WHITE MOUNTAIN COMMUNITY HEALTH CENTER

Whole Person. Whole Family. Whole Valley.

Welcome to White Mountain Community Health Center

White Mountain Community Health Center looks forward to working with you and your family. Your care and wellness are our primary goals. We are pleased that you have selected us as your healthcare home.

In order to better serve you, we ask that you bring a list of all your medications, insurance cards, completed forms, and other documents you feel are important to your visit. Please plan to arrive 15 minutes prior to your appointment.

If you are unable to easily read or understand the required forms, please bring them with you to your appointment and one of our staff will assist you.

Our Promise to You

- You are the most important member of your healthcare team.
- We are dedicated to providing coordinated, evidence-based care across all of your healthcare systems.
- Coordinating your care works best when patients provide their team with all of their healthcare information.
- We want you to think of White Mountain Community Health Center as your healthcare HOME - where all your care comes together.

If you see other healthcare providers outside of the health center, it is important to share this information with us, as it gives us important information about your overall health and wellness to help us serve you better.

Getting Started as a New Patient at White Mountain Community Health Center

- Please review this important information.
- Complete the record release and return it to our office. We will contact your previous provider(s) for your records. This process can take up to 30 days.
- If you have an urgent or immediate health concern, please let us know and we will do our best to get you in as soon as possible. It is still important for you to also schedule your “establish care” visit with your selected provider.
- If you have any questions or need assistance, please contact the front desk at (603) 447-8900.

Selecting Your Provider/Care Team Lead

It is important for you to feel comfortable with your provider and be able to play an active role in your healthcare planning and goals. Visit our website at www.whitemountainhealth.org and “meet” our providers. Each provider has a profile and bio to help you find the best match for you. If you need help making your choice, we would be happy to assist you.

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How Your White Mountain Community Health Center Care Team Works for You

- Our providers work in teams to help meet your needs. This ensures you will have access to a member of your provider's care team, even if he/she is not available.
- You will have access to medical, behavioral health, and dental services to meet all your primary care needs.
- Your Care Team will work with you to connect with any specialists or other providers you see outside of our agency to help in coordinating your care. When you see other healthcare providers outside of the health center, it is important for you to ask them to share your health information from the visit with your primary care provider here.

Important Information for Your First Visit

Bring with you all of the following:

- ☐ Insurance card(s)
- ☐ List of all your medications and supplements or the bottles
- ☐ Complete sliding fee discount program application, if needed and not already submitted
- ☐ Any other documents you feel are important to your visit.

→ Plan to arrive 15 minutes prior to appointment to complete the check-in process ←

Location and Hours

Monday - Friday 8:00 AM - 4:00 PM
298 White Mountain Highway
Conway, NH 03818
Phone: (603) 447-8900
Fax: (833) 972-5530

Appointments

- Simply call our office to schedule your appointment. Same day appointments are often available for acute or urgent health concerns.
- Please arrive 15 minutes prior to your appointment to complete the check-in process, which may include health screening paperwork.
- Bring a list of your current medications and information about any recent healthcare services you have received outside of White Mountain Community Health Center.
- Please notify our office immediately if you need to change or cancel your appointment.
- Your health and safety are our top priority. There could be times when you may be advised to go to the nearest Emergency Department instead of coming to the office.

After-Hours Access

Our patients can access advice by phone for urgent health concerns anytime we aren't open via our nurse triage on-call service. You can access this by calling us at (603) 447-8900.

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If you need to reschedule or cancel an appointment

We know life happens! If you are unable to make a scheduled appointment, please be sure to let us know as soon as possible.

- To avoid charges for a late cancelled or missed appointment, please be sure to call and cancel your appointment within 24 hours.
- If you have three or more late cancelled or missed appointments in one year, we may restrict you from scheduling appointments ahead of time.

Prescribing Medications at Your First Visit

In order to ensure you have the correct medications for your conditions and health concerns, before any prescription is filled for a new patient:

- Your medical records must be received from your previously prescribing provider(s) – this sometimes takes up to 60 days from the time of our request and your first appointment. **Please plan accordingly with your previous provider to ensure you do not run out of medication before your appointment**.
- If you have an active prescription and will be in need of refills, it is imperative you tell our staff when you are contacted to schedule an "establish care" visit.
- You MUST be seen for an "establish care" visit, at which the following will occur:
    - Review of existing health conditions, including evaluation and treatment history,
    - Review of your current medications,
    - Physical exam as needed to determine the necessity for the requested medications, and
    - If controlled substances are considered, a review of our policy for prescribing controlled medications and completion of our Controlled Medication Agreement is required.
- Controlled substances require in-person evaluation, will not be prescribed on the first visit, and may require periodic drug screening.
- Your new provider is not obliged to prescribe any previously prescribed medications you may be taking. There are often many options for treatment of chronic conditions and these will be reviewed with you at the visit. Any medications prescribed must be deemed appropriate by your provider for your current condition(s) and based on your medical history.

