



UNIVERSITY HEALTH CONNECTION

We would like to welcome you as a new patient and thank you for scheduling an appointment at the University Health Connection. We are pleased to serve your medical needs as you launch a new relationship with your Primary Care Physician (PCP).

Founded in 1999, the University Health Connection fosters an inter-professional health care team, whose mission is to enhance the overall health of Ohio State University faculty and staff. Our clinic serves members of university-sponsored health plans and handles more than 50 percent of all urgent care visits in the OSU network. We offer both appointments and walk-in hours at our convenient location in 100 Parks Hall to provide you with accessible, prompt, high-quality medical attention without “losing your parking spot.”

Our commitment to providing our patients with the best care possible has been nationally recognized by several professional organizations and we have received awards for teaching, practice innovation, service delivery, and collaboration with our founding partners.

Take the time to review and complete the enclosed forms prior to your appointment. Please arrive 15 minutes before your scheduled appointment time so that we may register your information and answer any questions you may have. In addition, **be sure to bring your insurance card.**

We look forward to serving your health care needs. Thank you for choosing University Health Connection. For a list of our services and office hours, visit our web site at <http://osumhcs.com/uhc>.

Stephanie Cook, DO
Medical Director

Kelly Hall, MD
Primary Care Physician

Jennifer Ellis, MD
Bridge Care Physician
Urgent Care Physician



NEW PATIENT CHECKLIST

This packet contains a number of forms and policies you will need to review, complete and sign prior to your first appointment at University Health Connection. Use this handy checklist to ensure you have reviewed all the documents necessary.

- ✓ Each item as you complete it.
- Welcome Letter**
- University Health Connection Services and Policies**
- University Health Connection Demographic Sheet**
- Privacy of Your Health Information (HIPAA)**
- Patient Contact Information**
- Authorization Form for Protected Health Information (if transferring records)**
- Completion of the PHA (Personal Health Assessment) within the last year**
Access at www.YourPlanforHealth.com. Complete and bring your Personal Health Summary report from this questionnaire to your appointment.
- Advance Directives (Living Will)** - An Advance Directives Packet will be available for you at your first visit if you are interested. For more information, contact, Patrice Rancour, MS, RN, CS, at (614) 688-5535 or patrice.rancour@osumc.edu. She is available to assist employees and their families with end of life decision making issues.



SERVICES AND POLICIES

Scheduling Appointments: To schedule an appointment with your physician, call UHC at (614) 688-0300. Be ready to specify the reason for your visit and describe your symptoms as this will allow the staff to schedule you for the correct amount of time with your physician. If you are calling to schedule a physical (sports, work, adult), allow a minimum of one month in advance.

Appointment Cancellations: Should you need to cancel your appointment, we ask that you notify our office within 24 hours of your appointment. This will allow us to accommodate other patients.

Late Arrivals: Please arrive at your scheduled appointment time. If you think you will be unable to arrive on time, call our office to insure that you can still be seen. We will make every attempt to see you, but due to the physician's busy schedule, your appointment may need to be re-scheduled.

No-Call/No-Shows: Our office has a policy to consider dismissal of patients from the practice after three (3) No-Call/No-Shows occurring within a 12-month period. Call our office ahead of your appointment time if you need to cancel or reschedule your appointment for any reason.

Urgent Care: The staff and physicians at University Health Connection realize that many illnesses can arise suddenly. Therefore, we try to accommodate patients in need of urgent care. Urgent care hours are Monday, Tuesday, Thursday, and Fridays from 8:30 a.m.-12:30 p.m. until capacity is met for the day.

On Call: If an emergency arises after normal business hours, call the hospital operator at (614) 293-8000 and ask to page the physician covering for University Health Connection. Please note, no prescription refills will be provided by the on-call physician.

Refills: Refill requests will be processed as soon as possible. Call the clinic pharmacist at (614) 688-0713 for refill requests. Typically, calls received Monday-Thursday by 4 p.m. can be processed within 24 hours. Calls Friday-Sunday will be processed the following Monday. Refills require approval by your physician.

Please note: The university medical plan benefit covers one (1) well-physical exam each calendar year at 100 percent, including no copayment. If other issues are discussed, a \$20 copayment will be charged.

DEMOGRAPHIC SHEET

Insurance Acceptance Policy: We will file your insurance claim if the patient is covered by an insurance plan with which we have a contract.	For office use only: OSUH MRN # _____
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PATIENT INFORMATION: (please print)

NAME: _____
Last First Middle Initial

SOCIAL SECURITY No. (optional): _____ **DATE OF BIRTH:** _____

SEX: M _____ F _____ **MAIDEN NAME:** _____

MAILING ADDRESS: _____
Apt. Number

CITY/STATE: _____ **ZIP CODE:** _____

HOME PHONE: () _____ **CELL PHONE:** () _____

RACE: _____ African American _____ Asian _____ Caucasian _____ Hispanic _____ Native American _____ Other	MARITAL STATUS: _____ Single _____ Widowed _____ Separated _____ Married _____ Divorced
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E-MAIL ADDRESS (OPTIONAL): _____

EMPLOYER NAME: _____ **WORK NUMBER:** () _____

EMPLOYER ADDRESS: _____

CITY/STATE: _____ **ZIP CODE:** _____

EMERGENCY CONTACT: _____ **PHONE NUMBER:** () _____

PATIENT RELATIONSHIP TO CONTACT: _____ Child _____ Other _____ Spouse _____ Student

EMERGENCY ADDRESS: _____

CITY/STATE: _____ **ZIP CODE:** _____

GUARANTOR/RESPONSIBLE PARTY INFORMATION (if different from patient):

NAME: _____
Last First Middle Initial

PATIENT RELATIONSHIP TO GUARANTOR: _____ Child _____ Other _____ Spouse _____ Student

SOCIAL SECURITY No.: _____ **DATE OF BIRTH:** _____

MAILING ADDRESS: _____
Apt. Number

CITY/STATE: _____ **ZIP CODE:** _____

PHONE: () _____ **EMPLOYER:** _____

INSURANCE INFORMATION:	PRIMARY	ALLERGIES
INSURANCE NAME: _____	_____	_____
ADDRESS: _____	_____	_____
CITY/STATE/ZIP: _____	_____	_____
GROUP NUMBER: _____	_____	_____
POLICY ID NUMBER: _____	_____	_____
PRIMARY CARE PHYSICIAN: _____	_____	_____

COMPLETE OTHER SIDE

CONSENT TO TREATMENT, AUTHORIZATION TO RELEASE INFORMATION, STATEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I authorize the hospital and physician(s) to provide diagnostic and treatment services to me. Although this form registers me for both hospital and physician services, I understand that any medical care provided by a physician is independent and separate from care provided by the hospital.

The hospital and physician(s) have my permission to release any information needed for completion of their claims for payment from third-party payors including, but not limited to: insurance companies, health maintenance organizations, preferred provider organizations, government agencies and their representative.

I permit release of information concerning dates of treatment, condition, diagnosis, procedures, medication lists or surgeries to my personal physician, referring physician and/or the referring facility for follow-up care. I am aware that this authorization to release information may include information regarding HIV or AIDS, alcohol or drug abuse and/or psychiatric treatment.

_____ *Please initial to indicate approval of the above paragraph*

I acknowledge financial responsibility for all hospital and physician(s) fees. I understand that the physician will file my insurance claim if my physician is a participating provider with my insurance carrier and I assign direct payment to the physician all payments made under the terms and provisions of my policy. Otherwise, physician will provide me with sufficient information to file my own insurance claim. I understand that I am responsible for and will pay any unpaid amount due for services performed by the hospital and physician(s).

Signature _____ Date _____

Signature of parent/guardian _____ Date _____

(Consent for minors or others unable to give consent)

Do you have an advanced directive (living will)? Yes No
If so, would you like to provide a copy for our records? Yes No

Do you have any special needs?



IMPORTANT NOTICE REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Your privacy is important to us. We create information about you so that we may provide you with quality care. We are committed to protecting this information. The Notice of Privacy Practices describes your rights with regard to your health information, as well as how we may use your health information, and how we must protect the confidentiality of your health information. This is the summary of the more detailed information contained in our Notice of Privacy Practices.

Your rights include:

- A right to inspect and copy your medical information
- A right to amend your health information
- A right to request restrictions on what information we use and how we disclose your health information
- A right to receive an accounting of certain disclosures we have made of your health information
- A right to receive a paper copy of your Notice of Privacy Practices

These rights do have special restrictions, so it is important that you read the full Notice.

We may use your health information and/or records to:

- Plan for your care
- Help your health care providers communicate and work together to care for you
- Submit bills to pay for your care
- Help health care payers make sure services were actually provided
- Help improve the quality of health care. For example, after your visit we may contact you to see how you are doing and to find out how you felt about our service.
- Disclose information to certain officials or organizations where we may, or are required to do so by law.

The Ohio State University Health System, of which University Health Connection is a part, is an academic and research institution. Researchers who are working to find new treatments and cures, or important information to improve your health care and the health care of the general public may use or access your information. We may share your information to assist in the training and education of health care professionals. Every person who may access your information is bound by our confidentiality requirements, as outlined in our Notice of Privacy Practices.

We encourage you to carefully read the Notice of Privacy Practices and speak with the office manager or privacy officer at (614) 292-5703 if you need more information.

I was offered the Notice of Privacy Practices for University Health Connection.

Signature: _____ Date: _____

Documentation of attempt:



PATIENT CONTACT INFORMATION

There are times that the staff of University Health Connection may need to contact me. In those instances, I hereby give permission for the staff to contact me as follows:

Please initial:

_____ I give University Health Connection permission to contact me at _____
to leave appointment reminder information.

_____ I give University Health Connection permission to contact me at _____
to leave appointment reminder information and leave information for me on my voice mail or
answering machine.

_____ I give University Health Connection permission to contact me at _____
to leave information about test results.

_____ I give University Health Connection permission to contact me at _____
to leave information about test results on my voice mail or answering machine.

_____ I give University Health Connection permission to mail me lab and test results to the
following address:

If at any time I decide that I do not want this information shared or contact made, I have the right to ask the staff of University Health Connection to discontinue this practice.

Signature: _____

Date: _____



AUTHORIZATION FORM FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Social Security No.: _____ Medical Record #: _____

By signing this authorization form, I understand that I am giving my authorization to University Health Connection to use and/or disclose my Protected Health Information (PHI), as described in more detail in the paragraphs below to the following person(s) or entity:

Person or entity to receive Protected Health Information:

Name of person or entity: _____

Address: _____

Phone Number: _____ Fax Number: _____

Information to be used or disclosed:

Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, or level of detail to be disclosed:

Reason for use or disclosure:

This Protected Health Information is being used or disclosed for the following purposes:

This authorization shall be in force and effect until the date or event specified below at which time this authorization to use or disclose Protected Health Information expires.

Date _____, or event _____.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to my physician's office to the attention of Privacy Contact. I understand that a revocation is not effective to the extent that has relied on the use or disclosure of the Protected Health Information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

OSU Physicians, Inc. will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the Protected Health Information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access to rights).
- Refuse to sign this authorization.

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority