



Community Medical Associates

Daniel Miller, MD · Douglas Sposetta, APRN-CNP, FNP-BC

1450 S. Canfield-Niles Rd., Austintown, OH 44515

Phone (330) 799-8752 · Fax (330) 799-8754

PATIENT INFORMATION AND INSURANCE

Complete this page and bring a photo ID and both sides of each insurance card. A parent or legal guardian completes this page if the patient is under 18. This is the only page for legal name, address, phone, email, pharmacy, emergency contact, and the full Social Security number.

Patient

Legal last name _____ Legal first name _____ Middle _____

Preferred name _____ Date of birth _____ Age _____ Sex on ID ☐ Female ☐ Male

Street address _____ Apt / unit _____

City _____ State _____ ZIP _____ Preferred language _____

Social Security number --

Marital status ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Other

Parent or guardian — complete only if the patient is under 18

Parent / guardian name _____ Relationship _____ Phone _____

Second parent / guardian _____ Relationship _____ Phone _____

Custody or decision-making notes _____

Who else may bring this child to a visit? Name and relationship _____

Phone and emergency contact

Mobile _____ Home _____ Work _____

☐ OK to text the mobile number about appointments and care. This is not a consent to marketing texts.

Email _____ ☐ OK to email appointment reminders

Best way to reach you _____ May we leave a detailed message? ☐ Yes ☐ No

Emergency contact name _____ Relationship _____ Phone _____

Pharmacy and prior doctor

Preferred pharmacy _____ City or cross-streets _____ Phone _____

Last family doctor or prior practice _____ City / phone _____

Preferred hospital, if any _____



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PATIENT INFORMATION AND INSURANCE

If the patient has Medicare, also complete the Medicare Secondary Payer page in this packet.

Primary insurance

☐ Ohio Medicaid ☐ Medicare ☐ Medicare Advantage ☐ Commercial / other ☐ Self-pay / no insurance

Plan / company name _____ Member ID _____ Group number _____

Plan phone number on the card _____ Effective date _____ Subscriber date of birth _____

Subscriber name, if not the patient _____ Relation to patient _____

Secondary insurance

☐ None

Plan / company name _____ Member ID _____ Group number _____

Plan phone number on the card _____ Effective date _____ Relation to patient _____

Subscriber name, if not the patient _____ Subscriber date of birth _____

Person responsible for the bill, if not the patient _____

Cards

☐ I brought a photo ID ☐ I brought my insurance card or cards ☐ Please make copies for the chart

I confirm that the information on this page is current. I will tell the office if my insurance, address, or phone number changes.

Patient / parent / guardian signature _____ Print name _____ Date _____



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PAYMENT AND OFFICE POLICY

Please read this policy, ask any questions, and sign at the end. A copy is available on request. A parent or legal guardian signs for a patient under 18.

1. Insurance

We participate with many plans, including Ohio Medicare and Ohio Medicaid. Coverage is not a promise that a service will be paid. If you do not have insurance we accept, payment is due at the visit unless we have agreed to another arrangement. If you are insured but do not have a current card with you, we may ask you to pay in full until we can verify coverage. Knowing your benefits is your responsibility.

2. Copayments and deductibles

Copayments, coinsurance, and deductibles are due at the time of the visit. This is part of your agreement with your insurance company. We are required to collect these amounts.

3. Services your plan may not cover

Some services, and sometimes an entire visit, may be denied as not covered or not medically necessary. If that happens, you are responsible for the allowed charges unless the law says otherwise.

4. Proof of insurance

Please let us copy a valid insurance card before you are seen. If we are not given current insurance information in time to bill the correct plan, you may be responsible for the balance.

5. How we bill

We will submit claims for plans we participate with. The balance after insurance is your responsibility whether or not the plan pays. Your insurance contract is between you and the plan. I assign to Community Medical Associates any benefits payable for services we provide, and I authorize the practice to release information needed to process claims.

6. When coverage changes

Tell us before your next visit if your insurance changes. If a plan does not pay a claim within 45 days, the balance may be billed to you.



