MID-STATE HEALTH CENTER
Where your care comes together.

101 Boulder Point Drive, Suite 1
Plymouth, NH 03264
603-536-4000
midstatehealth.org

Welcome!
New Patient Information

Getting Started as a New Patient at Mid-State

- Please review this important information, complete all forms, including the record release, and send it to our office.
- Once your paperwork arrives, we will contact your last provider for your records. This process can take up to 30 days.
- We will contact you to schedule your first visit as soon as we receive your records.
- If you have an urgent or immediate health concern before your records arrive, please let us know and we will do our best to get you in as soon as possible. Generally, we are able to accommodate urgent visits within a day or so. It is still important for you to schedule your "establish care" visit with your selected provider once we receive your records.
- If you have any questions or need assistance, please contact our Community Access Team at 603-536-4000 Ext: 1380.

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 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, our Community Access Team would be happy to assist you, call 536-4000 Ext: 1380.

How Your Mid-State Care Team Works for You

- Mid-State's providers work in teams to 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 Mid-State Care Team will work with you to connect with any specialists or other providers you see outside of Mid-State to help in coordinating your care. When you see other healthcare providers outside of Mid-State, it is important for you to ask them to share your health information from the visit with your primary care provider here at Mid-State.

Important Information for Your First Visit

Bring with you all of the following:

- ☐ Please complete all forms and bring them with you (if you have not already submitted them),
- ☐ Photo ID,
- ☐ Insurance card(s),
- ☐ List of all your medications and supplements or the bottles, and
- ☐ Any other documents you feel are important to your visit.

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

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Locations and Hours

PLYMOUTH OFFICE	BRISTOL OFFICE
101 Boulder Point Drive, Suite 1 Plymouth, NH 03264 (603) 536-4000	100 Robie Road Bristol, NH 03222 (603) 744-6200
OFFICE HOURS: MON - THUR: 7:30am – 5:30pm FRI: 8am – 5pm SAT: 8am – 12pm	**OFFICE HOURS:** MON - WED: 7:30am – 5:30pm THUR & FRI: 8am – 5pm Saturday hours are available in our Plymouth Office 8am – 12pm.
LAB HOURS: MON – FRI: 7:30 – 11:45 am and 1:15 – 4:00 pm	**LAB HOURS** MON – FRI: 7:30 - 11:45 am and 1:15 – 4:00 pm

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.
- Bring a list of your current medications and information about any recent healthcare services you have received outside of Mid-State.
- 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.
- 24-Hour Access to Advice: Our on-call clinicians provide Mid-State patients advice by phone for urgent health concerns 24-hours a day, 7-day a week.

If you need to reschedule or cancel an appointment

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

Important: To avoid charges for a late cancelled (or missed appointment), please be sure to cancel your appointment. Minimum times for cancellation are:

Appointment Type	Minimum time to reschedule or cancel to avoid charges
Medical	4 hours prior to appointment time
Behavioral Health	4 hours prior to appointment time
Dental	24 hours prior to appointment time

Note: Three or more late cancelled or missed appointments in one year, may result in termination from the practice.

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Prescribing Medications at Your First Visit

Mid-State recognizes that medications are often used to manage health conditions. In order to ensure you have the correct medications for your conditions and health concerns, the following will be considered 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 Mid-State's policy for prescribing controlled medications and completion of a controlled substance contract is required.
- Mid-State's providers cannot prescribe any controlled substance to someone who uses marijuana.
- *NOTE: Due to Federal regulations, Mid-State's Providers are NOT able to write prescriptions for cannabis or marijuana in any form.*
- Any medications prescribed must be deemed appropriate by your Mid-State provider for your current condition(s) and based on your medical history.
- Your new Mid-State 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.

Services to Ensure Your Visit is a Great Experience

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

Español (Spanish) Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Français (French) Attention: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.

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: Mid-State offers assistance in enrolling in a variety of coverage options, prompt payment discounts, and offers a sliding fee scale to those who qualify. To begin the eligibility process, please call our Patient Account Representatives at 603-536-400 and they will gladly assist.

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.

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We Welcome All People

Mid-State Health Center complies with applicable Federal civil rights laws and does not discriminate on the basis of color, race, national origin, age, disability, or sex.

Payment Options for Your Care

Mid-State accepts 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 Community Access Team at 536-4000 Ext: 1380.