Patient Portal

Our patient portal gives you 24-hour access to your personal health information and medical records. You can also use it to send secure messages to our staff, request a change to an existing appointment, request a prescription refill, and more. If you provide your email address, we will send you a sign-up link. If you don't get this email or need to reset your password, contact us at (603) 447-8900.

In An Emergency

White Mountain Community Health Center does not provide 24-hour crisis services. In a medical or mental health emergency:

- Call 911 or go to the nearest emergency room.
- Call the NH Rapid Response Access Point at 833-710-6477.
- Call or text the National Suicide Prevention Lifeline at 988.

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Services to Ensure Access

Interpretation and Language Services: We will provide an interpreter for our patients as needed at no cost, including ASL. Please let our office know ahead of time so we are able to plan accordingly.

Español Atención: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.

Assistance Completing Forms: If you would like assistance in completing your forms, we are happy to help. Simply call us to schedule a time to meet with a member of our team.

Assistance in Managing the Cost: We offer health insurance enrollment assistance, a sliding fee scale, and other assistance. Please call our office at (603) 447-8900 to learn more.

Assistance with Transportation to Your Visit: If you need assistance with transportation, let us know. Sometimes we are able to help coordinate a ride to and from your appointment or a referral.

We Welcome All People

White Mountain Community Health Center complies with applicable federal civil rights laws and does not discriminate on the basis of color, race, national origin, age, disability, sexual orientation, or gender identity.

Payment Options for Your Care

We accept most insurance carriers serving this region. We know that figuring out your insurance coverage is sometimes confusing. If you have any questions or need help navigating your coverage, call our office at (603) 447-8900.

General Payment Information

- Please let us know if you have any changes to your health insurance so we are able to submit your claim to the appropriate carrier.
- You will be responsible for all outstanding balances not covered by insurance.
- Co-pays are due on the day of your visit.
- Claims will be processed to insurance companies we do not contract with, but unfortunately, we cannot guarantee coverage or payment.
- Our office accepts personal checks, cash, and most major credit cards.

Financial Assistance is Available

If you think you might have trouble paying your medical bills, we offer a sliding fee scale to those who qualify. To learn more or begin the eligibility process, please call our office at (603) 447-8900 and they will gladly assist.

Contact Your Insurer Before Your Visit

- If you have a behavioral health appointment, it is important to contact your health insurance company in advance to receive their approval/authorization to avoid charges that your insurance may not cover. Be sure to ask about copay and deductible amounts, they may be different from your medical visit coverage.
- Insurance coverage for other services may vary as well. Please feel free to contact our billing office if you need help figuring out what your charges will be for any service you are considering.

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Summary of Payment and Billing Policies

General

- Please be sure to bring your insurance card(s) with you to each visit.
- White Mountain Community Health Center will request payment of all co-payments and charges not covered by a third party (insurance) at the time of your visit.
- Copayments and sliding fee scale payments are due in-full, at the time of service. Outstanding balances are due within 30 days of your visit.
- No show/late cancels may be charged $50

Sliding Fee Discount Program

- Sliding fee discounts apply only to services provided by the health center. It is your responsibility to renew your application before it expires.
- The discount is ***not insurance*** and will not pay for services provided by other doctors, labs or hospitals. You will need to make arrangements with these organizations directly.
- Nordx Laboratory and Memorial Hospital are willing to honor the White Mountain Community Health Center determination of discount for their own discount programs when we refer you.

Unpaid Balances

- You will receive a monthly billing statement from us until your balance is paid in full.
- We reserve the right to charge interest and collection fees.
- Payment plans are available for those unable to make payment in full. If you would like to set up a payment plan, please speak with the cashier or contact our billing department at (603) 447-8900.
- We understand that many patients are in situations that keep them from being able to pay their full bill. Please be in touch if you need extra assistance and explain your situation. We will do all we can to help as long as you stay in contact with us and stay current with the payment plan you've set up. In the event that your account balance remains outstanding for more than 120 days and you have not met these criteria, we may choose to place your account with a collections agent.
- If you don't make any payments for more than 120 days and you haven't been in contact with us about it, we may choose to place your account with a collections agent and suspend your ability to access care at the health center. Please call our billing department us if this happens to you. We can help you get back on track.

WHITE MOUNTAIN COMMUNITY HEALTH CENTER
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our commitment to your privacy

Each time you come to White Mountain Community Health Center, we create a record of the care and services you receive. We are committed to protecting the privacy and security of your protected health information (PHI).

We are required by law to:

- Maintain the privacy and security of your health information
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of this Notice currently in effect
- Notify you promptly if a breach occurs that may have compromised the privacy or security of your information

We reserve the right to update this Notice at any time. Updated versions will be posted in our office and made available on request.

You have the right to receive a paper copy of this Notice at any time.

How we may use and disclose your information:

For treatment
We may use and share your health information to provide, coordinate, or manage your healthcare.

Examples include:

- Sharing information with providers, specialists, and care team members
- Sending prescriptions to pharmacies
- Coordinating care with laboratories or imaging centers
- Working with outside providers involved in your care
- Sharing information with family members or caregivers involved in your care, when appropriate

We may also coordinate care with community partners or support services when appropriate to assist in your healthcare needs.

For payment
We may use your health information to bill and receive payment for services provided.

Examples include:

- Submitting claims to your insurance company
- Verifying eligibility and coverage
- Obtaining prior authorization for services

For healthcare operations
We may use and share your health information to support the operations of our organization.

Examples include:

- Improving the quality of care
- Training staff and providers
- Conducting audits, compliance reviews, and performance evaluations
- Managing our electronic health record system
- Business and administrative activities

We may use reasonable methods to identify you and communicate with you in our office, such as calling your name when it is time for your appointment.

If we use third parties (such as billing services), we require them to protect your information through a Business Associate Agreement.

Electronic communication
We may communicate with you electronically through secure systems such as patient portal, email, or text messaging when you have agreed to these methods.

While we take reasonable steps to protect your information, electronic communication may involve some level of risk.

Use and disclosures allowed by law
We may use or disclose your health information without your authorization in certain situations, including:

- When required by federal or state law
- For public health activities (such as disease reporting)
- To report abuse or neglect
- For health oversight activities (such as audits or inspections)
- To comply with Food and Drug Administration (FDA) requirements
- For workers' compensation claims
- For law enforcement purposes or legal proceedings
- To prevent or lessen a serious threat to health or safety
- For national security or military purposes
- To coroners, medical examiners, or funeral directors

With your authorization
Uses and disclosures not described in this Notice will be made only with your written authorization.

You may revoke your authorization at any time in writing, except to the extent that action has already been taken based on your authorization.

Your rights regarding your health information

Right to access your information
You have the right to inspect and obtain a copy of your health information, including electronic copies when available.

- Requests must be made in writing
- A reasonable, cost-based fee may apply
- You may request that we send your information to another person or entity

Right to request an amendment
You may request a correction to your health information if you believe it is incorrect or incomplete. If your request is denied, you may submit a written statement of disagreement that will become part of your record.

Right to request restrictions
You have the right to request limits on how your information is used or shared. We are not required to agree to all requests. However, we must agree if:

- You request that we not share information with your health plan
- The service was paid in full out-of-pocket
- Disclosure is not otherwise required by law

Right to confidential communications
You may request that we contact you in a specific way (for example, by mail or at a specific phone number).

Right to an accounting of disclosures
You have the right to request a list of certain disclosures we have made of your health information.

Right to a paper copy
You have the right to receive a paper copy of this Notice at any time, even if you have agreed to receive it electronically.

Breach notification
We will notify you if a breach occurs that may have compromised the privacy or security of your information, as required by law.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with us or with the U.S. Department of Health and Human Services. You will not be penalized or retaliated against for filing a complaint.

Contact information

Privacy Officer
White Mountain Community Health Center
298 White Mountain Highway
Conway, NH 03818
Phone: (603) 447-8900
Fax: (603) 447-4846

Last revised 9/4/2026

WHITE MOUNTAIN COMMUNITY HEALTH CENTER

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received or have been offered a copy of White Mountain Community Health Center's Notice of Privacy Practices.

The Notice of Privacy Practices explains how my health information may be used and disclosed for treatment, payment, and healthcare operations, as well as my rights regarding my health information.

I understand that:

- I may request a copy of the Notice at any time
- The Notice is available on the organization's website
- I may ask questions about my privacy rights

Patient name: _____ **Date of birth:** _____

Patient signature: _____ **Today's date:** _____

Or, signature by parent, guardian, or personal representative:

Name: _____ **Relationship to patient:** _____

Responsible party signature: _____ **Today's date:** _____

WHITE MOUNTAIN COMMUNITY HEALTH CENTER

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PATIENT REGISTRATION – MINOR OR ADULT WITH GUARDIAN

TODAY'S DATE	THE PATIENT IS REGISTERING FOR…
	☐ Primary care ☐ Dental care ☐ Behavioral health ☐ Substance use disorder treatment

Please provide the information used on the patient's insurance card or legal identification

We recognize that the name on the patient's insurance or legal ID may not match the name they go by. We need the name on their insurance for billing purposes, and the name they go by for their chart and other purposes.

LEGAL LAST NAME	LEGAL FIRST NAME	MI	DATE OF BIRTH

How would the patient like our staff to refer to them?

FIRST NAME USED	PRONOUNS

Please list contact information for this patient's legal parent(s) or guardian(s)

List the parent/guardian who should receive communications about this patient as parent/guardian 1. The only people we will communicate with about this patient are the parent(s) or guardian(s) listed below, unless otherwise authorized in writing.

PARENT/GUARDIAN 1			
NAME			**RELATIONSHIP TO PATIENT** ☐ Parent ☐ Guardian
PHYSICAL ADDRESS	city	state	zip
MAILING ADDRESS ☐ Same as physical	city	state	zip
MOBILE PHONE **Ok to send automated calls?** ☐ Yes ☐ No **Ok to send automated texts?** ☐ Yes ☐ No	**HOME PHONE** ☐ Same as mobile		**OTHER**
EMAIL ADDRESS *Required to use the patient portal*			
NEWSLETTER *We send a monthly newsletter to patients and supporters with updates on changes and events at the health center, resources, and health info. You can opt in or opt out. If you opt out, you may miss some important updates. You can also unsubscribe at any point.* ☐ **Send me the newsletter** ☐ **Do not send me the newsletter. I understand I may miss some important updates.**			
PREFERRED CONTACT METHOD *You can adjust your contact preferences at any time in the patient portal* ☐ Mobile phone ☐ Home phone ☐ Other phone (listed above) ☐ Patient portal ☐ Email			

Patient name: _____ **Date of birth:** _____

EMERGENCY CONTACT ☐ Parent/guardian 1 ☐ Parent/guardian 2 ☐ Other:

PARENT/GUARDIAN 2		
NAME		**RELATIONSHIP TO PATIENT** ☐ Parent ☐ Guardian
EMAIL ADDRESS *Required to use the patient portal*		
NEWSLETTER *We send a monthly newsletter to patients and supporters with updates on changes and events at the health center, resources, and health info. You can opt in or opt out. If you opt out, you may miss some important updates. You can also unsubscribe at any point.* ☐ **Send me the newsletter** ☐ **Do not send me the newsletter. I understand I may miss some important updates.**		
PHYSICAL ADDRESS ☐ Same as parent/guardian 1 city state zip		
MAILING ADDRESS ☐ Same as parent/guardian 1 city state zip		
MOBILE PHONE **Ok to send automated calls?** ☐ Yes ☐ No **Ok to send automated texts?** ☐ Yes ☐ No	**HOME PHONE** ☐ Same as mobile	**OTHER**
PREFERRED CONTACT METHOD *You can adjust your contact preferences at any time in the patient portal* ☐ Mobile phone ☐ Home phone ☐ Other phone (listed above) ☐ Patient portal ☐ Email		

Please share the patient's email address, if they have one, to allow for portal access for patients 12 years and older

PATIENT'S EMAIL ADDRESS

What is the patient's preferred pharmacy?

PHARMACY NAME	**TOWN**

If there are protective court orders, court-ordered parenting plans, custody agreements, or other documentation that affect this patient's care or access to information about this patient, please bring in a copy for us to add to their medical records. This helps ensure that we follow all legal requirements regarding consent and communication.

If it's likely that someone else will bring this patient to appointments, please fill out the form to authorize that person to consent to care for this patient on your behalf.

For patients ages 16 and older, a signed authorization form is required for unaccompanied appointments unless otherwise permitted by law.

