription refills MUST come from your pharmacy. Please contact your pharmacy, they will request your refill electronically. If you are out of refills you may be required to see your provider to get new prescriptions. Your signature below gives us access to your records at the pharmacy.
- **Paperwork Request:** Paperwork requests are processed as follows (NO EXCEPTIONS):
  - **FMLA Forms:** There will be a $20.00 fee upon drop off and we will have 7-10 business days to complete.
  - **Immunization Records:** The first copy is free and any request after the first copy will require a $10.00 charge and will be processed within 2 business days of the request.
  - **Medical Records:** The first copy is free and each additional copy is $1.00 per page. We will have 30 days to process this request.
  - **Medical Necessity Letters:** There is a $10.00 charge for each letter and we will have 2 business days to process this request.
- **Missed and Late Appointments:**
  - If you fail to show up for your appointment three times, you may be discharged from the practice. Provider and the manager's discretion.
  - Patients are requested to arrive 10-15 minutes prior to their appointment time to complete any necessary paperwork like updating demographics information.
  - If you are 15 minutes or more late to your appointment, you WILL be asked to reschedule.

Patients Printed Name Patients Signature Date

SCHC SHAWNEE CHRISTIAN HEALTHCARE CENTER
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Patient ID #:_____

Adult

Patient Information

First Name _____

Middle Name _____

Last Name _____

Address _____

City _____ State_____

Zip _____

Preferred Contact Numbers

Home Phone # _____

Cell Phone # _____

Work Phone # _____

Soc Sec # _____

Birth Date _____ / _____ / _____
(month) (day) (year)

Marital Status ☐ Single ☐ Married ☐Divorced ☐Other

Ethnicity _____

Race ☐ African American ☐ Hispanic ☐ Caucasian ☐ Other

Gender ☐ Male ☐ Female

Language ☐ English ☐ Spanish ☐ Other

Parent or Guardian (if under 18 years old)

Name _____

Phone # _____

Date of Birth _____

Relationship to patient _____

Pharmacy Information

Preferred Pharmacy _____

Pharmacy Address _____

_____

Emergency Contact Information

Name _____

Address _____

Phone # _____

Relationship to Patient _____

How did you hear about Shawnee Christian Healthcare Center?

☐ Word of Mouth ☐ Flyer ☐ Internet ☐ Another Facility/Physician

☐ Other: _____

Permission for Full Disclosure of Protected Health Information

With whom may we discuss your health information? (This includes any and all health information)

Name _____ Phone # _____

Relationship to Patient _____

Authorized to Make Medical Decisions?
☐ Yes ☐ No

COMPLETE THIS SECTION IF YOU HAVE INSURANCE (MEDICARE, MEDICAID, OR OTHER)

Name of Company _____ Effective Date _____

Insured Person's Name _____ Insured Peron's DOB _____

Insured Person's SSN _____ Patient Relationship to Insured Person _____

Member ID number _____ Group Number _____

Secondary Insurance

Name of Company _____ Effective Date _____

Insured Person's Name _____ Insured Peron's DOB _____

Member ID number _____ Patient Relationship to Insured Person _____

Assignment and Release

I hereby consent to all treatment deemed necessary by the medical staff of Shawnee Christian Healthcare Center. I authorize the release of any information necessary to process this claim. I request that any money due me for medical benefits be assigned to Shawnee Christian Healthcare Center, and I realize that I am responsible for any and all differences. I have received the HIPAA Notice of Privacy Practices and agree to its terms. I agree to pay my fee at the time of service, in accordance with Shawnee Christian Healthcare Center policies. I grant permission for third party auditors to view private health information as a part of the evaluation process. I further attest that, as of the date of my signature, the income sources listed constitute all of my household income, and that the family members listed are all solely dependent on that income, or that the explanation provided to verify my income level is truthful. All information on this form is truthful to the best of my knowledge and if there are changes to my income, insurance status, or other information I will inform Shawnee Christian Healthcare.

Patient/Guardian Signature X_____ **Date**_____

Relationship to Patient X_____

____ **(Initial)** -- I have received the Shawnee Christian Healthcare Policy Document and understand the terms, including my responsibilities as an SCHC parent/ guarantor. Should I have questions, it is my responsibility to inquire of the SCHC staff.

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234 Amy Avenue
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502-778-0001

Privacy consent for Use or Disclosure of Patient Information for the Purposes of Treatment, Payment and Healthcare Operations

I hearby consent to Shawnee Christian Healthcare Center using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for healthcare services rendered to me or to carry out the Practice's healthcare operations. I also consent to Shawnee Christian Healthcare Center using or disclosing my protected health information for treatment activities provided by another healthcare provider, as well as the payment activities conducted by another healthcare provider or entity. I further consent to the disclosure of my protected health information in order for another provider or healthcare entity to conduct healthcare operations including quality assessment and reviewing the competence of healthcare professionals.

Specific Records Expressly Include

I expressly authorize release of information for the purpose of treatment and healthcare operations if it is part of my protected health information. By signing this form, I acknowledge that this includes any and all information including:

- Chemical Dependency/ Substance Abuse
- Drugs
- Alcohol
- Sexually Transmitted Diseases

I further acknowledge Shawnee Christian Healthcare Center has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information. I have also been given a copy of the office policies.

Signature of Patient or Personal Representative	Date
Name of Patient or Personal Representative	Description of Personal Representative's Authority