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PAYMENT AND OFFICE POLICY

7. Unpaid balances

If an account is more than 90 days past due, we will send a letter giving 20 days to pay the balance in full. Partial payments are not accepted unless we have agreed to a written plan. If a balance remains unpaid, the account may be sent to collections.

8. Missed appointments and late cancellations

Please give at least 24 hours' notice if you cannot keep an appointment. A visit missed, or cancelled with less than 24 hours' notice, may be charged \$25. This fee is not charged to Medicare or Medicaid patients. Our usual course for other patients is: a first missed visit brings a letter explaining the policy; a second missed visit may add the \$25 fee; a third missed visit may lead to ending the relationship under the notice below. If you arrive more than 15 minutes late, we may need to reschedule.

9. Forms, letters, and copies

Current fees are \$25 per form completed for the patient, including disability, FMLA, school, camp, and similar forms, and \$350 when an attorney requests forms or a narrative letter. Copies of records may be charged a reasonable, cost-based fee allowed by Ohio law. Please allow several business days. Fees are due when the paperwork is requested unless we agree otherwise.

10. Refills requested after a visit

Please ask for routine refills during your visit, or through the pharmacy, at least three business days before you run out. A refill request made after a visit, or outside a planned follow-up, may require an appointment.

11. Ending the relationship

The practice may end the clinician-patient relationship when it is no longer workable. We will not end it for a reason prohibited by law, including race, color, national origin, religion, sex, age, or disability. Signing this packet does not end the relationship. Ending it requires a separate written notice, sent by certified mail, return receipt requested, to the last address we have on file. That notice will state that the relationship is terminated, that emergency treatment and access to services continue for up to 30 days from the date the letter is mailed, and that records will be transferred when the patient signs an authorization. The 30-day bridge may not apply if the patient or the patient's representative has been disruptive or threatening toward a clinician, staff, or other patients. A copy of the notice and the mailing receipt are kept in the chart.

By signing, I have read this Payment and Office Policy, I have had a chance to ask questions, and I agree to it. I assign insurance benefits as described above.

Patient / parent / guardian signature _____ Print name _____ Date _____

Relationship, if not the patient _____



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CONSENT TO TREAT AND PRIVACY ACKNOWLEDGMENT

Consent for evaluation and treatment

I consent to evaluation and treatment by the clinicians and staff of Community Medical Associates, including Daniel Miller, MD, Douglas Sposetta, APRN-CNP, FNP-BC, and licensed professionals covering the practice. This may include a history, examination, recommended tests, office procedures, immunizations, and prescriptions. Medicine is not exact, and no result is guaranteed. I may ask questions, refuse a recommendation, or withdraw consent at any time.

For a minor: I am the parent, legal guardian, or other person authorized under Ohio law, and I consent to care for the patient named below. I understand that Ohio law allows a minor to consent to certain services on the minor's own behalf in limited situations.

Notice of Privacy Practices

I was offered the Notice of Privacy Practices in the office. A copy is available on request. The notice describes how the practice may use and share health information and what rights I have. The practice may update the notice. Signing this page does not mean I agree with every use described in the notice, and care is not withheld if I decline to sign the acknowledgment.

I may ask the practice to limit how information is used for treatment, payment, or health-care operations. The practice does not have to agree, except that if I pay a service in full out of pocket and ask that the item not be billed to my health plan, the practice will not share that item with the plan unless the law requires it.

What this signature covers

- ☐ I consent to evaluation and treatment as described above.
- ☐ I was offered the Notice of Privacy Practices in the office.
- ☐ I understand a copy is available on request, and that care is not withheld if I decline to sign.
- ☐ I understand I may ask for limits on how information is used.
- ☐ I understand I may revoke a written authorization in writing.

Patient / parent / guardian signature _____ Print name _____ Date _____

Relationship, if not the patient _____

Witness, office staff, optional _____ Date _____



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WHO WE MAY SPEAK WITH ABOUT YOUR CARE

Federal privacy rules let us share limited information with family or others involved in your care unless you object. This page tells us who we may talk with about your health and your insurance. You may change this at any time by telling the office in writing.