Patient name: _____ **Date of birth:** _____

Demographic information

Having this information about our patients helps us get grants that allow us to offer more services and help more people in our community access the healthcare they need, and is required for our federal reporting. We never report individual information on our patients. Please help us by completing as much of this section as you are comfortable answering!

INCOME LEVEL

Please fill this out even if you are insured. We need to report our patients' average income level to retain our funding.

Household income $_____ ☐ Weekly ☐ Monthly ☐ Annual

How many people does this income support (including you)? _____

☐ I need help figuring this out ☐ Prefer not to answer

HOUSING STATUS

☐ Stable ☐ Unstable

☐ Homeless ☐ Prefer not to answer

ARE YOU…

A migrant or seasonal agricultural worker ☐ Yes ☐ No

A veteran ☐ Yes ☐ No

CURRENT OR MOST RECENT OCCUPATION

PREFERRED LANGUAGE

☐ English

☐ Español

☐ Português

☐ Other: _____

ETHNICITY

☐ Hispanic/Latino/Latina

☐ Not Hispanic/Latino/Latina

☐ Prefer not to answer

RACE *(check all that apply)*

☐ Asian Indian

☐ Chinese

☐ Filipino

☐ Japanese

☐ Korean

☐ Vietnamese

☐ Other Asian

☐ Native Hawaiian

☐ Other Pacific Islander

☐ Guiamanian or Chamorro

☐ Samoan

☐ American Indian or Alaskan Native

☐ White

☐ Black or African American

☐ More than one race

☐ Prefer not to answer

SEX AND GENDER IDENTITY

Gender identity: ☐ Female ☐ Male ☐ Non-binary ☐ Other:_____ ☐ Prefer not to answer

Sex assigned at birth: ☐ Female ☐ Male ☐ Prefer not to answer

Legal sex (if different from sex assigned at birth): ☐ Female ☐ Male ☐ Prefer not to answer

How did you hear about us?

☐ Friend/relative

☐ Drove by/saw our sign

☐ Community event

☐ Online search

☐ Social media

☐ Newspaper ad

☐ Newspaper article

☐ Emergency department

☐ I'm a former patient

☐ Other: _____

Patient name: _____ **Date of birth:** _____

New Patient Health Information

Do you have a living will? ☐ Yes ☐ No

Tell us who lives in your household: ☐ I live alone ☐ Children ☐ Other extended family ☐ Other ☐ Spouse/partner ☐ Parent(s) ☐ Roommate

How many children do you have? _____ **Children's ages:** _____

Current Medications & Supplements

Medication/Supplement	Dosage	Frequency	Medication/Supplement	Dosage	Frequency

Allergies

Please list any known allergies. Include any medication allergies, seasonal allergies, bees, shellfish, etc.

List what you are allergic to: What is your reaction?

_____ _____

_____ _____

_____ _____

Hospitalization

Have you ever spent the night in the hospital? If so, for what and when?

Date	Reason (Diagnosis)	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgical History

Have you ever had surgery? If so, for what and when?

Date	Reason (Diagnosis)	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Please list any diseases that your biological relatives have/had:

Father: _____ **Mother:** _____

Brother(s): _____ **Sister(s):**_____ **Son(s):** _____ **Daughter(s):**_____

Immunizations
(Include dates or attach immunization history)

☐ Flu (Influenza) _____
☐ Polio (OPV) _____
☐ Hepatitis B _____
☐ Hepatitis A _____
☐ Pneumonia _____
☐ Tetanus/Pertussis (Tdap/DTaP): _____
☐ Chicken Pox (Varicella): _____
☐ Measles, Mumps, Rubella (MMR) _____
☐ Shingles _____
☐ HPV _____
☐ Tuberculosis (TB) Test _____
☐ TB Vaccine (BCG) _____
☐ COVID _____
☐ Other: _____

Patient name: _____ **Date of birth:** _____

Health Screening
(Please provide the date of your most recent screening)

- ☐ Physical Exam _____
- ☐ Cholesterol Check _____
- ☐ HIV Screening _____
- ☐ Hep C Screening _____
- ☐ Mammogram _____
- ☐ Pap Smear _____
- ☐ Colon Cancer Screening
  - ☐ Colonoscopy _____
  - ☐ Fecal Immunochemical Testing _____
  - ☐ Stool Test for Blood _____
- ☐ PSA Test/Prostate Cancer Screening _____
- ☐ Measles, Mumps, Rubella (MMR) _____

