



Springfield Health Care Center

Dear Patient,

We have enclosed the following forms, which must be completed and returned to us prior to your scheduled appointment:

Patient Registration Form

- Payment Policy
- Health Questionnaire
- Request for Health Information from your Previous Provider
- Treatment Authorization and Disclosure of Information
- Notice of our Privacy Practices
- Protected Health Information Disclosure Questionnaire

The forms may be dropped off at our office, scanned and emailed to manager@springfieldhealthcarecenter.com, or may be faxed to 937-328-2303. Please be advised we must have these documents prior to your appointment, or it could need to be rescheduled.

If you have any questions about the completion of your packet or about any of our policies, Please do not hesitate to call us on 937-328-2310.

We appreciate your selection of Springfield Health Care Center for your medical care and look forward to serving your needs.

Sincerely,

Kimberly Packer,
Practice Manager
Springfield Health Care Center, Inc.

SPRINGFIELD HEALTH CARE CENTER, INC.

30 Warder Street Suite 100
Springfield, OH 45504-2577
937-328-2310

PATIENT INFORMATION

Name:		
Last	First	MI
Address:		
City:	St:	Zip:
Home Phone: ()	Cell Phone: ()	Email:
S.S.N.: - -	Birthdate: / /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other		
Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian / Alaska Native <input type="checkbox"/> Native Hawaiian / Other Pacific Islander		
Ethnicity: <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Not Hispanic / Latino		

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:		
MEMBER ID:		
Subscriber Name:		
Last	First	MI
S.S.N.: - -	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate: / /
SECONDARY INSURANCE NAME:		
MEMBER ID:		
Subscriber Name:		
Last	First	MI
S.S.N.: - -	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate: / /

EMERGENCY INFORMATION

Name:	Relationship with Patient:
Phone Number: ()	Alternate Phone Number: ()

RELEASE OF BENEFITS AND INFORMATION

I attest that the above information is correct to the best of my knowledge. I authorize the release of any medical or other information necessary to process my claim. I authorize payment of insurance benefits to my physician for all services rendered. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered or fees associated with my care.

PLEASE PROVIDE INSURANCE CARDS AND PICTURE ID TO THE FRONT DESK TO BE SCANNED

Signature:	Date:
Parent (if minor):	Date:

Patient Name: _____

PLEASE READ CAREFULLY BEFORE INITIALING

SPRINGFIELD HEALTH CARE CENTER PAYMENT POLICY AND PATIENT RESPONSIBILITY:

Payment Policy: It is our policy to collect the appropriate payment due from the patient at the time service is rendered. This may only be your co-payment, deductible, and/or co-insurance, but we do ask for your payment at the time of check-in. We accept cash, check, and all major credit cards.

Co-payment – Co-payment (also known as co-pay) is the cost-sharing part of your bill that is a fixed dollar amount designated by your insurance company. Common co-payment rates are \$10 or \$30 per visit.

Deductible – The amount of cost-sharing you must pay before your insurance company begins payment for your healthcare services.

Co-Insurance – In addition to a co-payment or deductible, your insurance company may designate an additional portion of your bill as your responsibility. It is usually a percentage of your total bill – for example, 20 percent.

Please be aware insurance coverage varies widely from one insurance company to another. It is your responsibility to be aware of your insurance coverage and financial obligations.

Patient Responsibility: Please read and initial each line. If you have questions, please ask for assistance at the front desk.

_____ I have given the office my current and correct address, phone, and insurance information. I will notify the office of all changes to this information.

_____ I acknowledge that I am responsible for all charges not covered or denied by my insurance provider and agree to pay any remaining balances promptly.

_____ I understand I may be charged \$50 for a missed appointment if I do not show up for my appointment or if I fail to provide a 24-hour notice of cancellation.

_____ I understand I may be dismissed from the practice for failing to show up or failing to provide 24-hour notice for three or more scheduled appointments.

_____ I understand my co-payment is due at each office visit, and I may be charged a \$15 administrative fee if this agreement is not met.

