MASCOMA COMMUNITY HEALTH CENTER

PATIENT REGISTRATION FORM

Welcome to Mascoma Community Health Center! We realize that the paperwork in our New Patient Packet takes some time and thought to fill in, but, we want to make sure that our providers have the information they need to take care of you, and your medical record is complete and up to date. Thank you for helping us to make your health care experience a good one!

Patient Information: Name: (First) _____(Middle)_____(Last)_____Suffix(Jr., Sr., etc.)_____

Previous Last Name:_____ Address (Street or PO Box, City, State, Zip):_____

Home Phone: (__)_____ Cell Phone: (__)_____ Work Phone: (__)_____ Email:_____

Is it OK to leave a message at these numbers: ☐ Yes ☐ No If yes, please select: ☐ Appointment. info only ☐ Appt. & Medical Info How would you like us to communicate with you (check all that apply): ☐ Phone call ☐ Text message ☐ Patient Portal

Date of Birth:_____ Sex: ☐ Male ☐ Female ☐ Unknown ☐ Transgender-Male/Female-To-Male ☐ Transgender-Female/Male-To-Female ☐ Choose not to disclose

Marital Status: ☐ Divorced ☐ Married ☐ Partner ☐ Single ☐ Unknown ☐ Widowed ☐ Legally Separated

Social Security Number _____-_____-_____

Employer Name: _____ Address: _____

Employment Status: ☐ Full-time ☐ Part-time ☐ Not employed ☐ Self-employed ☐ Retired ☐ Disabled ☐ Military – Active ☐ Military – Reserves ☐ Unknown ☐ Student Full-time ☐ Student Part-time

Are you a U.S. Veteran? ☐ Yes ☐ No Branch of Military Service _____ Number of years of service:_____

Responsible Party Information (Who is Responsible for Paying the Bill): ☐ Self ☐ Other person (fill in below)

Last Name_____First Name_____Middle Name:_____

Address:_____City_____State_____Zip _____

SSN_____-____-_____DOB:_____ Home Phone:( )_____ Work Phone:( )_____

Cell Phone: ( )_____Relationship to Patient:_____

Emergency Contact (Fill in if there is someone you want us to contact in the event of an emergency):

Relationship to you: _____ Is this person your legal guardian: ☐ Yes ☐ No Can we also share your medical information with his person: ☐ Yes ☐ No Contact's Name:_____ Address:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Pharmacy Information: Your local pharmacy name:_____ Location:_____

Phone Number:_____ Mail Order Pharmacy Name (if applicable):_____

Address:_____ Phone Number:_____

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****Prescription History Consent: I hereby give Mascoma Community Healthcare, Inc., permission to obtain a history of my prescribed drugs, during the course of my medical care.**

BY: _____ **(patient signature) MCHC Witness** _____ **Date:** _____

Primary Insurance Information: Name of Insurance:_____ Policy Number:_____Group Number:_____

Name on Insurance Card: _____ Insurance Is Provided to Patient By: ☐ Self ☐ Spouse ☐ Parent ☐ Other (specify)_____

Secondary Insurance Coverage Information: Name of Insurance:_____Policy Number:_____

Group Number:_____ Name on Insurance Card: _____

Insurance Is Provided to Patient By: ☐ Spouse ☐ Parent ☐ Self ☐ Other _____(specify)

We are required to collect the following information because we receive federal funding. It is always kept CONFIDENTIAL, as part of your medical record:

Sexual Orientation: ☐ Lesbian ☐ Gay ☐ Straight ☐ Bisexual ☐ Something Else ☐ Choose Not to Disclose

Legal Sex: ☐ Male ☐ Female **Sex as listed on your Insurance:** ☐ Male ☐ Female

Primary Language Spoken: ☐ English ☐ Spanish ☐ Other_____**Will you Need Interpreter Services?** ☐ Yes ☐ No

Race: ☐ Asian ☐ Black / African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ American Indian/Alaskan Native ☐ Other/Refused to Report

Ethnicity: ☐ Hispanic ☐ Non-Hispanic or Latino ☐ Refused to Report

Are you Homeless? ☐ No ☐ Yes **(If Yes)** → ☐ Homeless Shelter ☐ Transitional ☐ Doubling up ☐ Street ☐ Other

Are you a Migrant Worker? ☐ Yes ☐ No **Are you a Seasonal Worker?** ☐ Yes ☐ No

How many people currently live in your household (Including yourself): _____

Yearly Household Income (please check one): ☐ Less than $22,340. ☐ $22,341 to $30,260. ☐ $30,261. to $38180. ☐ $38,181. to $46,100. ☐ $46,101. to $54,020. ☐ $54,021. to 61,941. or more **If decline to answer, initial here:**_____

