# Welcome to

FCHC Medical Group

FCHC Primary Care Wauseon

**Providers**
Richard L. Grieser, MD
Rebecca L. McClarren, MD
Philip F. Ashton, MD
Leslie S. Clemensen, MD
Marissa M. Baus, NP
Jacob J. Grime, CNP
Taylor L. Short, CNP

**Address**
735 S Shoop Ave
Wauseon, OH 43567

**Office Phone**
(419) 335-3242

Use this number to schedule appointments, answer your general questions and connect you with team members.

**Office Fax**
(419) 335-3222

**Office Hours**
Monday-Thursday
8:00 am – 4:30 pm
Friday
8:00 am – 4:00 pm

**On Call Service Phone**
(844) 694-1264

Use this number after hours and on weekends to talk to the On Call provider when the office is closed.

**Website**

fchcprimarycarewauseon.org

## Welcome!

Thank you for choosing us to be part of your healthcare team. We look forward to working with you to make sure you receive the care you need and keep you healthy and happy. We hope that the information provided on this guide will answer many of the questions you may have about our practice.

## Appointments

If you have an emergency illness or symptom that requires immediate, urgent attention, call 911. If you need an appointment for illness, symptom, check-up, follow-up visit or annual visit call the office.

Please arrive 15 minutes prior to your appointment time. We require everyone who enters the building to wear a face mask/covering. Patients who are more than 10 minutes late may be required to reschedule their appointments. Patients with 3 no-show appointments may result in dismissal from practice. Patients under the age of 18 must be accompanied by a parent or legal guardian at all appointments unless authorization for another adult to bring minor patient has been completed.

## Appointment Check List

- Your insurance card.
- Current prescription bottles and non-prescription medications, vitamins and supplements bottles.
- A good description of the problem, how long you have had it and how it affects you.
- A list of questions you would like to discuss with your provider.
- A list of other health care providers you have visited.

## Payment Options

We participate in most insurance plans, including Medicare. Be sure to check with your insurance to see if we are an in network provider. Please note that it is your responsibility to ensure that we are a covered provider.

Please be prepared to pay your co-pay and/or patient balance at the time of service. We accept cash, checks, Visa, MasterCard and Discover credit cards.

We are happy to answer questions, discuss payments or your bill anytime by calling (419) 330-1550.

## Prescriptions

For refills of prescriptions, please contact your pharmacy. Please allow 48 hours for us to refill your prescriptions. We will contact you only if there is a problem or we have a question about your prescription refill request.

Please remember that refills can only be given to patients who have been seen within the past six months. If you have not been seen for more than six months, you will need to schedule an appointment.

If you have questions about a new prescription or about discontinuing medication(s), please call and speak with your provider's nurse.

## After-Hours Care

If you would like to speak to the clinician on call to help you decide how to treat an illness after hours or to help you decide whether to go to the emergency room, call the On Call Service. If you receive care at an emergency room or urgent care center, please let us know by calling the office within 48 hours so we can assist with follow-up care as needed.

FCHC Medical Group

# Patient Registration Form

Last Name_____ First Name_____ MI_____ Date of Birth_____

Birth Sex ❑ Male ❑ Female SS#_____-_____-_____ Preferred Name_____

Address_____ City_____ State_____ Zip_____

Email_____ Pharmacy/City_____

Home Phone (_____)_____ Cell Phone (_____)_____ May Leave Message ❑ Yes ❑ No

Appointment Reminders – Check One ❑ Call Home Phone ❑ Call Cell Phone ❑ Text Cell Phone

Primary Language ❑ English ❑ Spanish ❑ ASL ❑ Other _____ Interpreter Needed ❑ Yes ❑ No Marital Status_____

Employer_____ City_____ Primary Care Physician_____

| | | | | |
|---|---|---|---|---|
| Race: | ❑ American Indian/Alaska Native | ❑ Asian | ❑ Black/African American | |
| | ❑ Native Hawaiian/Other Pacific Islander | ❑ White | ❑ Other | ❑ Unknown |
| Ethnicity: | ❑ Hispanic/Latino | ❑ Not Hispanic/Latino | | ❑ Unknown |

FCHC Medical Group 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 Group, all healthcare facilities must comply.

| | | | | | | |
|---|---|---|---|---|---|---|
| Sexual Orientation: | ❑ Straight | ❑ Bisexual | ❑ Lesbian/Gay/Homosexual | | ❑ Don't Know | ❑ Declined |
| Gender Identity: | ❑ Female | ❑ Male | ❑ Trans Male (female to male) | ❑ Trans Female (male to female) | ❑ Don't Know | ❑ Declined |

## Guarantor – Person Financially Responsible

❑ Same as Patient Information

Last Name_____ First Name_____ MI_____ Date of Birth_____

Relationship to Patient_____ SS#_____-_____-_____

Address_____ City_____ State_____ Zip_____

Phone (_____)_____ ❑ Home ❑ Cell Employer_____

## Insurance Information

❑ Self-Pay

**Primary Insurance**_____ Policy/ID# _____

❑ Same as Patient Information (If the patient is NOT the Subscriber please provide additional information)

Subscriber Last Name_____ First Name_____ MI_____

Relationship to Patient _____ Date of Birth_____ SS#_____-_____-_____

Subscriber Employer_____ City_____

**Secondary Insurance**_____ Policy/ID# _____

❑ Same as Patient Information (If the patient is NOT the Subscriber please provide additional information)

Subscriber Last Name_____ First Name_____ MI_____

Relationship to Patient _____ Date of Birth_____ SS#_____-_____-_____

Subscriber Employer_____ City_____

I attest that the above information is correct to the best of my knowledge.

