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: ☐ Male ☐ Female

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Preferred Language:
☐ English ☐ Spanish ☐ Other

Race: ☐ White ☐ Black/African American ☐ Asian
☐ American Indian / Alaska Native ☐ Native Hawaiian / Other Pacific Islander

Ethnicity:
☐ Hispanic / Latino ☐ Not Hispanic / Latino

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:
MEMBER ID:

Subscriber Name:
Last First MI

S.S.N.: - -
Sex: ☐ Male ☐ Female
Birthdate: / /

SECONDARY INSURANCE NAME:
MEMBER ID:

Subscriber Name:
Last First MI

S.S.N.: - -
Sex: ☐ Male ☐ Female
Birthdate: / /

EMPLOYMENT INFORMATION

Employer Name:
Employer Phone: ( )

Address: City: St: Zip:

EMERGENCY INFORMATION

Name:
Relationship to 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 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 $20 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 obligation.

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 any and all changes to this information.

____ I understand I may be charged $40 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 for, or failing to provide24-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 _____

Patient Name: _____ **DOB:** _____

MEDICATION LIST

ALLERGIES: Please List All Allergies

_____ _____

_____ _____

_____ _____

PHARMACY NAME AND ADDRESS: _____

MEDICATIONS: Please list ALL medications you are taking, including over the counter medications, vitamins, etc.

MEDICATION NAME	DOSE	WHEN YOU TAKE IT

STAFF USE:

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, 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
_____ X-rays
_____ Progress notes
_____ Special studies

_____ Consults

_____ Other _____

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
___ Scott Golde, PA-C
___ Chris Wharton, PA-C

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.

PROTECTED HEALTH INFORMATON DISCLOSURE QUESTIONNAIRE

Generally, the HIPAA Privacy Rule gives individuals the right to request restriction on uses and disclosures of Protected Health Information (PHI). The individual is also provided the right to request confidential communication or that communication of PHI be made by alternative means, such as via email instead of telephone.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER FOR APPOINTMENTS AND TEST RESULTS:

(Check all that apply)

○ **Home Phone / Cell Phone** Home / Cell Phone Number:_____

___ Leave message with appointment date and time

___ Leave message with test results

___ Leave message with call back number only

___ Do not leave message

○ **Work Telephone** Work Phone Number:_____

___ Leave message with appointment date and time

___ Leave message with test results

___ Leave message with call back number only

___ Do not leave message

○ **Written Communication**

___ Mail to my home address _____

___ Mail to my work address _____

Patient/Guardian Signature:_____ Date:_____

Patient Name:_____ Patient Date of Birth:_____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use and disclosure of and the requests for PHI, to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by an individual.

Healthcare entities must keep record of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for reasons other than treatment, payment, or operations may be permitted without prior consent in an emergency.

The following listed names are those I give Springfield Health Care Center Inc. the authorization to give health information regarding appointments, test results, and treatment to:

_____ _____

Name/Relationship Phone Number

_____ _____

Name/Relationship Phone Number

_____ _____

Name/Relationship Phone Number

_____ **DO NOT PROVIDE** health information regarding appointments, test results, and treatment to anyone but me.

Initials

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices and that I understand my past medication history will be transferred to the new Electronic Health Record, Athena, for continuity of care.

_____ _____

Patient / Guardian Signature Date

Springfield Health Care Center Privacy Practices

Effective Date: September 1, 2013

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 Hilary Sisler 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 Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to 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 are involved 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 of 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 also may share information with other entities that have a relationship with you (for example, your health plan) for their health care 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 is involved 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, as long as 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.

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 of our business associates are obligated 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 handle 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 illness.

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 disclosure of your health information.

Lawsuits and Disputes. If you are involved 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, counter-intelligence, 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 or any other person you identify, your Protected Health Information that directly 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 give us an authorization, 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 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 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 Deborah Cox. 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 of 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 the 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 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 Deborah Cox.

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 Deborah Cox.

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 Deborah Cox. 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 that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Deborah Cox. 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 a paper copy 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 paper copy of this notice, 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 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.