People I allow the office to speak with

Write the name of each person. Leave a line blank if it does not apply.

Spouse / partner _____

Parent or parents _____

Adult child or children _____

Brother / sister _____

Grandparent or grandparents _____

Other (name and relationship) _____

Personal representative / healthcare power of attorney, if any _____

☐ Do not discuss my care with anyone other than me, except as the law requires.

Phone messages

A message left on voicemail, or with a person who answers the phone, may be heard by someone else who has access to that phone.

☐ You may leave a message on my mobile voicemail

☐ You may leave a message on my home voicemail or answering machine

☐ You may leave a message with the person who answers my phone

☐ Do not leave any message other than the practice name and a request to call back

Signature

Patient / parent / guardian signature _____ Date _____



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REQUEST FOR MEDICAL RECORDS

Use this page when you want another office to send records to Community Medical Associates. You do not have to complete it today if there are no prior records to request.

Patient whose records are requested

Name _____
Date of birth _____ Phone _____ Social Security number, to match the chart _____
Street address _____
City, state, ZIP _____

Send the entire medical record from

Office, hospital, or clinician _____
Address _____
Phone _____ Fax _____

Send records to

Community Medical Associates, 1450 S. Canfield-Niles Rd., Austintown, OH 44515

Phone (330) 799-8752 Fax (330) 799-8754

I request the entire medical record held by the office named above, for continuing care at Community Medical Associates. I authorize that office to release the entire medical record to Community Medical Associates. This authorization expires one year from the date below unless I revoke it sooner in writing. Revoking it does not undo records already sent.

Patient / parent / guardian signature _____ Date _____

Printed name and relationship, if not the patient _____



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CONTROLLED MEDICINE NOTICE

Every new patient, or parent or guardian, signs this notice. Signing it is not a promise that a controlled medicine will be prescribed, and it is not the pain agreement.

Community Medical Associates does not prescribe controlled medicines for new patients. That includes opioid pain medicines and medicines used for anxiety, sleep, or attention. Please do not establish care here in order to receive a controlled medicine.

A controlled medicine may be considered later for a short, temporary reason. The practice may also decline to prescribe one. A request is not a reason a prescription will be written. If a controlled medicine is prescribed here, lost or stolen medicine is not replaced as a routine.

Before this office prescribes an opioid for subacute or ongoing pain, the patient signs a separate Pain Treatment Agreement. That agreement is not part of this new-patient packet.

Patient name _____ Date of birth _____

I have read this notice. I understand that this office does not prescribe controlled medicines for new patients, that any later prescription is not guaranteed, and that a separate agreement is required before an opioid is prescribed here for ongoing pain.

Patient / parent / guardian signature _____ Date _____



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MEDICARE SECONDARY PAYER QUESTIONS

Complete this page only if the patient has Medicare. These questions follow the Centers for Medicare & Medicaid Services model used to decide whether Medicare pays first. Skip this page if the patient does not have Medicare.

Patient name _____ Medicare number (MBI) _____

Are you receiving Federal Black Lung benefits? ☐ Yes ☐ No

If yes, date benefits began _____

Is this visit for a work-related injury or illness? ☐ Yes ☐ No

Has the VA authorized and agreed to pay for this visit? ☐ Yes ☐ No

Is this visit for a non-work accident or injury? ☐ Yes ☐ No ☐ Car / no-fault

☐ Another party may be responsible

Date of the accident _____

Insurer or attorney name and phone _____

Medicare based on ☐ Age 65 or older ☐ Disability ☐ End-stage renal disease

Are you currently working? ☐ Yes ☐ No

Is a spouse or family member currently working? ☐ Yes ☐ No

Group health coverage through current work? ☐ Yes ☐ No

Employer size ☐ Under 20 ☐ 20-99 ☐ 100 or more

Patient / parent / guardian signature _____ Date _____



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NEW PATIENT HEALTH HISTORY

Please complete before your visit. Print clearly. A parent or legal guardian completes this form if the patient is under 18. Bring a photo ID and a current medicine list. Address, phone, email, pharmacy, emergency contact, and Social Security number are on the registration page.

