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 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.

Rev. 040118
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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Birth Date</th>
<th>Health Problems</th>
</tr>
</thead>
</table>

**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: ______________________________________________________________

**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)

<table>
<thead>
<tr>
<th>Name of Medication/Supplement</th>
<th>Dosage</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Sodium Fluoride Tablets</td>
<td>Example: 1 per day</td>
<td>Example: 0.5 mg</td>
</tr>
<tr>
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</tr>
</tbody>
</table>

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: ____________________________________________________________

**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
MASCOMA COMMUNITY HEALTH CENTER

PEDIATRIC MEDICAL HISTORY FORM
(for patients ages 0-18 years)

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? ______________________________

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? ______________________________

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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 _______________
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!
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: ____________
Authorization for Release of Information

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@mascomaahealth.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 administrative 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 authorize 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)