_____ Signature of Patient/Legal Representative

_____ Printed Name of Patient/Representative

_____ Date

MASCOMA COMMUNITY HEALTH CENTER

PEDIATRIC MEDICAL HISTORY FORM

(for patients ages 0-18 years)

Child's Name_____ Person Completing Form:_____

Date Of Birth _____ ☐ M ☐ F Relationship: _____

Is there a custody order: ☐ Yes ☐ No

If yes, please explain: _____

In the table below, please list all people that live in the child's home with him/her:

Name	Relationship	Birth Date	Health Problems

Birth History

Birth Weight: ____lbs. _____oz. How many weeks gestation at birth: _____

Was the delivery: ☐ vaginal? ☐ Cesarean? If Cesarean, why? _____

Did baby have any problems right after birth? ☐ Yes ☐ No

If yes, explain: _____

Did mother have any problems with her pregnancy? ☐ Yes ☐ No

If yes, explain: _____

During pregnancy, did mother:

☐ Smoke ☐ Drink Alcohol ☐ Use Drugs or Medications

Was initial feeding ☐ Breast? ☐ Bottle?

Did the baby go home with mother from hospital? ☐ Yes ☐ No

If no, please explain: _____

MASCOMA COMMUNITY HEALTH CENTER

PEDIATRIC MEDICAL HISTORY FORM

(for patients ages 0-18 years)

General

Do you consider your child to be in good health? ☐ Yes ☐ No

If no, please explain: _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No

If yes, please explain: _____

Has your child has serious injuries or accidents? ☐ Yes ☐ No

If yes, please explain: _____

Has your child has any surgeries? ☐ Yes ☐ No

If yes, please explain: _____

Has your child ever been hospitalized? ☐ Yes ☐ No

If yes, please explain: _____

Does your child take any medications or supplements/vitamins? ☐ Yes ☐ No
If "**yes**," please fill out below: (if more space needed, please use space at end of form)

Name of Medication/Supplement	Dosage	Strength
Example: Sodium Fluoride Tablets	Example: 1 per day	Example: 0.5 mg

Is your child **allergic** to any medications or drugs? ☐ Yes ☐ No

If yes, please explain: _____

Is your child allergic to any foods, plants, pets, etc.? ☐ Yes ☐ No

If yes, please explain: _____

MASCOMA COMMUNITY HEALTH CENTER

PEDIATRIC MEDICAL HISTORY FORM

(for patients ages 0-18 years)

Vaccinations:

Has your child had vaccinations such as Diptheria, Tetanus and Pertussis (DTap), Polio (IPV), Measles, Mumps Rubella (MMR), Chicken Pox (Varicella), Hepatitis A&B, H. Influenzae (Hib), Rotavirus, and Pneumococcal (PCV13), and Human Papilloma Virus (HPV)? ☐ Yes ☐ No

If **"yes,"** please attach a copy of his/her vaccination record to this form.

If **"no,"** please let us know your reason(s) for choosing to not vaccinate your child **(this is for purposes of completing your child's medical record, only):**_____

Development

Are you concerned about your child's physical development? ☐ Yes ☐ No

If yes, please explain: _____

Are you concerned about your child's emotional development? ☐ Yes ☐ No

If yes, please explain: _____

Are you concerned about your child's attention span? ☐ Yes ☐ No

If yes, please explain: _____

Is your child in school? ☐ Yes ☐ No

If yes, how is their behavior in school?_____

Have they failed or repeated a grade in school? _____

How are they doing academically? _____

Do they have an IEP and/or in special education classes? _____

Family History

Have any **family members** had the following:

Deafness ☐ Yes ☐ No Who? _____

Asthma ☐ Yes ☐ No Who? _____

Tuberculosis ☐ Yes ☐ No Who? _____

MASCOMA COMMUNITY HEALTH CENTER

PEDIATRIC MEDICAL HISTORY FORM

(for patients ages 0-18 years)

Heart Disease (before 50 years old)	☐Yes ☐ No	Who? _____
High Blood Pressure (before 50 years old)	☐Yes ☐ No	Who? _____
High Cholesterol	☐ Yes ☐ No	Who? _____
Anemia	☐ Yes ☐ No	Who? _____
Bleeding Disorder	☐ Yes ☐ No	Who? _____
Liver Disease	☐ Yes ☐ No	Who? _____
Kidney Disease	☐ Yes ☐ No	Who? _____
Diabetes (before 50 years old)	☐ Yes ☐ No	Who? _____
Epilepsy or seizures	☐ Yes ☐ No	Who? _____
Alcohol Abuse	☐ Yes ☐ No	Who? _____
Drug abuse	☐ Yes ☐ No	Who? _____
Mental illness	☐ Yes ☐ No	Who? _____
Mental retardation	☐ Yes ☐ No	Who? _____
Immune problems, HIV or AIDS	☐ Yes ☐ No	Who? _____

Past Medical History

Does your **child** have, or has he/she ever had:

Chicken Pox	☐ Yes ☐ No	Comments _____
Frequent Ear Infections	☐ Yes ☐ No	Comments _____
Problems with ears or hearing	☐ Yes ☐ No	Comments _____
Nasal allergies	☐ Yes ☐ No	Comments _____
Problems with eyes or vision	☐ Yes ☐ No	Comments _____
Asthma, bronchitis, bronchiolitis or pneumonia	☐ Yes ☐ No	Comments _____
Any heart problem or heart murmur	☐ Yes ☐ No	Comments _____

MASCOMA COMMUNITY HEALTH CENTER

PEDIATRIC MEDICAL HISTORY FORM

(for patients ages 0-18 years)

Anemia or bleeding problems	☐ Yes ☐ No	Comments _____
Blood Transfusion	☐ Yes ☐ No	Comments _____
Constipation requiring doctor visits	☐ Yes ☐ No	Comments _____
Bladder or kidney infection	☐ Yes ☐ No	Comments _____
Eczema or chronic skin problem	☐ Yes ☐ No	Comments _____
Frequent headaches	☐ Yes ☐ No	Comments _____
Seizures or other neurologic problem	☐ Yes ☐ No	Comments _____
Diabetes	☐ Yes ☐ No	Comments _____
Thyroid or other endocrine problem	☐ Yes ☐ No	Comments _____
Use of alcohol or drugs	☐ Yes ☐ No	Comments _____
(For girls) Started her menstrual period?	☐ Yes ☐ No	Comments _____
If "**yes,**" please tell us the *age at which periods started*		_____ (age)
and the *date of last period*		_____ (date of last period)
(For girls) Are there problems with her periods?	☐ Yes ☐ No	Comments _____

Is there anything else you want us to know about your child? Please comment below:

_____

_____

_____

THANK YOU!

MASCOMA COMMUNITY HEALTH CENTER

RELEASE OF INFORMATION FORM

AUTHORIZATION FOR RELEASE OF INFORMATION 2018

HIPAA COMPLIANT RELEASE

Patient's Name:_____DOB: _____

Release of Information ***FROM:*** _____

TO: ***Mascoma Community Health Center***
PO Box 550
Canaan, NH 03741
ATTN: MEDICAL RECORDS DEPT.
Phone: 603.523.4343 Fax: 866.277.5893
Dental Records can be emailed to dentalrecords@mascomahealth.org

I hereby authorize and request the exchange of information between Mascoma Community Healthcare and the above-named individual/organization. The following information is requested to be shared:

☐ **All**

☐ Office Notes	☐ Intake Assessment	☐ Test Results
☐ Psych/Social/Emotional Evaluation	☐ Medications	☐ Treatment Plan
☐ Immunizations	☐ Summaries	☐ Discharge Summary
☐ Counselor Reports	☐ Teacher Reports	

Date range of records to release (check one): ☐ Only documents from_____to_____ ☐ All dates

Reason for Request_____

Form of Disclosure (check all allowed): ☐ Written ☐ Verbal ☐ Electronic

☐Release of confidential information is subject to State and Federal Laws. By signing this release, I acknowledge my permission to release the above information to and/or from the individual or agency I have named which may include drug and alcohol abuse information.
Note: Federal regulations govern the confidentiality of alcohol and drug dependent persons (42CFR Par 2). Federal Law prohibits the disclosure of (1) psychotherapy notes, (2) information compiled in reasonable anticipation, or for the use in civil, criminal, or administration action or proceedings.

☐I understand I may revoke this authorization at any time by notifying **Mascoma Community Healthcare Inc.,** in writing, except to the extent that: a) action has been taken in reliance on this authorization; or, b) if this authorization is obtained as a condition or obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.
☐I understand I have a right to request and receive a **Notice of Privacy Practices** for Mascoma Community Healthcare, Inc.,

☐All releases expire one year from the date signed, unless otherwise indicated. Optional expiration date:_____
☐I hereby authorized the following; (please initial if applicable)__Disclosure of the results of HIV antibody blood testing and/or information concerning AIDS (Acquired Immune Deficiency Syndrome).

_____	_____	_____	_____
(Signature of Patient or Representative)	(Printed Name)	(Relationship to Patient if Representative)	(Date)

_____	_____	_____
(Witness Signature)	(Printed Name)	(Date)

MASCOMA COMMUNITY HEALTH CENTER

RELEASE OF INFORMATION FORM

Release (Disclosure) of Your Protected Health Information To Persons of Your Choice

Mascoma Community Health Center (MCHC) will release your protected health information to a person or persons whom you choose. However, you must give us the name(s) and phone numbers of the person(s), tell us what information we are allowed to disclose, and authorize us to do this by signing your name on this form. **If you do not want your protected health information released to anyone, disregard this form.**

Contact #1: Release information to the following person and for the purpose(s) as 'checked' below:

Name:_____ Relationship:_____ Phone:_____ Other Phone:_____

I give permission for MCHC to give the above-named person information about the following: (check all that apply):
___ Appointment information (date, time, with whom, for what)
___ Information and results from any tests or diagnostics such as labs, X-rays,
and other clinical information such as medications, diagnoses, prognoses, etc.
___ Emergency contact, only

Contact # 2: Release information to the following person and for the purpose(s) as 'checked' below:

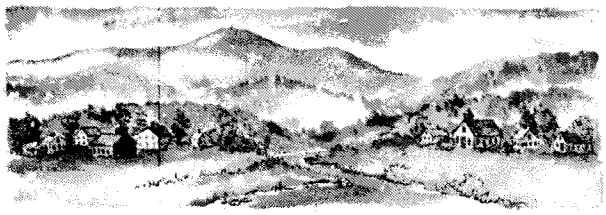
Name:_____ Relationship:_____ Phone:_____ Other Phone:_____

I give permission for MCHC to give the above-named person information about the following: (check all that apply):
___ Appointment information (date, time, with whom, for what)
___ Information and results from any tests or diagnostics such as labs, X-rays,
and other clinical information such as medications, diagnoses, prognoses, etc.
___ Emergency contact, only

Signed:_____ Date:_____

MASCOMA COMMUNITY HEALTH CENTER

Consent to Treat, Payment, Certification



Treatment Consent & Certification and Payment Policy Acknowledgement

Consent & Certification

I give my consent for Mascoma Community Health Center (MCHC) to conduct treatment and to receive payment for health care services. I have received a copy of Mascoma Community Health Center's Notice of Privacy Practices, and understand MCHC may disclose my health information for the purpose of providing and coordinating treatment, conducting health care operations, providing health information, and obtaining payment. This consent gives permission to obtain medical records for continuity of care and to obtain a history of prescribed drugs during the course of your medical care. I certify that the information I have given is complete and accurate to the best of my knowledge. I understand that failure to provide accurate information may result in termination of services at Mascoma Community Health Center, and report of the failure to my insurance company, and/or the federal government.

This consent remains in effect until I notify MCHC and I understand that I have the right to withdraw this consent at any time. Doing so will not affect any actions which were taken by MCHC before I withdrew this consent.

Patient Name: _____ DOB: _____

_____ Date: _____

Signature of: Patient / Parent / Guardian (Please CIRCLE One)

** Please note that if you are signing the consent as a patient's guardian, we will need to be provided with a copy of the current guardianship decree. **

Payment Acknowledgement

I have received a copy of Mascoma Community Health Center's Payment Policy and understand that **I am responsible** for any deductibles, co-payments, or non-covered services. I understand that my failing to do so may result in my being submitted to collections, reported to credit bureaus, and/or terminated from receiving services at Mascoma Community Health Center.

Patient Name: _____ DOB: _____

_____ Date: _____

Signature of: Patient / Parent / Guardian (Please CIRCLE One)

MASCOMA COMMUNITY HEALTH CENTER

NEW PATIENT INFORMATION

HELP US TAKE CARE OF YOU

At Mascoma Community Health Center (MCHC), we take pride in providing our patients with the very best health care, at an affordable price. **Please help us by following these simple rules:**

Co-Pays are due at the time of service

If you have insurance, please bring your insurance card with you. If you have a co-pay, please know how much your co-pay is and be ready to pay it when you come for your visit. Insurance companies require us to collect the co-pay at the time of service. If you do not pay your co-pay, we cannot continue to make appointments for you.

24-hour notice is needed to cancel or reschedule your appointment

Our schedules are getting full, and we often have a waiting list for patients to get an appointment. By providing 24-hours' notice, it allows us time to schedule a patient that may be waiting for care.

Missed (No-Show) Appointments

If you do not provide us 24-hour notice to cancel or reschedule your appointment, and you do not show up at the appointed time, you will be considered a "No Show". If you no-show two consecutive appointments or three total appointments you may be discharged from the practice.

