

Patient Name:

Date of Birth:

The best health care is a partnership between the patient, their family and the healthcare provider. Please review the information below and initial each item then sign below.

CHECK-IN: I will have my insurance card and/or my eligibility documents available when I check in and upon request for follow up visits.

ARRIVAL TIME: I will arrive 30 minutes early as a new patient, or to obtain a new service (medical, counseling, dental). I will arrive 15 minutes early as an established patient.

CURRENT MEDICATIONS: I understand that providers can help me best when I bring all my medications, prescription bottles, herbals and supplements to my appointments and thus I am required to bring them each time I see a medical provider.

PRESCRIPTION REFILLS & MEDICATION ASSISTANCE: I understand that providers are not always available and medicines that are shipped may take weeks. For medications through local pharmacies, I will call the pharmacy several days in advance of running out. For medications I obtain through the Clinic, I will call when I open my last bottle.

CONTROLLED SUBSTANCES: Shenandoah Community Health Clinic manages pain and other conditions with non-opiate and non-controlled substances. I understand that the Clinic will assist me by providing alternatives.

MEDICAL RECORDS: The Clinic participates with the prescription monitoring program. I give permission to the Clinic to obtain or share my medical records with any hospital, practice or pharmacy where I have received services and between the medical and dental programs at this Clinic. I understand that a consent form is required to transfer health records from a previous provider.

PRIVACY PRACTICE: I have read and understand the Clinic's Notice of Privacy Practice.

CANCELLATION OF APPOINTMENT: I understand that part of taking charge of my health is keeping up with health appointments. I understand that I should give at least 24 hours' notice if I am unable to come to an appointment so that other patients may be helped. I understand that I may be charged a \$10 reinstatement fee -- plus the cost of the missed appointment and advance payment of my next appointment -- if I miss an appointment without any advance notice.

Patient/Guardian Signature: _____ Date: ___ / ___ / _____

Print Name: _____ Relationship to Patient: _____

This person helped me with this paperwork: _____ Print Name: _____

Signature _____ Date: ___ / ___ / _____

OFFICE USE ONLY

Scanned By:

Date: