Dear New Medical Patient,

Thank you for choosing Choptank Community Health for your medical needs.

Enclosed please find information that needs to be completed and returned. This information will help us to provide you with a successful first visit and establish your new patient plan of care.

Please read all the enclosed materials carefully. Materials enclosed include:

- Demographic update form – please sign and date
- New Adult Patient Form – please complete
- Notice of Privacy Practices – for your information
- Consent and Assignments – *this form allows you to designate individuals we can share your health information with*, please complete and sign
- Patient Financial Responsibilities – *this form explains your financial responsibilities*, please sign
- Medical Record Authorization Form
- Sliding Fee Acknowledgement – *this form provides an overview our sliding fee program providing financial assistance for your medical, dental, and behavioral health care* – please complete and sign

When you have completed the enclosed forms, please return them to our office in the stamped return envelope provided. You may also fax them, using the enclosed fax cover sheet provided. **Once the materials have been returned you will be contacted to schedule an appointment.**

If you have questions, please contact us at:

Site	Phone	Fax
Bay Hundred Medical Center (St. Michaels)	**(410) 745-0200**	**(833) 908-2281**
Chestertown Health Center	**(443) 215-5353**	**(833) 615-2165**
Denton Health Center	**(410) 479-2650**	**(833) 908-2283**
Easton Pediatrics	**(410) 770-8910**	**(833) 908-2284**
Fassett Magee Medical Center (Cambridge)	**(410) 228-9381**	**(833) 908-2286**
Federalsburg Medical Center	**(410) 754-9021**	**(833) 908-2285**
Goldsboro Medical Center	**(410) 634-2380**	**(833) 908-2287**

Thank you again for choosing Choptank Community Health. We look forward to partnering with you to provide your medical care.

Which office do you want to establish care at?

- ☐ Bay Hundred Medical Center
- ☐ Chestertown Health Center
- ☐ Denton Health Center
- ☐ Easton Health Center
- ☐ Fassett Magee Medical Center (Cambridge)
- ☐ Federalsburg Medical Center
- ☐ Goldsboro Medical Center

Patient Demographic Update Form

PATIENT INFORMATION					
Last Name:			SSN#:		
First Name:		Mid. Initial:	DOB:	Sex:	
Home Address1:			Age:		
Apt/Suite #:			Home Tel#:		
City, State, Zip:			Race/Ethnicity:		
Email:			Cell Tel#:		
Language:					
Responsible Party					
Name:					
Address:					
Phone Number:					
PREFERRED PHARMACY					
Pharmacy Name:			Pharmacy Tel#:		
Pharmacy Address:			City/St/Zip:		
EMERGENCY CONTACT INFORMATION: (In case of emergency who should be notified?)					
Name:		Tel#		Relationship:	
PRIMARY INSURANCE					
Plan/Policy Name:			Group #:		
Plan Tel#:			Subscriber DOB:		
Subscriber Name:			Subscriber ID:		
SECONDARY INSURANCE					
Plan/Policy Name:			Group #:		
Plan Tel#:			Subscriber DOB:		
Subscriber Name:			Subscriber ID:		

Patient or authorized person's signature: ____ **Date:** __________________

NAME: Last____________________________________ First___________________________________ Middle Initial_______
DATE OF BIRTH:
PHONE NUMBER: Home Cell Work
INSURANCE:

CURRENT LIST OF CARE PROVIDERS, PHARMACIES, AND SUPPLIERS

Who was your previous Doctor or Provider?	
Date of Last Visit with Previous Provider:	
What are the names of specialists you have seen in the past year?	
What hospitals or emergency rooms have you been seen at in the past year?	
What pharmacy do you use for your medications?	
What are the names of any companies that provide you with medical supplies or services?	

ALLERGIES, MEDICATIONS, AND VACCINES

Are you allergic to any medications, food, or environmental allergens?	____ Yes ____ No If yes, please list: ______________________________ ______________________________ ______________________________
Do you take any prescription, over the counter, or herbal medications? *There is no guarantee that CCHS will continue to prescribe medications from	____ Yes ____ No If yes, please list the names, dosage and frequency of all medications that you take: ___________________ ______________________________ ______________________________ ______________________________ ______________________________

previous providers*	____ ____ ____ ____ ____
Have you received any of the following vaccines: Flu, Tdap, Pneumonia, Shingles, or COVID-19?	____ Yes ____ No If yes, please list the name of the vaccine and where you received it: ____ ____

GYNECOLOGICAL HISTORY (BIOLOGICAL FEMALE)

Date of last pap smear:	____
Have you ever had an abnormal pap smear?	____ Yes ____ No
Date of last menstrual period:	____
Flow, duration, and frequency of period:	How often do you have a period? ____ How long does your period last (days)? ____ How would you describe the flow (normal, light, heavy)? ____
How old were you when you started your period?	_____________ years old
Have you started menopause?	____ Yes ____ No If yes, at what age were you when you started menopause? ____
How old were you when you had your first child?	______________ years old

What is your current method of birth control?	____________________
Are you interested in a different method of birth control?	____ Yes ____ No If yes, what method are you interested in? ____________________
Are you sexually active?	____ Yes ____ No
Do you have any sexual problems?	____ Yes ____ No If yes, what problems are you having? ____________________
Have you been diagnosed with any sexually transmitted diseases?	____ Yes ____ No If yes, what disease and when? ____________________
Date of last colonoscopy:	____________________
Date of last mammogram:	____________________
Date of last bone density scan:	____________________

OBSTETRICAL HISTORY (BIOLOGICAL FEMALE)

How many times have you been pregnant?	____________________
How many full-term pregnancies have you had?	____________________
How many premature (early) pregnancies have you had?	____________________
How many abortions have you had?	____________________

How many miscarriages have you had?	______________________________
How many ectopic pregnancies have you had?	______________________________
Have you had any multiple births?	______________________________
How many of your children are living?	______________________________
Delivery dates of past pregnancies:	______________________________

FAMILY HISTORY

Has anyone in YOUR family had any of the following?

	Mother	Father	Siblings	Grandparents
Cancer (what kind? ________________________________)	____Yes	____Yes	____Yes	____Yes
Diabetes	____Yes	____Yes	____Yes	____Yes
Heart Disease	____Yes	____Yes	____Yes	____Yes
High Cholesterol	____Yes	____Yes	____Yes	____Yes
High Blood Pressure	____Yes	____Yes	____Yes	____Yes
ADD/ADHD	____Yes	____Yes	____Yes	____Yes
Allergies	____Yes	____Yes	____Yes	____Yes
Arthritis	____Yes	____Yes	____Yes	____Yes
Asthma	____Yes	____Yes	____Yes	____Yes
Bleeding or Clotting Disorders	____Yes	____Yes	____Yes	____Yes
Cystic Fibrosis	____Yes	____Yes	____Yes	____Yes
Depression	____Yes	____Yes	____Yes	____Yes
Early Deaths	____Yes	____Yes	____Yes	____Yes

Genetic Disease	____Yes	____Yes	____Yes	____Yes
Headache	____Yes	____Yes	____Yes	____Yes
HIV Infection	____Yes	____Yes	____Yes	____Yes
Kidney Disease	____Yes	____Yes	____Yes	____Yes
Psychiatric	____Yes	____Yes	____Yes	____Yes
Seizure Disorder	____Yes	____Yes	____Yes	____Yes
Sickle Cell Abnormality	____Yes	____Yes	____Yes	____Yes
Stroke	____Yes	____Yes	____Yes	____Yes
Thyroid Disorder	____Yes	____Yes	____Yes	____Yes
Tuberculosis	____Yes	____Yes	____Yes	____Yes

EDUCATION AND OCCUPATION

What is the highest grade or level of school you have completed or the highest degree you have received?	____
Are you currently in school?	____ Yes ____ No
Are you currently employed?	____ Yes ____ No
Who is your employer?	____
Are there any occupational health risks where you work?	____

ACTIVITIES OF DAILY LIVING AND RELATIONSHIP STATUS

Are you able to care for yourself?	____ Yes ____ No
Are you blind or have difficulty seeing?	____ Yes ____ No
Are you deaf or do you have difficulty hearing?	____ Yes ____ No
Do you have difficulty concentrating, remembering, or making decisions?	____ Yes ____ No
Do you have difficulty walking or climbing stairs?	____ Yes ____ No
Do you have difficulty dressing or bathing?	____ Yes ____ No
Do you have difficulty doing errands alone?	____ Yes ____ No
Are you able to walk?	____ Yes ____ No
Do you have any difficulties with transportation?	____ Yes ____ No
Do you have concerns about meeting your basic needs of food, housing, heat,	____ Yes ____ No

etc.?	
Do you live alone or with others?	
Are you married?	____ Yes ____ No If not, are you in a relationship? ____ Yes ____ No

ADVANCED DIRECTIVE

Do you have an advanced directive (MOLST, Living Will)?	____ Yes ____ No
What is your code status?	____ Full Code ____ Do Not Resuscitate (DNR)
Do you have a medical power of attorney?	____ Yes ____ No

SUBSTANCE USE

Do you or have you ever smoked tobacco?	____ Yes ____ No
How much tobacco do you smoke?	___________ Packs per day
Do you or have you ever used any other forms of tobacco or nicotine?	____ Yes ____ No
Do you or have you ever used e-cigarettes or vape?	____ Yes ____ No
Do you or have you ever used smokeless tobacco?	____ Yes ____ No If yes, how much tobacco do you chew? ____
Do you drink alcohol?	____ Yes ____ No If yes, how much alcohol do you drink? ___________________________
Do you use any street drugs, including marijuana?	____ Yes ____ No If yes, which drugs do you or have you used? ____ ____ ____ ____
How much caffeine do you drink?	____

HOME AND ENVIRONMENT

Are you a caregiver?	____ Yes ____ No
Do you use childcare?	____ Yes ____ No If yes, what type of childcare? ____
Do you have any pets?	____ Yes ____ No
Do you have smoke and carbon monoxide detectors in your home?	____ Yes ____ No
Are you exposed to someone else smoking in the home?	____ Yes ____ No
Are there any guns in your home?	____ Yes ____ No
Do you use bug spray/insect repellent on a regular basis?	____ Yes ____ No
Do you use sunscreen on a regular basis?	____ Yes ____ No

DIET AND EXERCISE

What type of diet are you following?	____ Regular ____ Low-Salt ____ Low-Carb ____ Low Cholesterol ____ Vegetarian or Vegan ____ Other ____
Do you have any dietary restrictions? (no dairy, gluten-free, etc.)	____ Yes ____ No If yes, what restrictions? ____________________________________
What is your exercise level?	____ Sedentary ____Lightly active ____Moderately active ____ Very active
How many days of moderate to strenuous exercise did you do in the past week?	____

LEARNING AND SOCIAL NEEDS

Have you ever been the victim of abuse or neglect?	____ Yes ____ No
What is your preferred language?	____
What language do you speak?	____

What language do you read?	____
Do you have any special learning needs we should be aware of?	____Hearing ____Sight ____Speech ____Spiritual ____Cultural Beliefs

GENDER IDENTITY AND LGBTQ IDENTITY

What gender do you identify with?	____
What sex were you assigned at birth?	____
What are your preferred pronouns?	____
What is your sexual orientation?	____

SURGICAL/IMPLANT HISTORY

Have you ever had surgery?	____ Yes ____ No If yes, please indicate what surgery and date if known ____ ____ ____ ____ ____ ____
Do you have any surgical implants or implanted devices (gynecological, pacemaker, orthopedic, optical, etc.)	____ Yes ____ No If yes, what implant(s) do you have? ____ ____ ____ ____ ____

PAST MEDICAL HISTORY

Do you have or have you had any of the following?

ADD/ADHD	____ Yes	Head Injury/Concussion	____ Yes
Abuse/Domestic Violence	____ Yes	Headaches	____ Yes
Acid Reflux (GERD)	____ Yes	Heart Disease	____ Yes
Acne	____ Yes	Hepatitis	____ Yes
Allergies (Food, seasonal, environmental)	____ Yes	High Cholesterol	____ Yes

Anemia	____ Yes	HIV	____ Yes
Anxiety Disorder	____ Yes	Hypertension (high blood pressure)	____ Yes
Autism Spectrum Disorder	____ Yes	Hyperthyroidism	____ Yes
Bladder or Kidney Problems	____ Yes	Hypothyroidism	____ Yes
Blood Transfusion	____ Yes	Kidney Disease	____ Yes
Breast Problem	____ Yes	Mental Health Disorders	____ Yes
Cancer	____ Yes	Osteoporosis	____ Yes
COPD (emphysema, etc.)	____ Yes	Polycystic Ovary Syndrome	____ Yes
Constipation	____ Yes	Pre-Eclampsia	____ Yes
Deep Vein Thrombosis (DVT blood clot)	____ Yes	Pulmonary Embolism	____ Yes
Diabetes	____ Yes	Skin Problems	____ Yes
Ear or Hearing Problems	____ Yes	TB Positive (positive TB skin test or QuantiFERON gold)	____ Yes
Endometriosis	____ Yes	Tuberculosis	____ Yes
Epilepsy (seizure disorder)	____ Yes		____ Yes

Please list additional information if needed:

____

____

____

____

____

____

____

____

____

____

____

____

____

Choptank Community Health System, Inc. Notice of Privacy Practices

March 25, 2014

This Notice of Privacy Practices describes the personal health information we collect, how and when we may use or disclose this information. It also describes your rights and our responsibilities related to your Protected Health Information (PHI).

How will CCHS use your Protected Health Information?

1. We will use your health information for **treatment**. Information obtained by the staff will be recorded in your medical record and used to determine the course of treatment that should work best for you.
2. We will use your health information for **payment**. A bill may be sent to you or your insurance company. The information on or with the bill may include information that identifies you as well as your diagnosis, procedures and supplies used during your visit.
3. We will use your health information for regular health **operations**. Members of the quality improvement team may use information from your health record to assess the care and outcomes in your case and others like it. This information may then be used as we strive to continually improve the quality and effectiveness of the health care we provide.

Additional ways we may use your health information:

1. There are some services provided in our organization through contracts with business associates. We may disclose your health information to them.
2. Unless you notify us that you object, we may use your name for directory purposes.
3. We may disclose information to notify a family member, a personal representative or another person responsible for your care of your location and general condition.
4. We may disclose your information for research purposes when researchers have established protocols to ensure your privacy.
5. We may disclose information to organ procurement organizations for the purposes of tissue donation or transplant or to funeral homes.
6. We may contact you to provide appointment reminders or information about treatment alternatives for you.
7. We may contact you as part of a fundraising effort. However, you may Opt Out by mailing a letter to CCHS at the address below requesting to Opt Out of this practice. See Opt Out/Revoke Authorization information below.
8. We may use your information to enable product recall, repairs or replacement.
9. We may use your information to comply with laws such as workers compensation or similar programs.
10. We may disclose your information to public health or legal authorities charged with preventing or controlling disease, injury or disabilities.
11. We may disclose your information to correctional institutes or law enforcement.

Your health information rights:

- Obtain a copy of this notice.
- Inspect and copy your health record.
- Amend your health record.
- Obtain an accounting of the disclosures of your health information.
- Request communications of your health information by alternative means.
- Request a restriction on certain uses and disclosure of the information if those services were paid for out of pocket and in full, unless required by State or Federal Law.
- Revoke your authorization to use or disclose your health information. See OPT OUT/Revoke Authorization Section below

CCHS is required to:

- Maintain the privacy of your health information.
- Provide you with this notice describing our legal duties and privacy practices.
- Abide by this agreement.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means.
- Obtain a separate authorization for the use and disclosure of psychotherapy notes, marketing purposes and sale of PHI
- Obtain a separate authorization for the use or disclosure of any other use not disclosed in this Notice of Privacy Practices.
- Inform you of any breach of information affecting your privacy and PHI.

CCHS reserves the right to change our practices and to make the new provisions effective for all the protected health information we maintain. Should our privacy practices change, we will provide you with a copy of the revised notice. We will not disclose or use your health information without your authorization (except as described in this notice). We will also discontinue to use or disclose your health information after we receive your written request.

OPT OUT/Revoke Auhtorization Process:

Should you wish to Opt Out of the use or Revoke an authorization regarding the use and disclosure of your PHI, please write a letter with your Name, Date of Birth and address along with your request to Opt Out or Revoke an authorization (be specific as possible) too:

Choptank Community Health System, Inc. Attention: Privacy Officer
301 Randolph Street
Denton, MD 21629

Chesapeake Regional information System for our Patients (CRISP)

Choptank Community Health System, Inc, along with many other healthcare organizations, participates with CRISP. The Chesapeake Regional Information System for Our Patients, or CRISP, is a not-for-profit membership corporation advised by a wide range of stakeholders responsible for the healthcare of Maryland's citizens. We receive input and advice from patients; hospital systems; physicians; insurance providers; technology providers; privacy advocates; public health officials; and advocates for seniors, the uninsured, and the medically underserved.

