



www.midstatehealth.org

Dear Patient:

Welcome to Mid-State Health Center. We are pleased that you have selected us for your health care needs. Enclosed are forms for you to complete in advance, **before** arriving to your appointment. Please fill out these forms completely in blue or black ink.

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

If MSHC has a contract with your insurance company, we contract with Medicare, NH Medicaid, Anthem Blue Cross, Cigna, Harvard Pilgrim, MVP, Aetna and Tricare/Martin's Point and you have a co-pay or deductible to meet please be prepared to pay this at the time of service. If your insurance company is not listed above please contact them to make sure your visit will be covered. If your insurance is not in the list above and does not pay for office visits, if you have a co-pay, deductible, or you are uninsured; we ask that these services be paid before leaving the office. Our office accepts: personal checks, cash, Visa, MasterCard, American Express, and Discover. We offer a 20 percent prompt pay discount to self pay patients who pay in full on the day of service.

If you are scheduled with a Behavioral Health Provider please contact your insurance company prior to your appointment to obtain authorization information. Please be aware that insurance companies typically do not cover educational testing. You will be responsible for all charges not covered by your insurance company.

If you have any questions regarding your appointment or our office policy please feel free to contact our office.

Mid-State Health Center looks forward to working with you and your family. Your care and wellness are our primary goals.

Thank You,

Mid-State Health Center

Enclosures

Mailing Address – 101 Boulder Point Drive, Suite 1 Plymouth, NH 03264

Plymouth Office – Internal/Family/Pediatric Medicine & Psychology – 101 Boulder Point Drive * PH (603) 536-4000 * FAX (603) 536-4001
Bristol Office – Family Medicine – 859 Lake Street * PH (603) 744-6200 * FAX (603) 744-9024

Mid-State Health Center Patient Information Sheet

Patient Information

Today's Date: _____

Last: _____ First: _____ M.I.: _____
Sex: M F Date of Birth: _____ Social Security #: _____ Marital Status: _____
Mailing Address: _____ **Street Address:** _____
City _____ State _____ Zip _____ City _____ State _____ Zip _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
E-mail address: _____ Income: _____
Employer & Occupation: _____ **PCP:** _____
Employer Address, City, State Zip _____

Ethnicity (Check One)

- Asian African American Native American Caucasian Hispanic or Latino
 Native Hawaiian or Other Pacific Islander Other

Spouse/Guarantor Information (If patient is a minor please list both parents, if both are legal guardians)

Last: _____ First: _____ Relationship: _____
Mailing Address: _____ **Street Address:** _____
City _____ State _____ Zip _____ City _____ State _____ Zip _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer & Occupation: _____

Last: _____ First: _____ Relationship: _____
Mailing Address: _____ **Street Address:** _____
City _____ State _____ Zip _____ City _____ State _____ Zip _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer & Occupation: _____

Emergency Contacts

Contact 1: _____ Relationship: _____
Mailing Address: _____ **Street Address:** _____
City _____ State _____ Zip _____ City _____ State _____ Zip _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Contact 2: _____ Relationship: _____
Mailing Address: _____ **Street Address:** _____
City _____ State _____ Zip _____ City _____ State _____ Zip _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance Information

Primary Insurance Company Name: _____ Phone# _____
Policy Holder Name: _____ Date of Birth ____/____/____ Social Security # _____
Policy ID #: _____ **Group #:** _____
Patient's Relationship to Policy Holder: (circle one) *Self Spouse Child*
Secondary Insurance Company Name: _____ Phone# _____
Policy Holder Name: _____ Date of Birth ____/____/____ Social Security # _____
Policy ID #: _____ **Group #:** _____
Patient's Relationship to Policy Holder: (circle one) *Self Spouse Child*

Mid-State Health Center
Medical History Form

Date Primary Care Clinician _____

Name Date of Birth _____

Occupation: _____ Retired: Yes No

Education: _____

Primary Support: Spouse Parents Other _____

Marital Status: Single Married Separated Divorced Widow/Widower

Pediatric/Adolescent
Parents Marital Status: Single Married Separated Divorced Widowed
Parents Occupation: Father _____ Mother _____

I live with: _____

Number of children: Son(s) _____ Daughter(s) _____

Do you have a living will? Yes No Do you have an organ donor card? Yes No

Allergies None known

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications

Medication Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name

Date of Birth

Past Medical Diseases None known

Abdominal Pain Yes No
 Alcohol/Drug Problems Yes No
 Anemia Yes No
 Angina Yes No
 Anxiety Yes No
 Arthritis Yes No
 Asthma Yes No
 Bleeding Problems Yes No
 Cancer of _____ Yes No
 Congestive Heart Failure Yes No
 Chronic Bronchitis Yes No
 Depression Yes No
 Diabetes Yes No
 Emphysema Yes No
 Gall Bladder Disease/Stones.. Yes No
 Glaucoma Yes No
 Gout Yes No
 Hay Fever Yes No
 Head or Neck Radiation..... Yes No

