Families First

support for families...health care for all

Dear Soon-to-Be Families First Patient,

Thank you for your interest in Families First, a Patient-Centered Medical Home where you can receive primary care, dental care, counseling, family services and more. We are looking forward to having you as a patient.

To begin receiving care at Families First, please:

1. Fill out the attached Patient Intake Forms.
2. If you have questions about the paperwork, call 603-422-8208.
3. Keep the Patient Handbook and Welcome Booklet or future reference.
4. Bring or mail your completed application to:

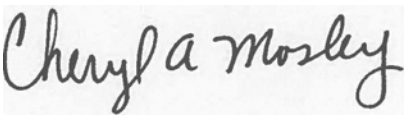
   Families First Health Center
   Community Campus
   100 Campus Drive, Suite 12
   Portsmouth, NH 03801

If you need photocopies of your insurance card or proof of income, please bring those to us with your application. We will copy them for you.

Once we receive your paperwork, we will contact you to schedule your first appointment with your new primary care provider. If you filled out a Sliding Scale form, we will also tell you the estimated fee for your visit.

Again, thank you for considering Families First. **Please tell your friends that we are accepting new patients and that *Families First's services are for everyone*** — infants to seniors, single people and families, insured or uninsured, all income levels.

Sincerely,



Cheryl A. Mosley
Health Center Office Manager

Primary:_____ Dental:_____ Prenatal:_____

Patient Registration Form (*2 pages*)

New ☐ **Annual** ☐

Home Location: ☐ Families First ☐ HH ☐ Goodwin Community Health ☐ Lilac City Pediatrics

PATIENT INFORMATION

Name: _____ Date of Birth: _____/_____/_____ Gender (at the time of birth): ☐ M ☐ F

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ **Okay to leave a voicemail?** ☐ Yes ☐ No

Cell Phone: (_____)_____ **Okay to text you?** ☐ Yes ☐ No **Okay to leave a voicemail?** ☐ Yes ☐ No

Email Address: _____ (Portal access available upon request)

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Gender Identity: ☐ M ☐ F ☐ Transgender Male/Female to Male ☐ Transgender Female/Male to Female ☐ Other ☐ Choose not to disclose

Sexual Orientation: ☐ Lesbian or Gay ☐ Straight ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose

Race: ☐White ☐Asian ☐Native Hawaiian ☐Pacific Islander ☐Black/African American ☐American Indian ☐More than one race ☐Other_____

Living Arrangements: ☐Rent ☐Own ☐Stay w/relatives/friends ☐Shelter ☐Other temporary housing _____

Language: _____ **Are you Deaf?** ☐ Yes ☐ No *An interpreter can be provided during medical visit upon request*

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Veteran Status:** ☐Veteran ☐Non-Veteran **U.S Citizen** ☐Yes ☐No

PARENT / GUARDIAN INFORMATION (Complete if patient is under 18 years old)

1.) Name: _____ Date of Birth: _____/_____/_____ Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient (circle one): Mother Father Other (please fill in): _____ Sex: ☐ M ☐ F

2.) Name: _____ Date of Birth: _____/_____/_____ Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient (circle one): Mother Father Other (please fill in): _____ Sex: ☐ M ☐ F

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone: (_____)_____

1. Okay to speak with regarding your appointments? ☐ Yes ☐ No 2.Okay to speak with regarding your medical care? ☐ Yes ☐ No

Name: _____ Relationship: _____ Phone: (_____)_____

1. Okay to speak with regarding your appointments? ☐ Yes ☐ No 2.Okay to speak with regarding your medical care? ☐ Yes ☐ No

Preferred Local Hospital: _____

***COVERAGE MAY REQUIRE NOTIFYING THE INSURANCE CARRIER OF YOUR PROVIDER. THIS IS THE RESPONSIBILITY OF THE PATIENT.** _____**(Initials)**