Patient legal name _____ Date of birth _____ Age _____

Preferred name _____ Preferred provider, if any _____

1. Today's visit

☐ New to the practice ☐ Transfer of care

Main reason for today's visit _____

Other concerns you would like addressed _____

2. Allergies

Medicines, foods, latex, contrast, bees, or other. Include the reaction.

☐ No known allergies

Allergen	What happens (rash, swelling, trouble breathing, nausea)	Severe?
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

3. Current medicines

Prescriptions, over-the-counter medicines, vitamins, herbs, and injections.

☐ I take no medicines or supplements ☐ I brought my bottles or a printed list

Name	Dose	How often	Reason	Prescriber
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

4. Specialists you see now

Name	Specialty	City or phone
_____	_____	_____
_____	_____	_____
_____	_____	_____



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NEW PATIENT HEALTH HISTORY

5. Past medical history — check any condition you have now or have had

- | | | | |
|--|---|---|--|
| ☐ High blood pressure | ☐ High cholesterol | ☐ Diabetes / prediabetes | ☐ Thyroid problem |
| ☐ Heart attack | ☐ Heart failure | ☐ Atrial fibrillation | ☐ Heart stent or bypass |
| ☐ Pacemaker / defibrillator | ☐ Stroke / TIA | ☐ Blood clot (leg or lung) | ☐ Anemia |
| ☐ Bleeding or clotting disorder | ☐ Blood transfusion | ☐ Asthma | ☐ COPD / emphysema |
| ☐ Sleep apnea | ☐ Seasonal allergies | ☐ Tuberculosis | ☐ GERD / reflux |
| ☐ Stomach ulcer | ☐ Gallbladder disease | ☐ IBD / IBS / colitis | ☐ Liver disease / hepatitis |
| ☐ Kidney disease | ☐ Kidney stones | ☐ Frequent UTIs | ☐ Prostate problem |
| ☐ Migraines | ☐ Seizures | ☐ Neuropathy | ☐ Parkinson's / tremor |
| ☐ Arthritis | ☐ Osteoporosis | ☐ Gout | ☐ Fibromyalgia / chronic pain |
| ☐ Chronic back or neck pain | ☐ Depression | ☐ Anxiety | ☐ Bipolar disorder |
| ☐ ADHD | ☐ PTSD | ☐ Cancer — type: _____ | ☐ HIV |
| ☐ Autoimmune (lupus, RA) | ☐ Glaucoma / eye disease | ☐ Hearing loss | ☐ Obesity |

Other conditions not listed _____

6. Surgeries, procedures, and hospital stays

☐ None

Surgery, procedure, or reason for the stay	Year	Hospital / location

7. Family history

Check the box under each blood relative who has had the condition. For cancer, write the type. If you were adopted or do not know a side of the family, check the box below.

Condition	Mother	Father	Sibling	Child	Grandparent
High blood pressure	☐	☐	☐	☐	☐
Heart disease or heart attack before age 60	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐
Cancer — type:	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐
Asthma or other lung disease	☐	☐	☐	☐	☐
Blood clot or bleeding problem	☐	☐	☐	☐	☐
Depression, suicide, or other mental illness	☐	☐	☐	☐	☐
Alcohol or drug problems	☐	☐	☐	☐	☐
Alzheimer's disease or dementia	☐	☐	☐	☐	☐
Sudden unexplained death	☐	☐	☐	☐	☐

☐ Adopted / family history unknown

☐ No significant family history that I know of

Other family conditions _____



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NEW PATIENT HEALTH HISTORY

8. Social history

Occupation / school / grade _____ Employer / school name _____

Living situation

☐ House ☐ Apartment ☐ With family ☐ Alone ☐ Assisted living ☐ Unstable / other

Who lives with you? _____ Children in the home — ages _____

Tobacco and vaping

☐ Never ☐ Former — quit year _____ ☐ Current cigarettes ☐ Cigars / pipe ☐ Vape
☐ Chew / dip Packs per day ____ Years smoked ____ ☐ Interested in quitting ☐ Secondhand smoke

Alcohol

☐ None Drinks per week ____ What do you usually drink? _____

Six or more drinks in one sitting ☐ Never ☐ Monthly ☐ Weekly or more ☐ I should cut down

Other substances

☐ None ☐ Marijuana / THC ☐ CBD ☐ Cocaine ☐ Meth / stimulants ☐ Heroin / fentanyl / other opioids
☐ Misuse of prescription medicine ☐ In recovery ☐ Interested in help

Other / how often _____

Sexual history

Sex partners ☐ Men ☐ Women ☐ Both ☐ Not sexually active ☐ Prefer not to answer

9. Activity, sleep, safety, and daily needs

Exercise (type and days per week) _____ Hours of sleep _____ ☐ Trouble sleeping

Caffeine drinks per day _____ ☐ I wear a seatbelt

Fallen in the past year? ☐ Yes ☐ No

How many falls _____

Feel safe at home? ☐ Yes ☐ No ☐ Talk privately

☐ Food _____

☐ Housing _____

☐ Rides to appointments _____

☐ Utilities _____

☐ None of these

Advance directive? ☐ Yes ☐ No ☐ Unsure

Healthcare power of attorney name _____

10. For children and teens — skip if the patient is an adult

Birth weight ____ Weeks of pregnancy ☐ Full term ☐ Premature ☐ NICU ☐ Vaginal ☐ C-section

☐ Development on track ☐ Early intervention / therapy ☐ IEP / 504 plan ☐ ADHD / learning concern

School / grade _____ Pediatrician or prior doctor _____ ☐ Shots up to date ☐ Unsure

Who else may bring this child to visits, besides the parent or guardian signing today? _____

Name and relationship _____



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NEW PATIENT HEALTH HISTORY

11. Women's health — skip if this does not apply

Age at first period _____ First day of last period _____ ☐ Periods regular Menopause — age _____
Pregnancies _____ Births _____ Miscarriages / losses _____ ☐ Currently pregnant ☐ Trying to conceive
☐ Hysterectomy ☐ Not applicable Birth control, if any _____ Last Pap year _____ ☐ Abnormal Pap
Last mammogram year _____

12. Men's health — skip if this does not apply

Last PSA year, if done _____ ☐ Enlarged prostate / BPH ☐ Trouble with urination
☐ Erectile dysfunction

13. Prevention and vaccines

A year is fine. Write "never" or "unsure" if needed.

Last physical _____ Last blood work _____ Last dental exam _____ Last eye exam _____
Colonoscopy year _____ Bone density year _____ Heart screening / stress test year _____
Vaccines (year) Flu _____ COVID _____ Tdap / tetanus _____ Shingles _____ Pneumonia _____
Hepatitis B _____ HPV _____ MMR _____ RSV, if offered _____ ☐ I have shot records with me
☐ Please request shot records

14. Mood over the last 2 weeks

Little interest or pleasure in doing things ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Feeling down, depressed, or hopeless ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

15. Review of systems — check anything that is a current or recent problem

General	☐ Fever / chills	☐ Night sweats	☐ Weight change	☐ Fatigue	☐ Poor appetite
Head / ENT	☐ Headaches	☐ Vision change	☐ Hearing change	☐ Ear pain	☐ Congestion
Heart	☐ Chest pain	☐ Palpitations	☐ Leg swelling	☐ SOB with activity	☐ Fainting
Lungs	☐ Cough	☐ Wheeze	☐ SOB at rest	☐ Coughing blood	☐ Snoring
Stomach	☐ Heartburn	☐ Nausea / vomiting	☐ Diarrhea	☐ Constipation	☐ Blood in stool
Urinary	☐ Pain with urination	☐ Frequency / urgency	☐ Up at night	☐ Blood in urine	☐ Leakage
Muscles	☐ Joint pain	☐ Muscle weakness	☐ Joint swelling	☐ Limited motion	☐ Recent injury
Skin	☐ Rash	☐ New or changing mole	☐ Itching	☐ Easy bruising	☐ Non-healing sore
Nerves	☐ Dizziness	☐ Numbness / tingling	☐ One-sided weakness	☐ Memory change	☐ Tremor
Mood	☐ Anxiety	☐ Panic	☐ Low mood	☐ Trouble sleeping	☐ Thoughts of self-harm

If you are having thoughts of harming yourself, tell the front desk now, or call 988 or 911. You do not have to wait for this visit.

