WESTERN RESERVE HOSPITAL
Proudly Physician Owned

WRH PHYSICIANS, INC.

John Park, MD
4016 Massillon Road., Ste. C
Uniontown, Ohio 44685
Phone: (330) 926-3313
Fax: (330) 945-7381

Appointment Date: _____ Time: _____

Scheduled with: Dr. John Park

Thank you for choosing WRH Physicians, Inc. for your healthcare needs.

We would appreciate if you could:

- Complete the enclosed paperwork and bring it with you on the day of your visit.
- Bring your current insurance card and a photo ID with you. If you do not bring your insurance card, you will be required to pay in full for your office visit.
- If your insurance requires a co-pay, we ask that it be paid at the time of your visit. Additional charges will incur if you cannot pay at time of visit.
- If your insurance requires a referral form your primary care physician, make sure this is done prior to your visit. IT IS THE PATIENT'S RESPONISIBILITY TO ENSURE THAT A REFERRAL HAS BEEN PUT IN PLACE PRIOR TO VISIT.
- If you do not have insurance, please be prepared to pay at the time of your visit. We offer a discount if the entire visit is paid in full.
- Please cancel your upcoming appointment within 48 hours of the scheduled time if you cannot make it. We know that there are unforeseen times when canceling in a timely manner is not possible, and we can work with you if that should arise. However, we will send you a bill for $25.00 if you do not cancel in a timely manner or no call, no show.

If you have any questions regarding the above, please do not hesitate to call our office at (330) 926-3313.

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Primary Care Physician: _____

Patient Name: _____

Patient Address: _____ City: _____ State: ____ Zip: _____

Phone #: _____

Marital Status: _____ Date of Birth: _____ Sex: _____

SSN: _____

E-Mail Address: _____

Primary Pharmacy Name: _____ Pharmacy Phone: _____

Race (check one) ☐ Asian ☐ Native Hawaiian ☐ African American ☐ White ☐ Hispanic ☐ Other ☐ Refused

Ethnicity (check one) ☐ Hispanic ☐ Non-Hispanic ☐ Refused

Patient Employer: _____

Employer Address: _____

Primary Insurance: _____ Group #: _____ ID #: _____

Policy Holder Name: _____ DOB: _____

Secondary Insurance:_____ Group #:_____ ID #: _____

Guarantor Name:_____

Guarantor Address: _____ City: _____ State: ____ Zip: _____

All professional services rendered are charged to the patient, necessary forms will be completed to help expedite insurance carrier payments. If you are covered by a plan with a restrictive network, it is your responsibility as the insured/patient to seek professional care with a participating provider within your plan. The patient (or guardian) is responsible for all fees, regardless of insurance coverage.

I hereby give the physicians of WRHPI permission to treat me or my dependent(s), and I authorize WRHPI to furnish any medical information necessary for insurance claim submission and/or payment. I understand that I am responsible for any remaining fees not covered by insurance.

I further understand that some or all of the services rendered may be deemed “non-covered” by my insurance carrier and that I will be billed for such services.

I authorize payment of medical benefits to the physicians of WRHPI for services described herein. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees and services rendered.

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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DISCLOSURE OF PERSONAL HEALTH INFORMATION

Personal Health Information Release / Emergency Contacts:

Name: _____

Relationship: _____

Home Phone #: _____

Cell Phone #: _____

Is this person able to receive your Personal Health Information?

☐ Yes ☐ No

Name: _____

Relationship: _____

Home Phone #: _____

Cell Phone #: _____

Is this person able to receive your Personal Health Information?

☐ Yes ☐ No

Name: _____

Relationship: _____

Home Phone #: _____

Cell Phone #: _____

Is this person able to receive your Personal Health Information?

☐ Yes ☐ No

Name: _____

Relationship: _____

Home Phone #: _____

Cell Phone #: _____

Is this person able to receive your Personal Health Information?

☐ Yes ☐ No

Preferred Pharmacy Name: _____

Preferred Pharmacy City: _____

Preferred Pharmacy Phone Number: _____

☐ Retail Pharmacy ☐ Mail Order Pharmacy

On occasion, we may need to call you and leave information regarding results of any treatments or tests that you have had. May we leave this information on your voicemail? ☐ Yes ☐ No

If yes please check preference:

☐ Home Phone ☐ Cell Phone

☐ Brief ☐ Extended

May we leave appointment reminders on your voicemail? ☐ Yes ☐ No

If yes, please list your preferred contact number. Preferred Phone#: _____

I,_____, do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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WRH PHYSICIANS, INC.

WRH PHYSICIANS, INC. FINANCIAL POLICIES

Thank you, _____for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a summary of our Financial Policies which we require you to read and sign prior to initial treatment. We welcome the opportunity to discuss any aspect of our financial policies with our patients. Please feel free to contact our billing office at (330) 923-5899 Monday thru Thursday 7:00 a.m. to 6:00 p.m.; or Friday 7:00 a.m. to 4:00 p.m.

INSURANCE CARD-It is very important that we receive the correct insurance information. Please present all current insurance card(s) at the time of service. Due to the many changes that occur in insurance coverage, you will be asked to present this card(s) at each visit. We will make every effort to bill your insurance company based on accurate, current information presented to us at the time of service.

CO-PAYMENT-Our contracts with insurance companies require that we collect the entire co-payment at the time of service. You will be assessed a $20.00 administrative charge for not paying your co-pay at the time of service.

INSURANCE PARTICIPATION-WRH Physicians, Inc. makes every effort to participate with insurance plans for the convenience of our patients; however, you are responsible for knowing your insurance coverage. Please verify your physician's participation, referral and pre-cert requirements with your insurance company prior to your appointment. WRH Physicians, Inc. assumes no liability for non-coverage due to insurance participation and/or plan design. You will be responsible for any balance that results as out-of-network benefits or non-participating provider. We do not accept UCR from non-participating insurance companies.

APPOINTMENT CANCELLATION-There will be a $25.00 fee for all appointments that are not attended and not cancelled at least 24 hours prior to scheduled time. This charge is not covered by insurance companies. After three (3) no-show or failed appointments, you may be dismissed from the practice.

PRESCRIPTION REFILLS-Please remember to obtain your prescription refills during your office visit. There is a $10.00 charge for calling or faxing a prescription into your pharmacy outside of a scheduled visit.

INSURANCE PAYMENT/PATIENT RESPONSIBILITY-After receiving payment from your insurance company, we will send you a statement for any additional patient responsibility. All balances billed are due within 30 days of the first statement. Unpaid balances greater than 90 days are subject to our collections process. An interest surcharge will be applied to any unpaid balances.

SELF-PAY DISCOUNTS-We offer a self-pay discount to patients that do not have any type of insurance. This discount is only available if charges are paid in full at the time of service. Our physicians will code the service to the level of specification appropriate for the service rendered, which has a corresponding self-pay charge.

We do not bill auto, home or other non-medical insurance. Patients presenting with conditions covered by these types of policies will be considered self-pay; and will NOT be eligible for the self-pay discount.

NON-COVERED SERVICES-All services deemed non-covered services by your insurance company are the responsibility of the patient or the patient's guarantor.

I have read the Financial Policy. I understand and agree to this Financial Policy. I verify the billing information provided is accurate and authorize release of any medical information necessary to process claims. I request payments be sent directly to the physician of the services provided when the physician accepts assignment of my insurance benefits.

I further understand and agree that my failure to follow this Financial Policy may result in WRH Physicians, Inc. terminating my patient-physician relationship.

_____

Patients Signature (or Parent/Guardian Signature as applicable)

Date: _____ Print Signed Name: _____

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WRH PHYSICIANS, INC.

Dear _____,

WRH Physicians Inc. is part of the Western Reserve Health System (WRHS). As part of our involvement with WRHS, we have implemented an electronic medical record in order to improve the efficiency in our offices and provide the highest quality healthcare services to our patients.

As part of that process, we will be able to check the medication history of all of our patients via a secure, electronic system; and we are able to seamlessly share patients' clinical information with other providers that are or may be involved with our patients' care. In addition, we continue to follow the regulations associated with the Health Insurance Portability and Accountability Act (HIPAA) and a notice of our privacy practices is available to you upon request.

We hope you recognize the importance of the steps we are taking in order to provide high quality, efficient, healthcare services. As always, our patients are our number one priority.

Sincerely,

The Physicians and Staff of WRH Physicians, Inc.

Please sign below indicating your receipt of this notification:

Print Name: _____

Signed: _____ Date: _____

Parent or Guardian Signature (if applicable): _____ Date: _____

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Name: _____ DOB: _____ Age: _____ Sex: _____

Reason for your office visit: _____

_____

_____

ALLERGIES: LATEX ALLERGY: ☐ Yes ☐ No

_____

_____

☐ See attached list

Medication Name	Dosage	Quantity	Frequency

☐ Have you ever had an endoscopic procedure? If so, please check:

☐ Colonoscopy When: _____

☐ Upper Endoscopy (EGD) When: _____

☐ Flex sigmoidoscopy When: _____

PAST SURGICAL HISTORY: Please indicate the year next to any surgery you may have had:

☐ Appendectomy ☐ Cardiac Surgery ☐ Cesarean Section

☐ Gallbladder Removal ☐ Hysterectomy ☐ Laparoscopy

☐ Lung Surgery ☐ Surgery for Adhesion Removal in abdomen

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PATIENT QUESTIONNAIRE — ANORECTAL HEALTH

Name: _____ Date: _____

Bowel & Dietary Habits

(Circle either Yes or No for each answer)

1. Do you suffer from Constipation? Y / N
2. Do you suffer from Diarrhea? Y / N
3. Do you have to strain or push hard when having a bowel movement? Y / N
4. Time spent on toilet during average bowel movement? _____Minutes
5. Does any tissue ever come out of your rectum (prolapse) during a bowel movement? Y / N
6. Do you often feel like you're "still not done" after a bowel movement? Y / N
7. Are you taking any fiber supplements? Y / N

If yes, which one(s)? _____

8. On average, do you drink the equivalent of 6-8 glasses of water per day? Y / N

Symptoms (In Rectal Area)

(Check all that apply)

☐ Bleeding ☐ Itching ☐ Prolapse ☐ Pressure or Swelling ☐ Leaking or Soiling

☐ Pain ☐ Burning

Additional Questions

(Circle either Yes or No for each answer)

1. Are you allergic to latex? Y / N
2. Are you pregnant? Y / N
3. Are you taking any erectile dysfunction medicine for EGD, any Viagra for hypertension, Cialis for your prostate or any nitrates for chest pain? Y / N
4. Are you taking any blood thinners or anticoagulation medication (Coumadin, Plavix, Pradaxa, Xarelto, Eliquis, etc.? Y / N
5. Have you ever been diagnosed with Crohn's disease, proctitis, portal hypertension or anal/rectal cancer? Y / N
6. Are you taking immunosuppressant medication or undergoing radiation treatments? Y / N
7. Do you need to take antibiotics before having dental or other procedures? Y / N

Additional Comments?

_____

_____

_____