



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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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

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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 _____