SPRINGFIELD HEALTH CARE CENTER -- HEALTH QUESTIONNAIRE

To be completed by patient -- Please print

Name _____ Date _____

Date of Birth _____

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

PREVIOUS OPERATIONS: Have you ever had the following? Circle Yes or No, or leave blank if uncertain

Appendix	Y	N	Carpal Tunnel	Y	N
Gall Bladder	Y	N	Cataracts	Y	N
Hernia	Y	N	Other	Y	N
Hysterectomy	Y	N	_____		
Prostate	Y	N	Blood Transfusion	Y	N
Sterilization Procedure	Y	N	Major Childhood Illness	Y	N
Tonsils	Y	N	Chickenpox	Y	N
Heart Surgery	Y	N	Med Illness Requiring Hospitalization	Y	N

MEDICAL HISTORY:

AIDS or HIV	Y	N	High Cholesterol	Y	N
Anemia	Y	N	Kidney Disease	Y	N
Arthritis	Y	N	Lung Disease	Y	N
Asthma	Y	N	Migraine	Y	N
Back Trouble	Y	N	Mitral Valve	Y	N
Bleeding Tendency	Y	N	Osteoporosis	Y	N
Cancer	Y	N	Pneumonia	Y	N
Diabetes	Y	N	Seizures	Y	N
Glaucoma	Y	N	Stroke	Y	N
Heart Disease	Y	N	Thyroid	Y	N
Hepatitis	Y	N	Tuberculosis	Y	N
Hernia	Y	N	Ulcers	Y	N
Hypertension	Y	N			

FAMILY HISTORY:

Alzheimer's Disease	Y	N	COPD / Emphysema	Y	N
Aortic Aneurysm	Y	N	Heart Attack (CAD)	Y	N
Asthma	Y	N	Congestive Heart Failure	Y	N
Bleeding Disorder	Y	N	Stroke (Cerebrovascular)	Y	N
Cancer	Y	N	Depression	Y	N
Bladder Cancer	Y	N	Diabetes	Y	N
Brain Tumor	Y	N	Gallbladder Disease	Y	N
Breast Cancer	Y	N	Hepatitis	Y	N
Cervical Cancer	Y	N	Hypercholesterolemia	Y	N
Colon Cancer	Y	N	Hypertension	Y	N
Uterine Cancer	Y	N	Inflammatory Bowel Disease	Y	N

FAMILY HISTORY, continued:

Patient Name _____ **DOB** _____

Esophageal Cancer	Y	N
Gastric Cancer	Y	N
Hepatic Cancer	Y	N
Lymphoma Cancer	Y	N
Leukemia	Y	N
Lung Cancer	Y	N
Ovarian Cancer	Y	N
Pancreatic Cancer	Y	N
Prostate Cancer	Y	N
Sarcoma	Y	N
Skin Cancer	Y	N
Testicular Cancer	Y	N
Other Carcinomas	Y	N
_____	Y	N

Kidney Disease	Y	N
Kidney Stones	Y	N
Osteoarthritis	Y	N
Osteoporosis	Y	N
Peptic Ulcer Disease	Y	N
Seizure Disorder	Y	N
Substance Abuse	Y	N
Sudden Deaths	Y	N
Thyroid Disease	Y	N
Tuberculosis	Y	N
Other	Y	N

SOCIAL HISTORY:

Lives with _____

Marital Status _____

Children _____

Alcohol Y N
 # of Drinks Per Week _____

Illicit Drugs Y N
 Type _____

Smoking Y N
 Packs per Day _____ for _____ years

Occupation _____

Spouse's Occupation _____

Exercise Y N

Seat Belt Y N

PLEASE LIST THE LAST YEAR YOU HAD A:

Hepatitis Vaccine _____

Pneumonia Shot _____

Stool Blood Test _____

Cholesterol Test _____

Tetanus Shot _____

TB Test _____

Eye Exam _____

FOR WOMEN ONLY:

Date of Last Menstrual Period _____

Number of Pregnancies _____

Number of Miscarriages or Abortions _____

Number of Live Births _____

Contraception Y N Type Used _____

Year of Last:

Mammogram _____ Results _____

Pap Smear _____ Results _____

SPRINGFIELD HEALTH CARE CENTER, INC.
REQUEST FOR HEALTH INFORMATION FROM ANOTHER PROVIDER

To: Physician/Provider Name _____
Address _____

Re Patient: Name _____ Date of Birth _____

Address: _____
Telephone:(Home) _____ (Cell) _____ (Work) _____
Email Address: _____
Worker's Compensation Claim #, if applicable _____
Social Security Number (last 4 digits) _____ Other Identifier _____