CRISP is formally designated Maryland's statewide health information exchange (HIE) by the Maryland Health Care Commission, as directed by the state's legislature and Gov. Martin O'Malley. CRISP has also been named Maryland's Regional Extension Center for Health IT (REC) by the Office of the National Coordinator for Health Information Technology (ONC), with an objective of assisting 1,000 primary care providers to deploy Electronic Health Records (EHRs) and achieve meaningful use by 2014.

Choptank Community Health System, Inc. has chosen to participate in the CRISP health information exchange. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination or care and assist providers and public health officials in making more informed decisions. You may OPT OUT and disable all access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an OPT OUT form to CRISP by mail, fax or through their website at www.crisphealth.org.cc
For more information or to report a problem, contact the CCHS Privacy Officer at 410-479-4306. You may also file a complaint with the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, NE, Room 509 F, HHH Building, Washington DC, 20201. There will not be retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights.

Consents and Assignments

PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITY AUTHORIZED ACCESS TO PROTECTED HEALTH INFORMATION: Name the persons you are authorizing Choptank Community Health System, Inc. to disclose your protected health information regarding treatment, payment and other healthcare operations in the event you are not available.

____

Name of Authorized Person | Relationship | Phone Number

____

Name of Authorized Person | Relationship | Phone Number

RELEASE OF INFORMATION: I authorize **Choptank Community Health System, Inc**. to release information from my medical record to any person, corporation or agency legally responsible for processing and/or paying of any part of the center's charges and/or professional fees. I also authorize release of healthcare workers/providers/consultants who are involved in my care. Release of information to any other party other than that stated above will require separate authorization.

ASSIGNMENT OF BENEFITS: In the event that I am entitled to benefits arising out of my medical insurance policy or contract of insurance benefits, I assign these benefits to **Choptank Community Health System, Inc**. I also assign benefits payable for physician services to **Choptank Community Health System, Inc**. I further understand that I am responsible for 'non-covered' charges by my insurance and/or for charges incurred without authorization or referral.

CONSENT FOR CARE: I hereby give consent to the providers of **Choptank Community Health System, Inc**. to examine, make an assessment and recommend the appropriate treatment for my condition. I also consent to the collection and testing of specimens required for the diagnostic evaluation of my symptoms/condition.

RIGHTS AND RESPONSIBILITY: I have received and read a copy of **Choptank Community Health System, Inc**. "Notice of Information Privacy Practices" HIPAA Notification.

Printed Name: ____ Date of Birth: ________________

Signature: ____ Date: ______________________

PATIENT FINANCIAL RESPONSIBILITIES

Thank you for choosing Choptank Community Health System as your healthcare provider. We are committed to providing you with high quality care and ask that you read and sign this form to acknowledge your understanding of our patient financial responsibilities.

Patient Name: ______________________________________ Date of Birth: _____________________

- Please be on time for appointments. If you are more than 10 minutes late, it may be necessary to reschedule your appointment.
- Please give us 24-hour notice if you need to cancel or re-schedule an appointment.
- If you miss three (3) appointments in a twelve (12) month period without notifying our office, you will lose your ability to schedule appointments in advance.
- It is your responsibility to contact us as soon as you change your insurance, name, address or phone number.
- Be knowledgeable of your insurance and pay any applicable co-payment upon arrival. If co-payments are not received upon arrival you will be asked to reschedule your appointment.
- All unpaid balances that are the guarantor's responsibility and are due upon receipt of the bill and due within 30 days unless special payment arrangements have been made with our billing office.
- Any account remaining unpaid after 120 days will be turned over to a collection agency and it will be reported to a credit bureau. The collection agency fee of 35% and attorney fees with be the responsibility of the patient and/or guarantor.
- If you are uninsured, please ask the receptionist for our sliding fee program package which may qualify you for services at a discounted rate. You may also qualify for Medicaid. In addition, Maryland also has a program for uninsured children. If you qualify for the sliding fee program, income verification is needed at the time of the appointment. If we do not receive the required documentation, you will be required to pay a $95 **deposit**. If you provide proof of income within 30 days, you may be eligible for a refund.
- If payment is made by check and it is returned or declined, your account will be charged a return check fee (service charge) of $25.00.

