

Thank you for choosing Mid-State Health Center to care for your health needs.

Our goal at Mid-State is to provide top-notch care to each of our patients, Mid-State has a team of highly skilled providers and a variety of services available to help you achieve your health goals. Our Health Navigator Team will assist you in finding a provider that best meets your health goals.

To get started, please complete and return the attached forms to our office:

- New Patient Registration Form** (includes important information about you)
- New Patient Health History Form** (includes important information about your health)
- Protected Health Information Release Authorization** (allows up to obtain your previous health records)

Optional Forms:

- Designation of a Personal Representative**

Please complete and sign each of these forms and return to Mid-State Health Center within 30 days of receiving them.

Completed forms can be returned to Mid-State via:

- Email: healthnavigators@midstatehealth.org
 - Fax: 603-536-4001
 - Mail: Mid-State Health Center, Attn: Health Navigators, 101 Boulder Point Drive, STE 1
Plymouth, NH 03264
 - Or dropped at any of our locations.
-

Once we receive your completed paperwork our team will contact you to schedule an appointment.

Please note that receiving your medical records from your previous provider may take up to 30 days. If you have an **immediate health concern before your first visit**, please call our office.

If you have any questions, or need assistance in completing paperwork, please contact our Health Navigator Team by calling 603-536-4000 Ext. 1550.

Wishing you good health,

The Mid-State Health Center Team

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 patient): _____

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

We can help. Mid-State offers a variety of payment options for those patients who have insurance plans with high deductibles or no insurance. Visit our website at midstatehealth.org for more information.

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.

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
- Radio
- Social Media
- Mid-State's Website
- Emergency Room
- Other: _____



Patient Name: _____ Date of Birth: _____

SURGICAL HISTORY (please complete to the best of your ability)

Date	Procedure/Surgery	Hospital	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CURRENT AND PAST MEDICAL CONDITIONS – PLEASE CHECK ALL THAT

Alcohol/Drug Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis/Yellow Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer of _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congestive Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Stones	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Enlargement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reaction to Anesthesia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eating Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
GERD/Acid Reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis / Positive PPD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Difficulty	<input type="checkbox"/> Yes <input type="checkbox"/> No		

FAMILY HISTORY

List disease that your relatives have / had:

Father: _____

Mother: _____

Sibling(s): _____

Son(s): _____ Daughter(s): _____

IMMUNIZATIONS

Immunizations Attached	<input type="checkbox"/>	Tetanus/Pertussis (DTap)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chicken Pox (Varicella)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles, Mumps, Rubella (MMR)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Polio (OPV)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Other: _____	
Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No		
COVID-19	<input type="checkbox"/> Yes <input type="checkbox"/> No		

HEALTH SCREENINGS (please complete to the best of your ability)

<input type="checkbox"/> Physical Exam _____	<input type="checkbox"/> Colonoscopy _____
<input type="checkbox"/> Cholesterol Check _____	<input type="checkbox"/> PSA Test / Prostate Cancer Screening _____
<input type="checkbox"/> HIV Screening _____	<input type="checkbox"/> Diabetes Screening _____
<input type="checkbox"/> Hep C Screening _____	(<input type="checkbox"/> fasting blood sugar or <input type="checkbox"/> HgbA1c)
<input type="checkbox"/> Mammogram _____	
<input type="checkbox"/> Pap Smear _____	

PATIENT HEALTH INFORMATION

Primary Support: Self Spouse Parents Other: _____

Occupation: _____ **Retired?** Yes No

Do you think of yourself as: Straight or Heterosexual Lesbian, Gay, or Homosexual Bisexual
 Something else Other

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

CURRENT MEDICATIONS AND SUPPLEMENTS

Medication / Supplement Name	Dosage	Frequency	Prescribing Provider

If you have any more medications/supplements than space allows, please attach a full and complete list

ALLERGIES

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

HOSPITALIZATIONS (NON-SURGICAL ONLY)

Date	Reason (Diagnosis)	Hospital	Physician

THIS SECTION FOR ONLY PATIENTS UNDER THE AGE OF 18

Parent's Marital Status:

Single Married Divorced Widow/Widower Other: _____

I live with: Name: _____ Relationship to You: _____



Patient Name: _____	DOB: _____
Address: _____	City: _____
State: _____	Zip: _____ Phone Number: _____

I hereby designate the following Personal Representative to **assist me in exercising my health information rights**, related to care received at Mid-State Health Center, under the New Hampshire Patient’s Bill of Rights (NH RSA 151:19-21) and the Federal Privacy Rule (45 CFR 164.502(g)).

You may nominate a Personal Representative to assist in obtaining and receiving services at MSHC. This Personal Representative does not have equal rights and responsibilities as a Durable Power of Attorney. The Representative can only assist in exercising your health information rights.

