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 8:30 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 indicate this to 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 a controlled substance contract is required.
- 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.

Services to Ensure Your Visit is a Great Experience

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 ban 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.

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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.

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
REVISED 12/26/2018

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.

Each time you come to **White Mountain Community Health Center**, we keep a record of your care and treatment. We take the protection of your personal information seriously. We are required to provide you with this **Notice of Privacy Practices** to tell you about our legal duties and ways we may use and share your information, and to inform you about your rights regarding your health information. We give a small number of examples to describe what the categories mean, but not every use or disclosure can be listed on this Notice.

You have a right to a paper copy of this Notice of Privacy Practices.

We will ask you to sign a written acknowledgment of receipt of our Notice. We reserve the right to change the terms of this Notice and post the current Notice in our office. You may obtain an updated Notice from our practice at any time.

How We May Use and Disclose Protected Health Information:

For Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and related services in our office or with a third party. For example, we may share your protected health information with a pharmacy for filling prescriptions, a laboratory or imaging center if you need diagnostic services, with a specialist to whom we refer you, or with a home health agency that provides care to you. We may share information with persons involved in your care, such as family members.

For Payment: We will use your protected health information to get paid for your healthcare services. We may share information with your insurance company to obtain payment for services or to seek pre-approval for a hospital stay or procedures.

For Our Healthcare or Business Operations: We may disclose your protected health information to support the business activities of this office, such as reviewing our care and our employees, for education and training, to support our electronic health record system, or for legal or accounting matters. We may use a sign-in sheet at the registration desk so that we may call you by name when we are ready to see you, and we may contact you to remind you of your appointment. If we involve third parties, such as billing services, in our business activities, we will have them sign a "business associate agreement" obligating them to safeguard your protected health information according to the same legal standards we follow.

When Allowed by Law: The law allows us to use or disclose your protected health information in certain situations, including:

- When required by state or federal law;
- To report abuse or neglect;
- To persons authorized by law to act on your behalf, such as a guardian, health care power of attorney or surrogate;
- For disaster relief purposes, such as to notify family about your whereabouts and condition;
- For public health activities such as reporting on or preventing certain diseases;
- To comply with Food and Drug Administration requirements;
- For health oversight purposes such as reporting to Medicare, Medicaid or licensing audits, investigations or inspections;
- Where required by U.S. Department of Health and Human Services to determine our compliance;
- In connection with Workers' Compensation claims for benefits; and
- To assist coroners or funeral directors in carrying out their duties.
- To comply with a valid court order, subpoena or other appropriate administrative or legal request if you are involved in a lawsuit or to assist law enforcement where there was a possible crime on the premises. We may also share your information where necessary to prevent or lessen a serious or imminent threat to you or another.
- If you are an inmate, we may release your information for your health or safety in the correctional facility; We may share your information with appropriate military entities if you are a member or veteran of the armed forces; We may be required to disclose information for national security or intelligence purposes.

With Your Authorization: Other uses and disclosures will be made only with your written authorization. For example, we will ask for your written permission before promoting a product or service to you for which we will be paid by a company, and generally

before sharing your health information in a way that is considered a sale under the law. If you sign an authorization, you may revoke it at any time, except where we have already shared your information based upon your permission.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to access, inspect and copy your protected health information.

- This usually includes medical and/or billing records. You must submit a written request to us, and you agree to pay the reasonable costs associated with complying with your request before we provide you with your record
- You may ask us to provide your electronic record in electronic format. If we are unable to provide your record in the format you request, we will provide the record in a form that works for you and our office. You may ask us to transmit your record to a specific person or entity by making a written, signed request.
- Under certain circumstances, your provider may not allow you to see or access certain parts of your record. You may ask that this decision be reviewed by another licensed professional.

You have the right to request to receive confidential communications, and request contact from us by **alternative means** or at an alternative location.

You have the right to request a restriction of your protected health information.