If you have any questions regarding the above patient responsibilities, please feel free to contact our Accounts Receivable Manager at (410) 479-9100 or toll free at (877) 745-2455.

Guarantor Signature: _____________________________ Date: _____________________

CCHS Representative: _____________________________ Date: _____________________

Choptank Community Health System
Medical Record Authorization Form

Patient Name: _______________________ Address: ____
Phone #: ___________________________ ____
Patient Date of Birth: _________________ Social Security Number: _________________________________

****

I hereby authorize the use or disclosure of protected health information as described below:

1. **Choptank Community Health System,** is authorized to use or disclose information about me:

2. CHOPTANK COMMUNITY HEALTH may release protected health information about me.

Send To:
Person(s)/Facility Name: ____
Address: ____
Phone Number: ____________________ Fax Number: ________________________

CHOPTANK COMMUNITY Health may receive protected health information about me.

Receive From:
Person(s)/Facility Name: ____
Address: ____
Phone Number: ____________________ Fax Number: ________________________

3. The specific information that should be disclosed is (please give dates of service if possible):____
   UNLESS YOU SIGN HERE NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
   YES, DISCLOSE THIS INFORMATION: ____
   NO, DO NOT DISCLOSE THIS INFORMATION: _______________________________

4. My purpose/use of the information is for:____

5. This authorization expires on ________, 20__, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me:____

I understand that this authorization may be revoked in writing. The request for revocation must be mailed to CCHS Attention – 'Privacy Officer' at P.O. Box 660 Denton, MD 21629. The revocation will not be effective for records whose release I have previously authorized, or any action that has been taken in reference to an authorization I have already signed.
I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I understand that CCHS shall have the opportunity to obtain direct or indirect compensation in the nature of:
________________from____
as a result of this authorization.

____

Signature of individual or representative **Relationship of representative** **Date**

Copy Provided: CCHS shall provide a copy of this authorization, when signed, to the subject individual: _________ (Initials)

- ☐ Bay Hundred Medical & Dental Center: 933 S Talbot Street, St. Michael's, Md 21663 Phone: 410-745-0200 Fax: 833-908-2281
- ☐ Chestertown Health Center: 126 Philosophers Terrace, Suite 101, Chestertown, MD 21620 21663 Phone: 443-215-5353 Fax: 833-615-2165
- ☐ Denton Health Center: 808 S. 5th Ave, MD 21629 Phone: 410-479-2650 FAX: 833-908-2283
- ☐ Easton Pediatrics: 522 Cynwood Drive, Suite 100 Easton, MD 21601 Phone: 410-770-8910 FAX: 833-908-2284
- ☐ Fassett Magee Health & Dental Center: 503A Muir Street Phone: 410-228-4045 FAX: 833-908-2286
- ☐ Federalsburg Medical & Dental Ctr: 215 Bloomingdale Ave, Federalsburg, MD 21632, Phone:410-754-9021 FAX: 833-908-2285
- ☐ Goldsboro Medical & Dental Center 316 Railroad Ave Goldsboro, MD 21636 Phone: 410-634-2380 FAX: 833-908-2287

Patient Financial Assistance Program

Sliding Fee Discount

The Choptank Community Health Sliding Fee program offers necessary medical, dental, and behavioral health care, lab work, and certain diagnostic exams to patients at reduced costs based on income.

To qualify you will need to meet income and family size requirements and provide supporting documents such as pay stubs, tax returns, social security award letters etc. And you will need to complete and submit a Patient Financial Assistance Application.

Please indicate below if you would like additional information about this program.

______Yes, please send me additional information about the Patient Financial Assistance Program.

_____ No, I am not interested in additional information about the Patient Financial Assistance Program at this time.

Print Name

Signature

Date: ____________________________ Date of Birth: _____________________________

Fax Cover Sheet

To: Choptank Community Health

From:

____
Name (please print)

Number of Pages: ___________

Date: _____________________

Please fax to:

Site	Fax
Bay Hundred Medical Center (St. Michaels)	**(833) 908-2281**
Chestertown Health Center	**(833) 615-2165**
Denton Health Center	**(833) 908-2283**
Easton Pediatrics	**(833) 908-2284**
Fassett Magee Medical Center (Cambridge)	**(833) 908-2286**
Federalsburg Medical Center	**(833) 908-2285**
Goldsboro Medical Center	**(833) 908-2287**