I authorize _____
to disclose the following (*write your initials next to the records to be included and draw a line through those that do not apply*):

Most recent:

_____ Labs	_____ Consults
_____ X-rays	
_____ Progress notes	_____ Other _____
_____ Special studies	

This permission includes records relating to:

_____ Diagnosis and / or treatment for alcohol and/or drug abuse or dependency
_____ AIDS/AIDS-related complex (ARC), or HIV status diagnoses and/or treatment
_____ Mental Health records

Send this information to:

Springfield Health Care Center, Inc.
30 Warder Street, Suite 100
Springfield, OH 45504-2577
Fax: 937-328-2303

_____ Dr. Vipul Patel, M.D
_____ Jaskaran Sidhu, PA-C
_____ Natalie Stanley, PA-C
_____ Dr. Lalith Misra, DO

Signature

Patient _____ Date _____

or:

Personal/Legal Representative: I, (*please print your name*) _____
represent that I am the (*circle one*): legal healthcare agent / guardian / surrogate /
parent of the patient named above.

Signature _____ Date _____

SPRINGFIELD HEALTH CARE CENTER, INC.

**AUTHORIZATION FOR TREATMENT, AND
DISCLOSURE OF INFORMATION FOR TREATMENT, PAYMENT, AND OPERATIONS**

AUTHORIZATION FOR TREATMENT

I authorize examination, diagnosis, and general treatment (including, but not limited to, the use of x-rays and other non-invasive procedures such as diagnostic tests) to be performed by physicians and staff of Springfield Health Care Center, Inc (SHCC). I realize if a medical procedure or surgery is required, I will be given additional information.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I consent to SHCC using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that SHCC reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office manager.

I have the right to revoke this consent by notifying SHCC in writing, except to the extent that SHCC has taken action in reliance on my consent.

I hereby authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid services and its agents any information needed to determine those benefits payable for related services. I hereby authorize Medicare/Medicaid to furnish to SHCC any information regarding my Medicare claims under title XVII and XIX of the Social Security Act.

FINANCIAL AGREEMENT

I realize the bill is my responsibility. I assign and authorize payments to be made directly to SHCC of all insurance benefits and agree to pay any balance due.

Signature of patient or patient's representative

Date

Printed Name of patient or patient's representative

Relationship to patient or
representative's authority to
act for the patient

Springfield Health Care Center Privacy Practices

Effective Date: January 1, 2026

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.

If you have any questions about this notice, please contact our office at 937-328-2310.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information.
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you (“Health Information”). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice's Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who participate in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to evaluate our treatment and services, or to evaluate our staff's performance while caring for you. We may also share information with other entities that have a relationship with you (for example, your health plan) for their healthcare operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who participates in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, if they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

HIPAA Notice of Privacy Practices: Disclosure of Health Information

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All our business associates are obliged to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that manage organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclose your health information.

Lawsuits and Disputes. If you participate in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend, new or any other person you identify with your Protected Health Information that relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do authorize us, you may revoke it at any time by submitting a written revocation to our Privacy Officer, and we will no longer disclose Protected Health Information under the authorization. But the disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding the health information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Kimberly Packer. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request if it is readily producible in such form or format. If Protected Health Information is not readily producible in the form or format you request, your record will be provided in either our standard electronic format or, if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that the Health Information, we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Kimberly Packer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Kimberly Packer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Kimberly Packer. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes, and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask if we only contact you by mail or at work. To request confidential communications, you must make your request in writing to Kimberly Packer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to copy a paper of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a copy of this note, ask at the reception desk.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top middle of the page.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, please contact the Practice Manager. All complaints must be made in writing. **You will not be penalized Patient for filing a complaint.**

TO CONTACT US:

Written requests may be sent to:

Springfield Health Care Center Inc.
30 Warder Street, Suite 100
Springfield, OH 45504
Attn: Practice Manager

For questions by phone:

Contact the office at 937-328-2310.

ACKNOWLEDGMENT AND AGREEMENT

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I agree with the terms and conditions outlined in this notice regarding the use and disclosure of my Protected Health Information.

Patient/guardian Signature: _____ **Date:** _____

Patient/guardian Signature _____