- This means you may ask us not to use or disclose all or part of your protected health information for certain purposes. We will consider your request carefully, and may honor reasonable requests where possible. The law does not require us to agree to every request.
- However, if you wish to restrict certain sensitive or other health information from your insurer after you or your personal representative have paid out of pocket in full for your services, please discuss this request with us. We will honor your request where we are not required by law to make the disclosure. If your insurance plan "bundles" your services together so that we cannot withhold only one item or service from your claim, we will discuss your options with you.
- You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to receive an accounting of certain disclosures we have made of your protected health information. Please speak with us if you have this request.

You may have the right to request amendment of your protected health information. While we cannot erase your record, we may add your written statement to your protected health information to correct or clarify the record where your provider approves. If the provider disapproves, you may submit a statement of disagreement and we may submit a rebuttal, which will remain with your record.

Breach notification. We are required to have safeguards in place that protect your health information. In the event that there is a breach of those protections, we will notify you, the U.S. Department of Health and Human Services and others, as the law requires.

You may file a complaint with us by notifying our Privacy Officer with your written complaint. We will not retaliate against you for filing a complaint with us or the Office of Civil Rights.

You may complain to the Office of Civil Rights at the Department of Health and Human Services (OCR) if you believe your privacy rights have been violated by us. You should contact the OCR in writing at:
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

If you have any questions about this notice, please contact:

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

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HIPAA AUTHORIZATION

I understand and acknowledge that White Mountain CHC is obligated to keep my health information confidential, but legally may use my health information for purposes of treating me, getting paid for services provided to me, or for the internal operations of the Practice such as improving care and treatment services. I understand that a detailed list of permissible uses and disclosures is included in White Mountain CHC's Notice of Privacy Practices.

Signature

By signing below, I acknowledge that I have read the above information, and that:

- I understand and agree to the above statements
- I have been given the opportunity to have my questions about this form answered
- I understand that a copy of the Notice of Privacy Practices is available by my request and is available on White Mountain CHC's website
- I understand that this document is valid for one year or until updated, whichever comes first

Patient signature: _____ Today's date: _____

The undersigned certifies that the patient is (unable to consent) (a minor) and the undersigned certifies that he/she has read and agrees to the above as the responsible party of the patient.

Responsible party signature: _____ Today's date: _____

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PATIENT REGISTRATION – MINOR OR ADULT WITH GUARDIAN

Please provide the information used with the patient's health insurance or legal identification

We recognize that for some people, the name listed on their insurance or legal ID will not match the name they go by. Please be aware that the name listed on the patient's insurance must be used on documents pertaining to insurance, billing and correspondence. If the patient's name does not match their ID, please let us know below.

LAST	FIRST	MI	DATE OF BIRTH

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

FIRST NAME	PRONOUNS

What services are the patient registering for?

☐ **Primary care** ☐ **Dental care** ☐ **Behavioral health** ☐ **Substance use disorder treatment**

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

PARENT/GUARDIAN 1			
NAME			**RELATIONSHIP TO PATIENT** ☐ Parent ☐ Guardian
PHYSICAL ADDRESS	city	state	zip
MAILING ADDRESS ☐ Same as physical	city	state	zip
MOBILE PHONE ☐ None **Ok to send automated calls?** ☐ Yes ☐ No **Ok to send automated texts?** ☐ Yes ☐ No	**HOME PHONE** ☐ Same as mobile		**WORK PHONE** (if different)
EMAIL ADDRESS *Required for patient portal registration. We also email patients occasional newsletters about goings on at the health center.*			
CONTACT PREFERENCE ☐ Mobile phone ☐ Home phone ☐ Work phone ☐ Mail ☐ Patient portal			

EMERGENCY CONTACT ☐ Parent/guardian 1 ☐ Parent/guardian 2			
PARENT/GUARDIAN 2			
NAME			**RELATIONSHIP TO PATIENT** ☐ Parent ☐ Guardian
EMAIL ADDRESS *Required for patient portal registration. We also email patients occasional newsletters about goings on at the health center.*			
PHYSICAL ADDRESS ☐ Same as parent/guardian 1	city	state	zip
MAILING ADDRESS ☐ Same as parent/guardian 1	city	state	zip
MOBILE PHONE ☐ None	**HOME PHONE** ☐ Same as mobile	**WORK PHONE** (if different)	

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 or court ordered parenting plans in effect regarding this child and you'd like the documents included in their patient records, please bring in a copy for us to scan.

If it's likely that someone else will bring this patient to appointments, please fill out the additional form to authorize that person to make medical consents on your behalf, or for patients 16+ to have unaccompanied appointments.

Demographic information

We use this information both for statistical reporting purposes and to ensure we are providing appropriate care for each person.

PREFERRED LANGUAGE

- ☐ English
- ☐ Español
- ☐ हिंदी
- ☐ українська мова
- ☐ Other: _____

ETHNICITY

- ☐ Hispanic/Latino/Latina
- ☐ Not Hispanic/Latino/Latina
- ☐ Prefer not to answer

RACE

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Guiamanian or Chamorro
- ☐ Samoan
- ☐ Black or African American
- ☐ American Indian or Alaskan Native
- ☐ White
- ☐ Black or African American
- ☐ White
- ☐ More than one race
- ☐ Prefer not to answer

SEXUAL ORIENTATION

- ☐ Lesbian or gay
- ☐ Heterosexual (straight)
- ☐ Bisexual
- ☐ Other
- ☐ Don't know
- ☐ Prefer not to answer

GENDER IDENTITY

- ☐ Female (cisgender)
- ☐ Male (cisgender)
- ☐ Female (transgender)
- ☐ Male (transgender)
- ☐ Nonbinary, genderqueer, or not exclusively male or female
- ☐ Other: _____
- ☐ Prefer not to answer

SEX ASSIGNED AT BIRTH

- ☐ Female
- ☐ Male
- ☐ Other
- ☐ Prefer not to answer

SEX ON HEALTH INSURANCE REGISTRATION OR LEGAL ID

☐ F ☐ M

IS THE PATIENT…

Homeless ☐ Yes ☐ No

A migrant or seasonal agricultural worker ☐ Yes ☐ No

A veteran ☐ Yes ☐ No

EMPLOYMENT

Current or most recent occupation:

_____

INCOME LEVEL

Household income $_____

☐ Weekly ☐ Monthly ☐ Annual

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

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: _____

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: _____

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 at White Mountain Community Health Center (White Mountain CHC) to conduct examinations, diagnostic tests and procedures to assess my healthcare conditions, and to provide care, services or therapies necessary to effectively diagnose and treat me. I understand that it is the responsibility of my treating healthcare provider(s) to explain to me the nature of proposed care, treatment, services, prescribed medications, suggested interventions, or procedures. Before I undergo particular procedures or tests, my provider(s) will explain the potential benefits, risks, or side effects, including potential problems that might occur during recuperation, the likelihood of achieving goals, reasonable alternatives, and the relevant risks, benefits, and side effects related to alternatives, including the possible results of not choosing to undergo the recommended treatment.

Right to Refuse Treatment

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my treating healthcare provider(s).

Medical Education and Participation of Students and Trainees

I understand that White Mountain CHC participates in medical education, and that authorized, appropriately supervised students and trainees may observe and assist in my diagnosis, treatment and care, unless I expressly object to their participation in my healthcare.

Minor Consents

I understand that in New Hampshire, if I am 12 years old or older, I can consent to substance use disorder treatment without the consent of a parent or guardian, and if I am 14 years old or older, I can consent to services related to contraception and sexually transmitted infections without the consent of a parent or guardian.

Medication Consent

I authorize White Mountain CHC to access my medication history. I acknowledge that my provider is not obligated to prescribe any previously prescribed medications I may be taking. I understand that there are often many options for treatment of chronic conditions and these will be reviewed at my visit.

Signature

By signing below, I acknowledge that I have read the above information, and that:

- I understand and agree to the above statements
- I have been given the opportunity to have my questions about this form answered
- I understand that this document is valid for one year or until updated, whichever comes first

Patient signature: _____ Today's date: _____

The undersigned certifies that the patient is (unable to consent) (a minor) and the undersigned certifies that he/she has read and agrees to the above as the responsible party of the patient.

Responsible party signature: _____ Today's date: _____

WHITE MOUNTAIN COMMUNITY HEALTH CENTER

Whole Person. Whole Family. Whole Valley.