My designated Personal Representative is:		
Name: _____	Phone: _____	Relation to patient: _____
Address: _____	City/ State: _____	Zip Code: _____

I request that my Personal Representative be allowed to assist me in exercising the following rights related to my **protected health information (PHI)**: (check all that apply)

- ___ The right to execute, on my behalf, any medical consents, or other documents that may be required in order to exercise my health information rights; (including sliding fee application)
- ___ The right to request and obtain a copy of my **medical records** and other PHI
- ___ The right to request an amendment of any of my protected health information and/or request an accounting of disclosures of my protected health information
- ___ The right to **communicate verbally** regarding my appointments; (cancel, schedule or reschedule)
- ___ The right to have verbal discuss my health concerns with my provider and care team
- ___ Other (please specify): _____

Restriction(s): _____

- No expiration Date
- Expires on (MM/DD/YYYY): _____

I understand if I wish to revoke personal representative designation, I must deliver notice of written revocation to: Mid-State Health Center – Health Information Management. I understand that it is my responsibility to notify my designee that I have revoked their personal representative designation. Submitting additional Personal Representative Forms will **NOT** revoke existing forms.

Patient’s Name (**Print**) Date: _____

Patient (**Signature**) / Legal Guardian (Signature) Printed Legal Guardian’s Name (If Applicable)



Patient Name: _____ **DOB:** _____

Instructions: Complete **ALL** sections to have information disclosed **FROM** and/or **TO** Mid-State Health Center (MSHC). Refusal to complete this form will not affect the quality or access to care, condition of treatment, payment, enrollment or eligibility for benefits.

1. Who is permitted to send and receive your personal health information?

	Name:	Address:	Phone #	Fax #
<input type="checkbox"/> FROM: <input type="checkbox"/> TO:	Mid-State Health Center	101 Boulder Point Dr, Suite 1 Plymouth, NH 03264	603-536-4000	603-536-4001
<input type="checkbox"/> FROM: <input type="checkbox"/> TO:				

2. What records would you like to share?

(Check all that apply) Medical Behavioral Health Dental Physical Therapy

A. Type of information to be released:

___ Office Visit Notes ___ Immunizations ___ Laboratory ___ Medication Lists
___ Radiology Reports & Images ___ Other: _____

B. Time period or date of information to be released: (MM/YY) From: _____ To: _____

3. Why is this information being released?

A. I request that the information be released for the following purpose: **(Initial)** all that apply)

___ Transfer of Care ___ School ___ Attorney/ Legal * ___ Insurance/Billing/Financial
___ Continuing Care ___ Disability ___ Personal Use ___ Other: _____

B. All **record requests** will be delivered via fax or mail unless otherwise specified. Please initial requested delivery method:

___ In Office Pick-Up (valid photo ID required) ___ Patient Portal ___ Encrypted Email ___ Other: _____

*I understand that a processing **fee may apply** for the requested information.

4. Patient Acknowledgement

This authorization form does not authorize the release of Substance Use Therapy Records. A separate Authorization to Disclose Substance Use 42 Part 2 Form must be completed. Psychotherapy notes will not be included unless authorized by provider under 45 CFR 164.508(a)(2).

- ❖ I understand that the information in my health record may include information relating to or referencing: Genetic counseling; Human Immunodeficiency Virus (HIV) or acquired immunodeficiency syndrome (AIDS) treatment; history of drug or alcohol abuse; mental, behavioral health, or psychiatric care; and/or other sensitive information.
- ❖ I understand that I may revoke this authorization in writing at any time, except to the extent that MSHC has relied on this authorization. The written revocation should be addressed to the Health Information Management Department. Unless otherwise revoked, I understand that the date upon which this authorization **expires is 180 days** unless otherwise specified _____.
- ❖ I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA).

Patient's Printed Name:

Patient's Signature:

Date:

Legal Representative's Printed Name:

Legal Representative's Signature

Date:

(Proof of legal authority may be required)

Return Form To:

Mid-State Health Center – Release of Information

101 Boulder Point Dr, Suite 1, Plymouth, NH 03264

Phone: 603-536-4000 x1500, **Fax:** 603-536-4001, **Email:** medicalrecords@midstatehealth.org



MID-STATE HEALTH CENTER
101 Boulder Point Drive, Suite 1
Plymouth, NH 03264
P: 603-536-4000 | F: 603-536-4001

**Mid-State Health Center: Consent to Treat,
Guarantee of Payment, and
Acknowledgment of Notice of Privacy Practices**

Patient's Printed Name

DOB

CONSENT TO TREAT:

I, the patient identified below or the parent or legal guardian of the patient identified below (the "Patient"), consent to receive health services from Mid-State Health Center ("MSHC"). This service may include diagnostic tests and/or procedure(s), treatments and/or tests that a physician, nurse practitioner(s), clinician, and other professional staff member(s) (each a "Provider") deems to be necessary and advisable in regards to my specific care plan. The name, credentials, licensure/certification, and/or qualifications of the Provider providing my care is available upon request.

I understand that services may include routine or specialized diagnostic tests and procedures up to and including diagnostic x-rays, the administration or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examinations. I understand that no guarantees have been made to me as to the results or effectiveness of treatments or examinations performed by MSHC personnel.

I understand that as part of the diagnostic process, my health condition may necessitate that the Provider obtain a photograph or image in certain situations (i.e., wound care). I consent and agree to the use of this image and acknowledge that it may be necessary when providing quality healthcare services. I understand that all or a part of the image may become part of my medical record.