Hearing Difficulty..... Yes No
 Heart Attack..... Yes No
 Heart Murmur Yes No
 Hemorrhoids Yes No
 Hepatitis/Yellow Jaundice..... Yes No
 High Blood Pressure Yes No
 High Cholesterol Yes No
 Kidney Disease Yes No
 Kidney Stones Yes No
 Pneumonia Yes No
 Reaction to Anesthesia..... Yes No
 Rheumatic Fever Yes No
 Skin Disease/Dermatitis Yes No
 Stomach Ulcers..... Yes No
 Thyroid Disease Yes No
 Tuberculosis/Positive PPD..... Yes No
 Vision Problems Yes No
 Other: _____
 Other: _____

Hospitalization (Non-Surgical)

Date	Diagnosis	Hospital	Attending Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Surgical History

Date	Procedure	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

List any diseases that your relatives have

Father _____
 Mother _____
 Brother(s) _____
 Sister(s) _____
 Son(s) _____
 Daughter(s) _____

Immunizations (include dates) Hepatitis B _____ Influenza _____ TB test/results _____
 DPT/Td (tetanus) _____ OPV (Polio) _____ MMR (measles, mumps, rubella) _____
 Varicella _____ Other _____

Name

Date of Birth

Health Screening

When was your most recent?

	Date		Date
Pap Smear	_____	Stool Check for Blood	_____
Mammogram	_____	Cholesterol Check	_____
Breast Exam	_____	Fasting Blood Sugar	_____
Prostate Exam	_____	Sigmoidoscopy/Colonoscopy	_____

Behavioral Health History

Have you ever received psychiatric, psychological, or substance abuse help or counseling of any kind before?

YES NO If yes, please list and explain:

Date or Age	Reason	With Whom
_____	_____	_____
_____	_____	_____
_____	_____	_____

Over the last 2 weeks, how often have you been bothered by:

- 1. Little interest/pleasure in doing things? None Several Days More than 1/2 the days Nearly every day
- 2. Feeling down/depressed/hopeless? None Several Days More than 1/2 the days Nearly every day

Please circle any of the following that you feel are currently problematic:

- | | | | |
|------------------------|----------------------|-----------------------|--------------------------|
| 1. Nervousness/Anxiety | 11. Depression | 21. Fears | 31. Inferiority Feelings |
| 2. Shyness | 12. Sexual Problems | 22. Suicidal Thoughts | 32. Nightmares |
| 3. Drug Use | 13. Marriage | 23. Unhappiness | 33. Sexual Abuse |
| 4. Anger | 14. Alcohol Use | 24. Work | 34. Temper |
| 5. Irritability | 15. Sleep | 25. Self Control | 35. Appetite |
| 6. Money Problems | 16. Making Decisions | 26. Relaxation | 36. Emotional Abuse |
| 7. Stress | 17. Concentration | 27. Legal Matters | 37. Children |
| 8. Headaches | 18. Health Problems | 28. Energy Tiredness | 38. Physical Abuse |
| 9. Memory | 19. Stomach Problems | 29. Loneliness | 39. Parents |
| 10. Insomnia | 20. My thoughts | 30. Education | 40. Other: _____ |

Would you like to talk with a behavioral health consultant in the clinic about any of the above problems?

YES NO

Health Risks

- Do you wear seatbelts? YES NO
- Do you wear a bike helmet? YES NO
- Do you use tobacco? YES NO If yes, how many packs per day? _____
- Do you drink alcoholic beverages? YES NO If yes, how many drinks per day? _____
- Do you drink caffeine beverages? YES NO If yes, how many cups per day? _____
- Is there a gun in your home? YES NO If yes, is it locked/secured? _____
- Do you use drugs? YES NO If yes, explain: _____
- Are you in a relationship in which you are being physically hurt (slapped, kicked, punched, and bruised) by someone? YES NO
- Do you feel afraid of your partner? YES NO If yes, explain: _____

Mid-State Health Center
Pain Management Philosophy and Policy

If you have chronic pain, you know how it affects every area of your health and your life in negative ways. Having the pain go away entirely is not usually possible, but finding ways to manage the pain and live with it is possible. Mid-State Health Center's goal is to help you reach your highest level of functioning and quality of life, even if you have chronic pain.

Successful pain management depends on a treatment plan that:

1. is designed especially for you, based on your own special situation, AND
2. has the right balance between the risks of treatment (especially medications) and your overall health and function.

To create this type of plan, Mid-State will start with a complete evaluation of your pain problem. We will obtain a complete history, do a physical exam, obtain and review previous records, and order and review any additional lab tests and/or x-rays that may help define the problem. What you want to get out of treatment will also play an important part of this evaluation. Along with your clinician's guidance, your treatment goals will become part of your overall plan.

You and your clinician will measure the success of the treatment plan against these goals. It will be important for you to follow-up with your clinician when scheduled to make decisions about treatment success and to refine your plan, if needed.

