

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.

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: _____

MASCOMA COMMUNITY HEALTH CENTER

PATIENT REGISTRATION FORM



****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 \$38,180.

☐ \$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

ADULT MEDICAL HISTORY FORM

(for patients ages 18 yrs. and older)



To Our New Patients: Please fill in this Medical History form as completely as possible. It helps us create your electronic "chart," and, most importantly, helps your provider get a better picture of your health before you became an MCHC patient. Thank You!

Name _____ Date of Birth _____

Previous care:

- Previous Primary Care Provider _____
- Any specialists you have seen in the last 10 years (ie. OB/GYN, orthopedic, cardiology, surgeons, psychiatrists)

- Any hospitals or emergency departments you have visited in the last 10 years (even if just for X-rays, labs, or other tests):

- Dentist _____
- Eye care _____

For each of the places you have listed, except for your dentist and eye care, please complete a records release form. (Attached to this form.) This also allows us to more fully understand your health history as we care for you.

Your Medical History: (Please circle any that apply, and explain on lines below.)

Depression	Heart disease	Obesity	Kidney disease
Anxiety	High blood pressure	Diabetes	Kidney stones
PTSD	Stroke	Thyroid disease	Gout
ADD/ADHD	Hepatitis	High cholesterol	Arthritis
Bipolar	COPD/emphysema	GERD	Cancer
Schizophrenia	Asthma	Migraines	Epilepsy/seizures
Alcohol Abuse/Drug Abuse	Seasonal allergies	Osteoporosis	Other

Have you ever had a blood transfusion? If yes, list date and reason. _____

Do you have a Living Will or Power of Attorney? Who is your designee/proxy? _____

MASCOMA COMMUNITY HEALTH CENTER
ADULT MEDICAL HISTORY FORM
(for patients ages 18 yrs. and older)



Medications (List ALL prescription, over the counter medications, or supplements, even those you use infrequently.):

<u>Medication</u>	<u>Dose</u>	<u>Directions</u>

Allergies:

<u>Medication or substance</u>	<u>Reaction</u>

Surgeries:

Any complications from surgery or anesthesia?: (explain) _____

<u>Date</u>	<u>Surgery</u>	<u>Hospital</u>

Hospitalizations:

<u>Date</u>	<u>Reason</u>	<u>Hospital</u>

Social History:

Please list all members of your household _____

Your Occupation _____ Religious preference _____

All states/countries where you have lived _____

Do you eat a special diet? If yes, explain. _____

Do you **currently** use tobacco? _____ If so, what form (ex. - cigarettes, chew, etc.) _____ Amount per day (ex. – number of packs, tins, etc. _____ Number of years you have used tobacco? _____ Are you interested in quitting? _____

MASCOMA COMMUNITY HEALTH CENTER
ADULT MEDICAL HISTORY FORM
(for patients ages 18 yrs. and older)



Did you use tobacco **in the past**? If so, what form? (ex.- cigarettes, chew, etc.) _____ Number of years that you used tobacco? _____ When did you stop? _____

How many alcoholic drinks do you have in the average week? _____

Do you currently use non-prescribed drugs, such as other people's medications, marijuana, cocaine, heroin, or narcotic pain medications? If so, how much? _____

Do you feel safe at home? _____

Do you feel safe at work? _____

Family History:

Are your parents still living? _____ If not, give age and cause of death _____

Please note any close family member with the following illnesses:

(MGM= Maternal Grandmother MGF= Maternal grandfather PGM= Paternal Grandmother PGF= Paternal Grandfather)

	<u>Mom</u>	<u>Dad</u>	<u>Other (specify)</u> (ie MGM, MGF, PGM, PGF,			<u>Mom</u>	<u>Dad</u>	<u>Other (specify)</u> (ie MGM, MGF, PGM, PGF,
Alcoholism					Hypertension			
Asthma					High cholesterol			
Bipolar					Kidney disease			
COPD/emphysema					Migraines			
Depression					Osteoporosis			
Diabetes					Stroke			
Epilepsy					Thyroid disease			
Gout					Cancer (List type)			
Heart disease					Other Physical Illness: _____			
Drug Abuse					Other Mental Illness: _____			
Hepatitis								

Vaccinations: (List the most recent date, if applicable.)

Tdap/Tetanus _____ Shingles _____ Hepatitis A _____ Hepatitis B _____

Pneumonia (PPSV 23) _____ Pneumonia (PCV 13) _____ HPV _____ Flu _____

MASCOMA COMMUNITY HEALTH CENTER
ADULT MEDICAL HISTORY FORM
(for patients ages 18 yrs. and older)



Preventive (List the most recent date if you know it. Estimate is ok – example – 1/2014)

Cholesterol test	Diabetes screen
Colonoscopy	Hepatitis C screen
Lung Cancer Screen	HIV Screen
Complete Physical Exam	
<u>Women only</u>	<u>Men only</u>
Pap smear	AAA screen
Mammogram	
Bone density	

Women only:

If you use birth control, what method? _____

How many pregnancies have you had? _____ How many live births? _____

How many C-sections? _____ How many miscarriages? _____ How many preterm births (before 37 weeks)? _____

Have you ever had complications during a pregnancy? If yes, explain. _____

Age of menopause, if applicable _____

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
RELEASE OF INFORMATION FORM



**AUTHORIZATION FOR RELEASE
OF INFORMATION**
HIPAA COMPLIANT RELEASE

2018

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**

- | | | |
|--|--|--|
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> Intake Assessment | <input type="checkbox"/> Test Results |
| <input type="checkbox"/> Psych/Social/Emotional Evaluation | <input type="checkbox"/> Medications | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Summaries | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Counselor Reports | <input type="checkbox"/> 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)