I acknowledge that in cases where the Patient discloses the intent to harm to self or others, or instances of past or present child neglect or abuse, disclosure and/or mandated reporting may result in accordance with applicable local, state or federal law and/or MSHC's policies and procedures.

I authorize MSHC to retrieve and store relevant treatment history through a health information exchange as permitted by state law and to use and disclose PHI as permitted under the Health Insurance Portability and Accountability Act ("HIPAA"), HITECH, other applicable law, and by MSHC's Notice of Privacy Practices. I understand that I may choose to opt out of the health information exchange, pursuant to applicable state law.

I understand that I will have access to my medical record through MSHC's Patient Portal. I may obtain copies of such records from the Patient Portal for my own use. Alternatively, I may request a copy of my medical records by filling out an Authorization to Release Protected Health Information through the Health Information Management (HIM) department. A form is available through www.midstatehealth.org, emailing medicalrecords@midstatehealth.org or by calling (603) 536-4000.

Medical/ Behavioral Health Visits for Adolescent during School Hours

I understand that, in some instances, such as when the Patient is in school or elsewhere, that the parent or legal guardian may not be available to accompany the adolescent to an appointment. If the patient is over 16 years old and if I so choose to allow them to attend an appointment without a parent or legal guardian present, I will complete an Authorization to Treat a Minor Child Form in advance and submit to MSHC's HIM Department.

I understand that the Provider will not prescribe to the Patient any new medications or controlled substances under federal law, without consulting and getting informed consent of the parent or guardian.

I agree that MSHC will not be held responsible for any accidents, events or incidents that may occur before or after the office visit or during transportation to the Patient's appointment.

**Mid-State Health Center: Consent to Treat,
Guarantee of Payment, and
Acknowledgement of Notice of Privacy Practices**

II. RELEASE OF INFORMATION: I hereby consent to the use and disclosure of the Patient's health information for purposes of treatment, payment and to facilitate MSHC's health care operations as described in the Notice of Privacy Practices. I hereby authorize and direct MSHC to release to government agencies, insurance carriers, managed care companies, or other entities who are or may be financially liable for the Patient's medical care (and to authorized agents of such entities) all information needed to substantiate payment for this medical care and to permit representatives thereof to examine and request copies of records related to the Patient's case and medical treatment. I further authorize MSHC to release billing information to any healthcare provider the Patient chooses or who may be involved in the Patient's care.

III. ASSIGNMENT: I hereby assign, transfer and set over to MSHC sufficient monies and/or benefits to which I am or may be entitled from government agencies, insurance carriers, or others who may be financially responsible for the Patient's medical care to cover costs of the care and treatment rendered.

IV. PATIENT GUARANTEE OF PAYMENT: I accept that I am financially responsible for all services rendered on the Patient's behalf for which a charge may be associated. I accept personal responsibility for all co-payments, deductibles, and non-covered services, as dictated by my or the Patient's insurance coverage (hereinafter, the "insurance plan"), plus any collection costs for amounts personally owed by me. I acknowledge that there may be services provided by MSHC that may not be covered by the insurance plan for one or more reasons, including but not limited to exclusions under the insurance plan, exhaustion of benefits, the insurance plan's designation of MSHC as an out-of-network provider, and/or my failure to provide the insurance card. I understand that if I do not fulfill the requirements of the insurance plan, do not receive the requisite prior approval, if the authorization is denied, or if the insurance plan refuses to pay the cost of the telemedicine services for any other reason, I understand and agree that I am financially responsible for the cost of these services.

If the insurance plan sends me, or the Patient, money that is designated to pay for the services provided by MSHC, I agree to promptly send the check or an amount equal to the amount received by the insurance plan to MSHC. I understand that all bills are to be paid immediately upon receipt. Should a medical bill create an unexpected financial hardship, I will contact MSHC to discuss payment arrangements. I also understand that in the event my account is transferred to a collection agency due to my failure to pay for services, that I will be responsible for any reasonable attorney's fees and costs collection fees and costs incurred by MSHC in collecting payment, in addition to the amount of the bill.

V. HIPAA ACKNOWLEDGEMENT: I understand that MSHC has a Notice of Privacy Practices that contains a description of the permissible uses and disclosures of my health information. I further understand that MSHC may update its Notice of Privacy Practices at any time, and that I may receive an updated Notice of Privacy Practices by submitting a request in writing to MSHC or by accessing the most current Notice of Privacy Practices online at www.midstatehealth.org. I acknowledge that I have received a copy of MSHC's Notice of Privacy Practices and understand that I may request a copy of this Notice in the future.

VI. AFFIRMATION: I affirm that I have read and fully understand this Consent to Treat, Guarantee of Payment, and Acknowledgement of Notice of Privacy Practices form and have been given the opportunity to ask questions and that all my questions have been answered to my satisfaction.

Patient's Signature:

Date:

Legal Representative's Printed Name:

Legal Representative's Signature

Date:

Authority/ Relationship of Representative to Patient