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.
- If you are uninsured, we offer a 30% "prompt pay" discount to self-pay patients who pay in full on the day of service (excludes all dental services and sliding fee scale fees).
- 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, Mid-State offers a sliding fee scale to those who qualify. To determine if you might be eligible, our sliding fee scale for services is publicly posted in our lobby and on our website in the Payment and Insurance section. To learn more or begin the eligibility process, please call our Patient Account Representatives at 603-536-4000 and they will gladly assist.

Behavioral Health Appointments – 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 are often different from your medical visit coverage.
- Educational testing is not typically covered by insurance. You will be responsible for all charges not covered by your insurance company.

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

Name: _____ **Date of Birth:** _____

Please Check ☒ and enter information for preferred method of contact:

☐ Home Phone _____
☐ Work Phone _____
☐ Cell Phone _____
☐ Mail _____
☐ MSHC Online (please provide email address) _____

Can messages be left at any of the above? Yes ☐ ***No*** ☐

Please list all individuals that may obtain your information, including *any* and *all* legal guardians if the patient is 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, including psychiatric care and the prescribing of medications 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. If psychiatric medications are prescribed, I agree to discuss these medications with the psychiatrist to clearly understand their risks and potential benefits or alternatives.

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 bills from Mid-State Health Center and 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 an agency or attorney for collection, agree to the assignment of all third party payor benefits to Mid-State Health Center, its clinicians or 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 _____ **Today's Date** _____

Mid-State Health Center
Patient Registration

Services Requested

Services Requested (Check all that apply): ☐ Medical ☐ Behavioral Health ☐ Dental (Bristol Office)

Who is your preferred Mid-State Primary Care Provider: _____

Patient Information

Prefix: ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss ☐ Other: _____

Last Name: _____ First Name: _____ M.I.: _____ Suffix: _____

Preferred/Nick Name: _____ Preferred Pronoun: ☐ He ☐ She ☐ Other _____

Legal Gender: ☐ Female ☐ Male Social Security # ___ - ___ - ___ Date of Birth ___/___/___

Phone: Home (___) _____ Cell (___) _____ Work (___) _____

Mailing Address: _____ City: _____ State: _____ Zip _____
☐ Street address is the same as mailing address

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

Preferred Language: ☐ English ☐ French ☐ Spanish ☐ Other: _____
Do you wish to have translation/interpreter services for your visits? (Offered at no cost - prior notice required): ☐ Yes

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow/Widower ☐ Other: _____

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Other: _____

Ethnicity: ☐ Hispanic/Latino/Latina ☐ Not Hispanic/Latino/Latina

Have you ever served in the military? ☐ Yes ☐ No If yes, what is your current status: _____

Emergency Contact (person we contact only in an emergency):

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip _____

Phone: Home (___) _____ Cell (___) _____ Work (___) _____

Statistical Information As a Federally Qualified Health Center, Mid-State is *required* by Federal Law to collect the following information for *statistical purposes only*. *Individual patient information is NOT reported or disclosed*. Thank you for your cooperation.

Are you: Homeless? ☐ Yes ☐ No A Migrant/Seasonal Worker? ☐ Yes ☐ No

Income: ☐ 0-$24,999 ☐ $25,000-$49,999 ☐ $50,000-$74,999 ☐ $75,000-$99,999 ☐ $100,000 or more

Household Size: Number of people in household including yourself: _____

Patient Health Information

Last Name: _____ First Name: _____ M.I.: _____ Suffix: _____

Date of Birth _____ Primary Support: ☐ Self ☐ Spouse ☐ Parents ☐ Other: _____

Occupation: _____ Retired: ☐ Yes ☐ No ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐ Other _____

Do you think of yourself as: ☐ Straight or Heterosexual ☐ Lesbian, Gay, or Homosexual ☐ Bisexual ☐ Something else ☐ Not sure

Do you identify as transgender or transsexual? ☐ Yes ☐ No ☐ Not sure

Patient's number of children: Daughter(s): _____ Son(s): _____

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

ONLY for Patients Under the age of 18 years old, please complete the following:

Parent's Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Re-married ☐ Widow/Widower ☐ Other _____

I live with(their name): _____ Relationship to you: _____

Current Medications & Supplements

Medication/Supplement Name	Dosage	Frequency	Medication/Supplement Name	Dosage	Frequency

Allergies

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

List what you are allergic to:	Reaction:

Hospitalizations (Non-Surgical Only)

Date	Reason (Diagnosis)	Hospital	Attending Physician

Patient Name: _____ Date of Birth: _____

Surgical History

Date	Procedure/Surgery	Hospital	Physician

Current and Past Medical Conditions – Check all that apply

Alcohol/Drug Problems	☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Hemorrhoids	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Hepatitis/Yellow Jaundice	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Bleeding Problems	☐ Yes	☐ No	HIV	☐ Yes	☐ No
Cancer of _____	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No	Kidney Stones	☐ Yes	☐ No
Chronic Bronchitis	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Reaction to Anesthesia	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Emphysema/COPD	☐ Yes	☐ No	Skin Disease/Dermatitis	☐ Yes	☐ No
Gall Bladder Disease/Stones	☐ Yes	☐ No	Stomach Ulcers	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Gout	☐ Yes	☐ No	Tuberculosis/Positive PPD	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Vision Problems	☐ Yes	☐ No
Head or Neck Radiation	☐ Yes	☐ No	Other: _____	☐ Yes	☐ No
Hearing Difficulty	☐ Yes	☐ No	Other: _____	☐ Yes	☐ No

Family History

List any diseases that your 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 (_____)
☐ Other: _____ (_____)
☐ Tetanus/Pertussis (DTap) (_____)
☐ Chicken Pox (Varicella) (_____)
☐ Measles,Mumps,Rubella (MMR) (_____)
☐ Tuberculosis (TB) Test: ☐ Negative ☐ Positive (_____)

Health Screenings (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 (_____)
☐ Diabetes Screening (☐ fasting blood sugar or ☐ HgbA1c) (_____)

Payment Information

Party Responsible for Payment: ☐ Self ☐ Parent ☐ Spouse ☐ Other: _____

Complete this section about the person responsible for payment ONLY if someone other than the patient

Full Name (of person responsible for payment): _____

Relationship to Patient: _____ Social Security # ___ - ___ - ____ Date of Birth ___ / ___ / ____

Phone: Home (___) _____ Cell (___) _____ Work (___) _____

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

☐ Street address is the same as mailing address

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

Insurance Coverage Information

Patient Insurance Coverage: ☐ Insured ☐ Insured, but with high deductibles ☐ Uninsured

☐ Please check here if the patient (or person responsible for payment) would like to meet with a Patient Account Representative to discuss payment options or to determine if the patient is eligible for Mid-State's sliding fee scale program.

We can help. Mid-State offers a variety of payment options for those patients who have insurance plans with high deductibles or no insurance.

Primary Insurance: _____ Phone: (___) _____

Policy ID#: _____ Group#: _____ Co-pay for Office visit: $ _____

Policy Holder's Name: _____

If the policy holder is not the patient, please complete the following information about the policy holder:

Relationship to Patient: _____ Social Security # ___ - ___ - ____ Date of Birth ___ / ___ / ____

Secondary Insurance: _____ Phone: (___) _____

Policy ID#: _____ Group#: _____ Co-pay for Office visit: $ _____

Policy Holder's Name: _____

If the policy holder is not the patient, please complete the following information about the policy holder:

Relationship to Patient: _____ Social Security # ___ - ___ - ____ Date of Birth ___ / ___ / ____

How did you hear about Mid-State: ☐ Friend/Relative ☐ Online Search ☐ Newspaper

☐ Facebook ☐ Mid-State's Website ☐ Emergency Room ☐ Other: _____

Mid-State Health Center

Authorization to Release Patient information **TO** Mid-State Health Center

Patient Name:_____ Date of Birth:_____

Release Previous Medical Records From (Organization/Provider):

Name of Organization/Provider: _____

_____

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)

☐ Entire medical record	☐ Verbal exchange of information	☐ Progress notes
☐ Immunization record	☐ Most recent history and physical	☐ Behavioral Health treatment & evaluation records
☐ Laboratory reports	☐ Consultations	☐ Copy of dental chart
☐ Radiology/Imaging reports		☐ Copy of dental x-rays

☐ 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"), or genetic testing. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

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

Mid-State Health Center
101 Boulder Point Drive Suite 1
Plymouth, NH 03264
Phone Number (603) 536-4000 Fax Number (603) 536-4001

****If there are fees associated with this request, please contact our office prior to processing.***

Description of purpose of the use and/or disclosure:

☐ Continuing care	☐ Second opinion	☐ Personal Use
☐ Consultation	☐ Insurance	☐ ARCHIVE FILES
☐ Legal purposes	☐ Social Security/Disability	

☐ 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 _____ (date or event).

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)