_____ _____

Patient/Authorized Representative Signature Date

FCHC Medical Group

# Communication Release Form

Last Name_____ First Name_____ MI_____ Date of Birth_____

FCHC Medical Group strives to keep your Protected Health Information (PHI) and personal information secure. Requests, usage and disclosure of information is only granted to meet the intended need. You may change your Authorized Representatives at any time.

❑ **DO NOT DISCLOSE** any information to anyone but me.

## Authorized Representatives

I give permission for the following people to receive information as specified. Please mark all that apply.

***Primary Contact***

Last Name_____ First Name_____ MI_____

Relationship to Patient _____ Phone (_____)_____ ❑ Home ❑ Cell

Staff may speak with contact regarding the following: ❑ Appointments ❑ Clinical/Medical ❑ Financial

***Secondary Contact***

Last Name_____ First Name_____ MI_____

Relationship to Patient _____ Phone (_____)_____ ❑ Home ❑ Cell

Staff may speak with contact regarding the following: ❑ Appointments ❑ Clinical/Medical ❑ Financial

***Additional Contact***

Last Name_____ First Name_____ MI_____

Relationship to Patient _____ Phone (_____)_____ ❑ Home ❑ Cell

Staff may speak with contact regarding the following: ❑ Appointments ❑ Clinical/Medical ❑ Financial

***Additional Contact***

Last Name_____ First Name_____ MI_____

Relationship to Patient _____ Phone (_____)_____ ❑ Home ❑ Cell

Staff may speak with contact regarding the following: ❑ Appointments ❑ Clinical/Medical ❑ Financial

_____ _____

Authorized Representative Signature Date

# FCHC Medical Group - 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 |
|---|---|---|---|
| **CARDIOVASCULAR** | | | |
| Drug Allergies | | | |
| Hay Fever | | | |
| Latex Allergy | | | |
| 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) | | | |

## SPIRITUAL/RELIGIOUS PRACTICES

| | No | Yes | Explanation |
|---|---|---|---|
| Are there any spiritual/ religious practices or restrictions we should know about in providing your medical care? | | | |

## ALLERGIES

| | No | Yes | Reaction |
|---|---|---|---|
| Aspirin | | | |
| Banana | | | |
| Bee Sting | | | |
| Codeine | | | |
| Drug | | | |
| Hay Fever | | | |
| Latex | | | |
| Peanuts | | | |
| Penicillin | | | |
| Shellfish | | | |
| Sulfa | | | |
| Other | | | |
| | | | |
| | | | |
| | | | |
| | | | |

# FCHC Medical Group - 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 Father | | | | | | | | | | | |
| Father's Mother | | | | | | | | | | | |
| Mother's Father | | | | | | | | | | | |
| Mother's Mother | | | | | | | | | | | |
| 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

FCHC Medical Group

# Financial Policy

Thank you for choosing an office of the FCHC Medical Group 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.

***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 insurance 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.

***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.

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

***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.

***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.

***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 and Discover.

***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.**

_____

Patient Name Patient DOB

_____

Signature of Patient or Guardian Date

FCHC Medical Group

# PHI Release Authorization

Patient Name: _____Date of Birth: _____

Address: _____

By signing this authorization form, you are agreeing to the release or disclosure of your protected health information. Your medical care or payment for care will not be conditioned on the signing of this form.

Please be aware that any information disclosed to a third party pursuant to this authorization may be subject to re-disclosure and no longer protected by our policies and applicable law.

This authorization will expire one year from the date of the signature below. You have the right to revoke this authorization by completing the revocation section below. Revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I hereby authorize _____ to release my protected health information to:

❑ FCHC Primary Care Delta
6696 US Highway 20A
Delta, OH 43515
Phone: 419-822-3242
Fax: 419-822-9008

❑ FCHC Primary Care Fayette
124 W Main St, PO Box 399
Fayette, OH 43521
Phone: 419-237-2501
Fax: 419-237-2671

❑ FCHC Primary Care Wauseon
735 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-3242
Fax: 419-335-3222

❑ FCHC Orthopedics
735 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-2663
Fax: 419-335-9615

❑ FCHC OB/GYN
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-6377
Fax: 419-335-6807

❑ FCHC Pediatrics
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-3333
Fax: 419-337-7845

❑ FCHC Behavioral Health
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-330-2790
Fax: 419-330-2774

❑ FCHC General Surgery
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-337-7478
Fax: 419-337-7846

❑ FCHC Urology
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-2000
Fax: 419-335-7500

❑ FCHC Urgent Care
735 S Shoop Ave
Wauseon, OH 43567
Phone: 419-337-7467
Fax: 419-337-7468

❑ FCHC Heart & Vascular
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-330-2769
Fax: 419-330-2738

❑ FCHC Ear, Nose & Throat
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-3712
Fax: 419-335-3713

The information to be disclosed may include information related to diagnosis and treatment for HIV, alcohol and/or substance abuse and mental illness.

Information and date(s) of service to be disclosed: _____

Purpose for disclosure: _____

Patient/Representative Signature:_____Date:_____

*****Revocation*** (Sign below ONLY if you wish to revoke this authorization)**

I hereby revoke this authorization

Patient/Representative Signature:_____Date:_____