PAYMENT AND INSURANCE INFORMATION (ASSIGNMENT OF BENEFITS)

Person responsible for payment (guarantor)

PATIENT NAME AND DATE OF BIRTH			PATIENT'S RELATIONSHIP TO GUARANTOR ☐ Self (skip this section) ☐ Other – 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** ☐ Same as patient		

Patient health insurance information

HEALTH INSURANCE TYPE ☐ Private insurance ☐ Medicaid ☐ Medicare ☐ Uninsured (skip this section)	
NAME ON INSURANCE CARD	
HEALTH INSURER	**MEMBER ID**

Financial agreement

I understand and acknowledge that:

- I am financially responsible for paying all costs associated with the healthcare services I receive from White Mountain Community Health Center (White Mountain CHC).
- I may be financially responsible for such costs even if I have health insurance, depending on the benefits and coverage limitations of my health insurance policy.
- I am financially responsible for charges not covered by my health insurance, including deductibles and co-payments.
- I may choose to pay privately in full for particular services if I do not wish certain sensitive health information to be disclosed to my third-party payer.
- If I fail to provide White Mountain CHC with accurate and updated insurance information, including a copy of my most recent insurance card, I will be billed for services that may otherwise be covered by insurance.

I authorize White Mountain CHC to share health information about me with my health insurance carrier(s) or other third-party payers responsible for paying for my healthcare, including specially protected information such as mental health, substance abuse, and/or HIV/AIDS information. I agree that the patient named in this form is covered by the insurer(s) that I have shared with White Mountain CHC and that I have received no notice of discontinuation of benefits. I authorize such health insurers or other third-party payers, including Medicare, Medicare and TRICARE, to pay the costs associated with my healthcare directly to White Mountain CHC or its contracted agents.

For minors consenting to healthcare services on their own behalf: I understand that if I use a health insurance policy held by my parent or guardian to pay for services, they will receive an Explanation of Benefits describing the nature of the services provided and, as a result, these services will no longer be confidential. **INITIAL HERE: _____**

Please speak with a staff member if you would like to pay for your services in a different way to keep your care confidential.

Patient signature: _____ Today's date: _____

The undersigned certifies that the patient is (unable to consent) (a minor) and the undersigned certifies that he/she has read and agrees to the above as the responsible party of the patient.

Responsible party signature: _____ Today's date: _____

WHITE MOUNTAIN COMMUNITY HEALTH CENTER

Whole Person. Whole Family. Whole Valley.

COMMUNICATION PERMISSIONS

It is the policy of White Mountain Community Health Center not to release protected health information regarding your treatment to anyone besides parents (if you are a minor), legal guardians, or other people you authorize, except in emergency situations or when otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you expect that you will need or want your medical information to be shared with anyone else, such as family members or caretakers, please indicate below. If there is a person you DO NOT want us to share medical information with, please include them as well and check "NO." Please also indicate if there are ways we should not contact you.

Permission to contact others

NAME	RELATIONSHIP	PERMISSION TO SHARE MEDICAL INFORMATION?
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO
		☐ YES ☐ NO

Permission to contact you

Please DO NOT contact me in these ways:

☐ Phone – Specify any numbers we should not call: _____

☐ Voicemail – Specify any numbers where we should not leave a voicemail: _____

☐ Text – Specify any numbers we should not text: _____

☐ Email – Specify any email addresses we should not contact you at: _____

Signature - NOT EFFECTIVE UNLESS SIGNED AND DATED

☐ By checking this box, I am revoking all previous Communications Permissions forms.

I authorize White Mountain Community Health Center to share my confidential medical information only with the people listed above for whom I have checked "YES."

Patient signature: _____ Today's date: _____

The undersigned certifies that the patient is (unable to consent) (a minor) and the undersigned certifies that he/she has read and agrees to the above as the responsible party of the patient.

Responsible party signature: _____ Today's date: _____

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 **WHAT** do you want shared? **CHECK** the appropriate boxes.	**Indicate date(s) of service to be included: FROM: _____ TO: _____** **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): _____