48-hour notice is needed for prescription refill requests

Please keep track of ALL of your prescriptions. When you need a refill, call us, or your pharmacy, AT LEAST 48 hours before you run out of your medication, so that we can process the prescription. We DO NOT refill prescriptions after normal business hours, or on weekends. Please also understand that some medications can't be refilled without an office visit, blood and/or urine testing, or other lab tests.

If you don't have insurance, we offer a Sliding Fee Scale

If you don't have insurance, please ask us about eligibility requirements for our sliding fee scale program. If you need to sign up for NH Medicaid, Medicare, or need assistance with other programs, please ask us for assistance. We have care coordination services to help you access the resources you may need.

Keep your Health Care "Up-To-Date"

It is important for people of all ages to have regular "wellness visits" with your health care provider. Although you may not require frequent visits to your provider, health care standards and regulations require us to keep accurate records of our patients. If you have not seen your provider in over three years, you will receive a notice from MCHC, asking if you wish to remain a patient here, and to schedule a wellness visit. If you wish to transfer, or stop your care here at MCHC, please let us know.

Contact our office with billing questions

If you get a bill, you can help us by paying it upon receipt. If you believe there is a mistake with the bill, or you need help understanding it, please contact our billing department at 603-523-4343.

THANK YOU FOR GIVING US THE OPPORTUNITY TO SERVE YOU AND FOR WORKING WITH US TO MAKE OUR HEALTH CENTER A CARING, HELPFUL, AND SUCCESSFUL PART OF THE COMMUNITY!

MASCOMA COMMUNITY HEALTH CENTER

NEW PATIENT INFORMATION

Mascoma Community Health Center Payment Policy

Thank you for choosing Mascoma Community Health Center (MCHC). Prompt payment for the services that you receive ensures that we can continue to provide you and our community with affordable, quality medical care. The following explains the guidelines and rules of our Payment Policy. **Please read it, and feel free to ask us questions.**

RESPONSIBILITY

As a patient of MCHC you are responsible for payment of services.

ABOUT INSURANCE

MCHC participates in most insurance plans, including Medicare and Medicaid. **Your insurance benefit is a contract between you and your insurance company; knowing your insurance benefits and co-pay amount is your responsibility.** You must contact your insurance company with any questions you may have about your coverage. Please be aware that you might be responsible for the entire amount of the bill, if your insurance company does not have a contract with MCHC.

Please note the following:

1. **Co-payments MUST** be paid at the time of service. This arrangement is part of your contract with your insurance company. **Failure of MCHC to collect co-payments from patients can be considered fraud.** Please help us in upholding the law, by paying your co-payment at each visit.
2. **If you have an active insurance card,** we will bill your insurance company. If any balance remains, you are responsible for its payment.
3. **If you do NOT have an active insurance card, you will be responsible for payment of the service at the time the service is provided.**
4. MCHC accepts personal checks, credit cards, and cash. **If you need financial help to pay your bill,** ask to speak with our billing office, to set up payment options. MCHC offers a **Sliding Fee Scale,** available to income eligible patients. A payment plan can be arranged before you make your appointment.

OTHER THINGS TO KNOW:

- **IF YOUR INSURANCE CHANGES,** call us before your next visit. MCHC will make the necessary changes to help you receive your maximum benefits. **If your insurance company has not paid your claim within 45 days, you will be responsible for outstanding balances before additional services are provided.**

- **PROOF of insurance** – **MCHC must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide the correct insurance information in a timely manner, you will be responsible for the balance of a claim at time of service.

- **NON-COVERED services** - Please make sure that you know which services are covered by your health insurance. If you receive services at MCHC that are not covered by your insurance plan, you will be responsible for paying for these services.

- **CLAIMS submission** - MCHC submits your claims, and assists you in any way we can, to help get your claims paid. You may be asked by your insurance company to supply certain information directly to them, such as more information about when or where an injury happened, if it was work-related, etc. It is your responsibility to supply your insurance company with information that they request from you. If your claim is not paid because you have not supplied requested information, you will be responsible for paying the claim..

NONPAYMENT –If your account is over 60 days past due, you will receive a letter giving you 10 days to either pay the balance in full, or make a partial payment and set up a payment plan with our billing office. **If you do not respond to the letter, you will be given an additional 30 days of urgent care only from the initial date of notice. You will need to pay for urgent care services provided at the time of service. At the end of the 30 days, you could be discharged from MCHC due to non- payment.** In order to be reinstated as a patient at MCHC, you will need to pay all past due balances in full and establish a payment plan for future services.