Anything else we should know? _____

16. Signature

I have reviewed this form. The information is true and complete to the best of my knowledge. I will tell the office if anything changes.

Patient / parent / guardian signature _____ Print name _____ Date _____

Relationship, if not the patient _____



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NOTICE OF PRIVACY PRACTICES

Effective date: October 7, 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.

This notice describes the privacy practices of Community Medical Associates, including Daniel Miller, MD, Douglas Sposetta, APRN-CNP, FNP-BC, and the staff who work with them at 1450 S. Canfield-Niles Rd., Austintown, OH 44515. If you have questions, call (330) 799-8752 and ask for the privacy contact. This notice is offered in the office. A copy is available on request. It is not inserted into the signature page of the new-patient packet.

Our duty

We are required by law to maintain the privacy of your protected health information, to give you this notice of our legal duties and privacy practices, and to follow the notice that is currently in effect. If we change this notice, the new notice applies to information we already have and to information we receive later. We will notify you if a breach of your unsecured protected health information occurs, as required by law.

Treatment, payment, and health-care operations

Treatment. We use and share information to care for you. For example, we share notes with a specialist we refer you to, or with a hospital that is treating you. Payment. We use and share information to bill and collect payment, including sending a claim to your health plan. Health-care operations. We use and share information to run the practice, including quality review, training, accreditation, scheduling, and customer service.

Other uses permitted by law

We may also use or share information without a separate authorization when the law allows it. Examples include public-health reporting, health-oversight activities, workers' compensation, judicial and administrative proceedings, law enforcement in the situations the law describes, coroners and funeral directors, organ donation, research that meets privacy rules, a serious threat to health or safety, specialized government functions, and correctional institutions. Unless you object, we may share limited information with a family member or other person involved in your care or payment, and we may contact you with appointment reminders or information about treatment alternatives.

Authorization required for other uses

Other uses and disclosures require your written authorization. That includes most uses of psychotherapy notes, marketing, and the sale of protected health information. We will not use or sell your information for those purposes without an authorization. You may revoke an authorization in writing. Revoking it does not undo a disclosure we already made in reliance on it.

Your rights

Access. You may ask to see or get a copy of your record. We may charge a reasonable, cost-based fee allowed by Ohio law. Amend. You may ask us to amend information you believe is incorrect or incomplete. We may say no, and we will tell you why in writing. Accounting. You may ask for a list of certain disclosures we made in the six years before your request. Restrictions. You may ask us to limit how we use or share information for treatment, payment, or health-care operations. We are not required to agree, except for the out-of-pocket restriction below. Confidential communications. You may ask us to contact you at a different address or phone number, or by a different method. We will agree to a reasonable request. Paper copy. You may ask for a paper copy of this notice at any time.

Out-of-pocket restriction

If you pay a service in full out of pocket and ask us not to share that item with your health plan, we will not disclose that item to the plan unless the law requires it.

Breach notification

We will notify you if a breach of your unsecured protected health information occurs, as required by law.

Complaints

If you believe your privacy rights have been violated, you may complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. You will not be retaliated against for filing a complaint.

Privacy contact: Community Medical Associates, 1450 S. Canfield-Niles Rd., Austintown, OH 44515. Phone (330) 799-8752. Fax (330) 799-8754. Ask for the privacy contact. Office for Civil Rights, U.S. Department of Health and Human Services. Complaint forms and instructions are at www.hhs.gov/hipaa/filing-a-complaint. Mailing address: 200 Independence Avenue, S.W., Washington, D.C. 20201. Phone 1-877-696-6775.

This notice is offered in the office. A copy is available on request. Care is not withheld if you decline to sign an acknowledgment that it was offered.