Narcotic medications can be part of the treatment plan, but only after all other treatment options have been tried. If narcotics are prescribed as part of your treatment plan, you will be required to participate in the following, special monitoring activities, to ensure safe use of the medication:

1. evaluation for addiction risk by the Mid-State Behavioral Health staff, prior to the time of the initial prescription,
2. urine drug screening prior to the initial prescription, and
3. urine drug screening at subsequent visits, as determined by your clinician.

Narcotics will not be continued unless there is an improvement in function and pain noted by you or your clinician.

Mid-State Health Center

Authorization to Release Patient information to Mid-State Health Center

Patient Name _____

Date of Birth _____

I hereby authorize (fill in where you are requesting records from)

Name Address City State Zip

Telephone Number _____

Fax Number _____

to disclose the above named individual's health information as described below: ___ VERBAL ONLY ___ RECORDS ONLY ___ BOTH

Date(s) of Service Requested (if known): _____

Description of Information to be released: (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Most recent history and physical | <input type="checkbox"/> Behavioral Health treatment & evaluation records |
| <input type="checkbox"/> Laboratory reports | <input type="checkbox"/> Consultations | <input type="checkbox"/> Entire Medical Record |
| <input type="checkbox"/> Radiology/Imaging Reports | <input type="checkbox"/> Progress notes | |
| <input type="checkbox"/> Verbal exchange of information | <input type="checkbox"/> Other _____ | |

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome ("AIDS"), or Human Immunodeficiency Virus ("HIV"), behavioral or mental health, alcohol/drug abuse or any such related information.

This information may be disclosed to and used by the following individual or organization:

(circle office you would like records sent to)

Mid-State Health Center

101 Boulder Point Dr, Suite 1
Plymouth, NH 03264

Phone Number (603) 536-4000

Fax Number (603) 536-4001

Mid-State Health Center

859 Lake Street
Bristol, NH 03222

Phone Number (603) 744-6200

Fax Number (603) 744-9024

Description of purpose of the use and/or disclosure:

- | | | |
|---|---|--|
| <input type="checkbox"/> Continuing care | <input type="checkbox"/> Second opinion | <input type="checkbox"/> Personal use |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Insurance | <input type="checkbox"/> ARCHIVE FILES |
| <input type="checkbox"/> Legal purposes | <input type="checkbox"/> Social Security/Disability | |
| <input type="checkbox"/> Other: Please describe _____ | | |

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until _____

I understand that I may revoke this authorization at any time by notifying the facility from which I am requesting my health information. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient or Patient's Representative

Date

Printed Name of Patient or Patient's Representative

OR

Relationship to Patient

Legal Authority (attach supporting documents)

**COMMUNICATION DIRECTIVE, CONSENT FOR TREATMENT,
INSURANCE AUTHORIZATION AND ASSIGNMENT:** (Must be signed and dated before treatment.)

Name _____ Date of Birth _____

Please Check how you would like us to send your confidential health care information. Check all that apply.

You may email* me at (address) _____

***PLEASE NOTE THAT THE CONFIDENTIALITY OF ELECTRONIC COMMUNICATIONS CANNOT BE GUARANTEED.**

You may phone me at: _____ (daytime)

You may leave a phone message:

on my answering machine at _____

with another person at _____

Please list all individuals that may obtain your information, including any and all legal guardians if (a minor) or (unable to consent).

Name _____	Relationship _____	Phone # _____
Name _____	Relationship _____	Phone # _____
Name _____	Relationship _____	Phone # _____
Name _____	Relationship _____	Phone # _____

1. CONSENT TO DIAGNOSTIC TESTS, PROCEDURES, AND TREATMENT:

I consent to care involving routine diagnostic tests, procedures, and treatment as performed or ordered by the clinicians at Mid-State Health Center, including their assistants or designees, including testing for the human immunodeficiency virus (HIV) if a clinician is testing for diagnostic purposes or if there has been an exposure to health care personnel. No guarantee has been given to me as to the results that may be obtained from my care.

2. NOTICE OF PRIVACY PRACTICES:

By my signature below, I acknowledge that I have read and/or received and agree to the terms of the Notice of Privacy Practices and Patient Rights and Responsibilities from Mid-State Health Center. I also acknowledge that I have read and/or received and agree to the terms of the treatment agreement.

3. FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS:

I agree that I am responsible for payment of my bills from Mid-State Health Center and the designees. I have read and/or received a copy of the Summary of Payment and Billing Policy for Mid-State Health Center. I understand that I am solely responsible for collecting insurance claims or negotiating a settlement on all disputed claims. I also understand that any unpaid account may be assigned to a collection agency or attorney for collection, agree to the assignment of all third party payor benefits Mid-State Health Center, its clinicians, or independent providers.

I agree that a copy of this consent, release and assignment of benefits may be used in place of the original. I understand that I am entitled to a copy of same if I make such a request and that this consent release, and assignment are valid until rescinded in writing or replaced by one of a later date.

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 _____ Date _____