Primary Insurance Name: _____ Policy #: _____ Group #: _____

Subscribers Name: _____ Subscribers DOB: _____ Relationship to Patient: _____

Secondary/ Dental Insurance Name: _____ Policy #: _____ Group #: _____

Subscribers Name: _____ Subscribers DOB: _____ Relationship to Patient: _____

1. How did you hear about us? _____
2. Are you transferring your care from another medical office? ☐ Yes ☐ No If yes, where? _____

Patient / Guardian Signature: **X** _____ Date: _____ (OVER)--->

GREATER SEACOAST COMMUNITY HEALTH

Goodwin Community Health | Families First — support for families...health care for all

FOR OFFICE USE - PATIENT NOTIFICATION
☐ **APPROVAL** ☐ **DENIAL**
Sliding Fee Category & Discount: _____/_____
Expires:_____

SLIDING FEE DISCOUNT APPLICATION

Greater Seacoast Community Health offers a discount based on income for patients who are uninsured, or whose insurance doesn't cover certain services (such as dental or behavioral health care).

IF YOU DO NOT WISH TO APPLY: Please provide the information and signature requested below. This helps us meet the requirements of the state and federal grants we receive. Family size:_____ Annual household income: $_____

☐ I do not wish to apply for the sliding fee discount. Patient/guardian signature: _____ Date: _____

TO APPLY FOR THE SLIDING FEE DISCOUNT: Please fill in the table below and supply proof of income within the next 30 days. Discounts are based on family size and household income. We will tell you what your sliding fee category and discount are, and you will be eligible for this discount for one year. (After one year, you will be asked to submit proof of income again.)

Examples of *types* of income:
- Social Security
- Retirement
- Business
- Welfare payments
- Child support
- Alimony
- Disability
- Others

Examples of *proofs* of income:
- 4 weeks of current and consecutive pay stubs
- Current tax return
- 4 weeks of unemployment check stubs

Please provide the information requested below for yourself and all persons living with you.

Name (First, MI, Last)	Sex	Relationship to you	Date of Birth	Income and Frequency	Income Type
		SELF		$	
				$	
				$	
				$	
				$	
Family Size:			Household Income:	$	

The above information supplied is current and accurate to the best of my knowledge. I understand that if the information I provide is found to be inaccurate, any discount given may be reversed.

Patient/Guardian Signature X_____Date:_____

☐ I would like a free appointment to understand the insurance options available to me.

OFFICE USE ONLY:

Approved Date: _____	❒ Category 1	❒ Category 2	❒ Category 3	❒ Category 4	❒ Full Pay
Usual Medical Fee:	❒ $30	❒ 40%	❒ 60%	❒ 80%	❒ Full Pay
Basic Dental Payments:	❒ $40	❒ 50%	❒ 65%	❒ 80%	❒ Full Pay
Major Dental Payments:	❒ $40+	❒ 60%	❒ 75%	❒ 90%	❒ Full Pay

Based on POI of $_____ ❒ monthly ❒ annually ❒ refused

Staff Name: _____ Date: _____

Reviewed by: Front Office Supervisor or Authorized Designee * Verification and Approval is reflected with initials, date and category directly on the income (subject to additional review).

Please PRINT the patient's name clearly: _____

PLEASE READ CAREFULLY! SIGNATURES ARE REQUIRED BELOW BEFORE YOU MAY BECOME A PATIENT.

WE WILL ASK FOR YOUR SIGNATURE EVERY TWELVE MONTHS.

The Foundation for Seacoast Health: Community Campus — Safe Campus Restrictions

In order to keep children and others on the community campus safe, our landlord, (The Foundation for Seacoast Health) will not allow on the Campus people who fall into the following categories:

People who have been determined to be a sexual offender as defined by RSA 651-B,
People who have been determined to be an offender against children as defined by RSA 651-B,
Individuals who may pose a risk to the safety of others.

The Foundation for Seacoast Health is requiring that Families First take steps to make sure that people who fall into the above three categories are not coming to the Community Campus.

By signing this form, I agree to the following:

If Families First determines in its own judgment that I fall into any of the three categories listed above:
I will be immediately discharged from Families First, and will not receive any more services;
I will immediately leave the Community Campus and will not return;
Families First will immediately release my name and address to the Foundation for Seacoast Health; and
I will hold neither Families First nor the Foundations for Seacoast Health responsible for the release of my name and address to the Foundation for Seacoast Health.