Current and Past Medical Conditions – Check all that apply

	Current	Past	Never		Current	Past	Never
Anemia	☐	☐	☐	Heart Murmur	☐	☐	☐
Angina	☐	☐	☐	Hemorrhoids	☐	☐	☐
Anxiety	☐	☐	☐	Hepatitis/Yellow Jaundice	☐	☐	☐
Asthma	☐	☐	☐	High Blood Pressure	☐	☐	☐
Bleeding Problems	☐	☐	☐	HIV	☐	☐	☐
Cancer of _____	☐	☐	☐	Kidney Disease	☐	☐	☐
Congestive Heart Failure	☐	☐	☐	Kidney Stones	☐	☐	☐
Chronic Bronchitis	☐	☐	☐	Pneumonia	☐	☐	☐
Depression	☐	☐	☐	Reaction to Anesthesia	☐	☐	☐
Diabetes	☐	☐	☐	Rheumatic Fever	☐	☐	☐
Emphysema/COPD	☐	☐	☐	Skin Disease/Dermatitis	☐	☐	☐
Gall Bladder Disease/Stones	☐	☐	☐	Stomach Ulcers	☐	☐	☐
Glaucoma	☐	☐	☐	Substance use disorder (alcohol or drug)	☐	☐	☐
Gout	☐	☐	☐	Thyroid Disease	☐	☐	☐
Hay Fever	☐	☐	☐	Tuberculosis/Positive PPD	☐	☐	☐
Head or Neck Radiation	☐	☐	☐	Vision Problems	☐	☐	☐
Hearing Difficulty	☐	☐	☐	Other: _____	☐	☐	☐
Heart Attack	☐	☐	☐	Other: _____	☐	☐	☐

If you answered "current" or "past" to any of the above, please describe and include dates:

Sexual & Reproductive Health Services

Are you sexually active? ☐ Yes ☐ No

Do you think of yourself as:
☐ Straight or heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Queer, pansexual, and/or questioning ☐ Something else ☐ Don't know ☐ Decline to answer

How many pregnancies have you had? _____

How many live births have you had? _____

Do you need any of the following services today? Please check all that apply.

- ☐ Birth control
- ☐ Pregnancy testing
- ☐ STD testing
- ☐ HIV testing
- ☐ Pregnancy planning
- ☐ Referral for sterilization

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CONSENT TO TREATMENT

General consent to treatment

By signing below, I authorize the healthcare providers and staff at White Mountain Community Health Center (White Mountain CHC) to provide medical, dental, and behavioral health care, including examinations, diagnostic testing, treatment, and other services necessary for my care. I understand that my provider will explain:

- The nature and purpose of recommended care or treatment
- The expected benefits and potential risks or side effects
- Reasonable alternatives, including the option of no treatment

Right to refuse treatment

I understand that I have the right to accept or refuse any recommended care, treatment, or service at any time.

Participation of students and trainees

White Mountain CHC participates in healthcare education. I understand that supervised students or trainees may observe or participate in my care. I may decline their participation at any time.

Minor consents

I understand that:

- Patients age 12 and older may consent to substance use disorder treatment
- Patients age 14 and older may consent to contraception and sexually transmitted infection services

As permitted by New Hampshire law.

Medication history & treatment decisions

I authorize White Mountain CHC to access my medication history as needed for safe and effective treatment. I understand that:

- My provider will determine appropriate medications based on my current condition and medical history
- Previously prescribed medications may not be continued if not clinically appropriate

Telehealth & electronic care

I understand that some services may be provided using electronic communication methods (such as telehealth or patient portal messaging). These services will be conducted in accordance with applicable privacy and security standards.

Acknowledgment

By signing below, I acknowledge that:

- I have read and understand this Consent to Treatment
- I have had the opportunity to ask questions
- I voluntarily consent to receive care and treatment

This consent will remain in effect for **one year from the date signed,** unless revoked in writing or updated.

Patient name: _____ **Date of birth:** _____

Patient signature: _____ **Today's date:** _____

Or, signature by parent, guardian, or personal representative:

Name: _____ **Relationship to patient:** _____

Responsible party signature: _____ **Today's date:** _____

Last revised 5/4/2026

WHITE MOUNTAIN COMMUNITY HEALTH CENTER

Whole Person. Whole Family. Whole Valley.