The Foundation for Seacoast Health may prohibit me from coming to the Community Campus if it is determined that I fall into any of the three categories listed above.

_____ _____

Signature **Date**

I hereby give permission for Families First Health Center to examine and conduct such referrals, tests and procedures as are needed for my diagnosis and care, and to give such treatment as the health center's providers deem necessary. I understand that Families First, medical and support staff, may disclose and use this information for treatment, including sharing this information with other providers to provide continuity of care.

I hereby authorize release of PHI (Personal Health Information) necessary to file a claim and audit with my insurance company and assign benefits to the provider or group indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier, including, but not limited to, deductible and co-payments. At the end of sixty days, billing is my responsibility. A copy of this signature is valid as the original. The information I have provided is accurate and complete to the best of my ability.

_____ _____

Signature **Date**

I acknowledge that I have read and understand the following documents: Health Center Patient Compact, Notice of Information Practices (Summary), Consent to Use and Disclose Health Information, "Safe Campus" Policy, Late Policy and **Health Insurance/PCP responsibility**. They are all located in Part II of the Patient Handbook (pages 18-30).

_____ _____

Signature **Date**

If you have MEDICARE coverage you must sign below.

I request that payment of authorized Medicare benefits be made to Families First of the Greater Seacoast for services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services. (This payment authorization is to be completed, signed by the beneficiary and retained in the files of the provider of service. It is valid for any service Families First provides to the beneficiary during his/her lifetime, unless revoked.)

Print Name of Beneficiary: _____ Medicare # _____

Signature of Beneficiary or Representative: _____ Date: _____

Families First Health & Support Center
100 Campus Dr., Portsmouth, NH 03801
Ph: 603-422-8208 Fax: 603-422-8218

RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Phone(s): _____

I authorize Families First to release or obtain personal health information of the above-named individual to the person/facility named below. ☐ Release to ☐ Obtain from

Name/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

City, State, Zip: _____ Email: _____

For dates of care from: _____ to: _____

Purpose of release: _____

If leaving our practice, reason: _____

Please initial all types of information that you authorize us to release or obtain:

_____ Medical diagnostic, testing, and treatment information
_____ Dental diagnostic, testing and treatment information and /or x-rays taken: _____
_____ Records of immunizations and physicals
_____ Current prenatal records, copies of all lab tests (including HIV results) and/or scans
_____ Summary of labor and delivery notes for the following date of delivery: _____
_____ Information about Sexually Transmitted Diseases and/or HIV/AIDS
_____ Psychiatric/psychological evaluation(s), reports, assessments, summaries, psychotherapy notes or other documents with diagnosis, prognoses, recommendations, or testing records and behavioral observations.
_____ Drug and alcohol information including evaluation, diagnostic, treatment and progress notes.
_____ Other: _____

Methods of Disclosure Authorized: Faxed, written, phone conversation, in-person and/or secure e-mail

- I understand that I may revoke (withdraw) this authorization at any time by notifying Families First in writing. Revocation will be effective as of the date received.
- I understand that a revocation will not apply to: 1) any actions that Families First has already taken while relying on this authorization before I revoke it; or 2) if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that I might be denied services if I refuse to consent to disclosure for purposes of **treatment, payment, or health care operations**, if permitted by state law. I will not be denied services if I refuse to consent to disclosure for other purposes.
- I understand that the recipient of some information disclosed under this authorization may re-disclose this information and that the information will no longer be protected by federal privacy regulations.
- I understand that I have the right to: 1) Inspect or copy the protected heath information to be used or disclosed as permitted under Federal law; 2) Refuse to sign this authorization.
- This authorization will remain in effect **for one year** and may be revoked at any time in writing.
- Unless otherwise noted, only the **past two years** of electronic records as stipulated above will be sent.

Signature of Patient and/or Legal Representative: _____ **Date:** _____

***To receiving provider**: This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

For office use only: Witness: _____ Date: _____

Sent by: _____ Date: _____