PAYMENT AND INSURANCE INFORMATION

TODAY'S DATE	PATIENT NAME	PATIENT DATE OF BIRTH

Guarantor information

IS THE PATIENT THE GUARANTOR? *The "guarantor" is the person responsible for payment of medical bills* ☐ Yes – skip guarantor details below ☐ No – complete below		IF NO, RELATIONSHIP TO PATIENT	
GUARANTOR LAST NAME	**FIRST NAME**	**MIDDLE, SUFFIX**	**DATE OF BIRTH**
MAILING ADDRESS ☐ Same as patient city		state	zip
PHONE ☐ Same as patient	**EMAIL**		

Patient insurance information

PRIMARY HEALTH INSURANCE TYPE ☐ Private insurance ☐ Medicaid ☐ Medicare ☐ TRICARE ☐ Uninsured (skip this section)			
POLICY HOLDER NAME ☐ Patient is the policy holder			**DATE OF BIRTH**
POLICY HOLDER MAILING ADDRESS ☐ Same as patient city		state	zip
INSURANCE COMPANY	**MEMBER ID**		

DENTAL INSURANCE	
NAME ON INSURANCE CARD	
INSURANCE COMPANY	**MEMBER ID**

Please provide a copy of your insurance card(s).

We will ask for your insurance card at every visit to make sure we have the most current information

WHITE MOUNTAIN COMMUNITY HEALTH CENTER

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FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

TODAY'S DATE	PATIENT NAME	PATIENT DATE OF BIRTH

I authorize White Mountain Community Health Center (White Mountain CHC) to bill my insurance company or other third-party payer for services provided to me.

I assign payment of medical benefits directly to White Mountain CHC for services rendered.

I authorize White Mountain CHC to release any medical or other information necessary to process claims and receive payment, including information related to mental health, substance use disorder treatment, and HIV/AIDS, as permitted by law.

Financial responsibility

I understand that:

- I am responsible for charges not covered by my insurance, including copayments, deductibles, and services that aren't covered
- Insurance coverage does not guarantee payment for all services
- I am responsible for providing accurate and current insurance information
- Failure to provide updated insurance information may result in charges being billed directly to me

White Mountain CHC offers financial assistance programs, including the Sliding Fee Discount Program (SFDP), for patients who qualify. No patient will be denied access to services due to inability to pay.

Self-pay and confidential services

I understand that I may choose to pay out-of-pocket for services instead of using my insurance.

If I request that services be paid out-of-pocket in full, I may ask that this information not be shared with my health plan, as permitted by law.

Insurance accuracy

I certify that the insurance information I have provided is accurate and current to the best of my knowledge.

Confidential services for minors

For minors who consent to their own care:

- I understand that if I use a parent or guardian's insurance, an Explanation of Benefits (EOB) may be sent to them, which could disclose what services I received.
- I understand that I may ask to pay for my services in a different way to keep my care confidential.

INITIAL HERE:_____

Acknowledgement and authorization

By signing below, I acknowledge that:

- I have read and understand this form
- I agree to the financial responsibility and assignment of benefits outlined above
- I authorize White Mountain CHC to bill my insurance and receive payment directly, if I am using health insurance

Patient name: _____ Date of birth: _____

Patient signature: _____ Today's date: _____

Or, signature by parent, guardian, or personal representative:

Name: _____ Relationship to patient: _____

Responsible party signature: _____ Today's date: _____

WHITE MOUNTAIN COMMUNITY HEALTH CENTER

Whole Person. Whole Family. Whole Valley.

COMMUNICATION PERMISSIONS & AUTHORIZATION

White Mountain Community Health Center (White Mountain CHC) is committed to protecting your privacy. We will only share your health information with individuals you authorize, unless otherwise permitted or required by law.

Authorization to share information with others

"Scheduling only" means these people can make appointments, receive appointment reminders, and receive basic information
"Full medical information" means these people can receive test results, diagnoses, treatment details, and other care information

NAME	PHONE NUMBER	RELATIONSHIP	SCHEDULING ONLY	FULL MEDICAL INFORMATION
			☐	☐
			☐	☐
			☐	☐

Restrictions

Please list any individuals you do **NOT** want us to share information with:

Name: _____ Name: _____

Name: _____ Name: _____

Important information

- This authorization applies only to the individuals listed above
- This form does **not** allow those individuals to make medical decisions unless separately authorized
- This authorization will remain in effect for **one year from the date signed,** unless revoked in writing.

Acknowledgement and signature

By signing below, I…

- Authorize White Mountain CHC to share my information as indicated above
- Understand that I may revoke this authorization at any time in writing
- Understand that information shared may no longer be protected by HIPAA once disclosed.

Patient name: _____ **Date of birth:** _____

Patient signature: _____ **Today's date:** _____

Or, signature by parent, guardian, or personal representative:

Name: _____ **Relationship to patient:** _____

Responsible party signature: _____ **Today's date:** _____

Last revised 9/4/2026

AUTHORIZATON TO RELEASE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

If you are filling this out electronically, please upload the completed form to your PORTAL account. Email is not a secure way to send protected health information. Call us at (603) 447-8900 if you need help.

WHITE MOUNTAIN COMMUNITY HEALTH CENTER
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PATIENT INFORMATION

Name: _____ Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

WHO has the information you want released?

Please include essential info needed to contact the right location

☐ Name: _____

Address: _____ City: _____ State: _____

Phone: _____ Fax: _____

OR

☐ **White Mountain Community Health Center, Conway, NH 03818 Phone: (603) 447-8900 Fax: (833) 972-5530**

I hereby authorize the above named healthcare office to: ☐ **Release medical records to**

☐ **Speak/discuss with** ☐ **BOTH release medical records to and discuss medical information with**

WHO do you want to receive your records?

☐ **White Mountain Community Health Center, Conway, NH 03818 Phone: (603) 447-8900 Fax: (833) 972-5530**

OR

☐ Name: _____

Address: _____ City: _____ State: _____

Phone: _____ Fax: _____

INFORMATION TO BE RELEASED

Indicate date(s) of service to be included: **FROM: _____ TO: _____**

WHAT do you want shared?

CHECK the appropriate boxes.

Type of information to release:

- ☐ Entire medical record
- ☐ Immunization record
- ☐ Most recent history and physical
- ☐ Verbal exchange of information
- ☐ Laboratory reports
- ☐ Radiology/imaging reports
- ☐ Genetic testing
- ☐ Dental chart
- ☐ Dental X-rays
- ☐ Other: _____
- ☐ Consultations
- ☐ ER notes
- ☐ Surgical report
- ☐ Discharge summary
- ☐ Psychiatric evaluation
- ☐ Psychiatric notes
- ☐ Therapy notes
- ☐ Substance use disorder diagnosis/treatment
- ☐ HIV diagnosis/treatment

Authorization to Release Protected Information

☐ **I DO** authorize disclosure of any information relating to substance use disorder ☐ **I DO NOT**

☐ **I DO** authorize disclosure of any information relating to mental health diagnosis and/or treatment ☐ **I DO NOT**

☐ **I DO NOT** want to review mental health information before it is sent ☐ **I DO WANT TO**

☐ **I DO** authorize disclosure of information which refers to HIV infection status and/or treatment ☐ **I DO NOT**

☐ I understand that my substance use disorder treatment records are protected under Title 42 of the Code of Federal Regulations (CFR) Part 2: Confidentiality of Substance Use Disorder Patient Records and the HIPAA 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and in the event that this consent expires automatically as follows (*Specify the date, event or condition upon which this consent expires, if any*):_____.

PURPOSE OF RELEASE

Why is this info needed?

☐ Continuing care ☐ Transfer of care ☐ Personal use ☐ Legal purposes ☐ Worker's compensation claim

☐ Other: _____

Fees may be charged in accordance with state and federal statutes

I understand that:

- ☐ I can revoke all or part of this authorization at any time by notifying White Mountain Community Health Center in writing that no future disclosures should be made. This will not affect any protected health information that has already been released under this authorization.
- ☐ I can refuse to disclose some or all of the information in my record, but refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences.
- ☐ If protected health information is disclosed to a third party, the information may no longer be protected by federal or state privacy laws and may be re-disclosed by the individual or entity that receives this information.
- ☐ I am entitled to a copy of this authorization, upon request.

Accessing and obtaining your medical records is a requirement under 45 CFR 164.524 which requires that any request made to access or transfer medical records must be completed within **30 days** or a letter must be sent to the requestor stating why the records are delayed.

This authorization is effective for **1 year** from the date of signing. I authorize future disclosures to the same individual and/or entity of the same record set during this time pursuant to this authorization.

Signature: _____ **Date:** _____

Printed name of person signing (if not patient): _____

Relationship of authorized representative (e.g. parent, guardian, power of attorney): _____