

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



Services Requested: Primary Care Behavioral Health Dental (BRISTOL OR LITTLETON)
 Physical Therapy (PLYMOUTH) Orthopedic Recovery

PATIENT INFORMATION

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

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

Preferred /Nickname: _____ **Maiden Name:** _____ **Gender at Birth:** Male Female

Social Security Number: _____ - _____ - _____ **Date of Birth:** ____/____/____

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

Preferred Pronoun: He/Him She/Her They/Them

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

Ethnicity: Hispanic / Latino / Latina Non-Hispanic / Latino / Latina

Language: English French Spanish Chinese Other: _____

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

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

Phone: Home: _____ Cell: _____ Work: _____

Email: _____

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:** _____

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

Phone: Home: _____ Cell: _____ Work: _____

STATISTICAL INFORMATION:

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

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

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

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

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: _____



**MID-STATE
HEALTH CENTER**

**Designation of Personal
Representative - *Optional***

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



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

1. Consent for Treatment

I, the patient or parent/legal guardian of the patient named above (the “patient”), agree to receive health services from Mid-State Health Center (“MSHC”). Care may be provided by staff, residents, students, and supervised trainees (the “provider”). Information about the provider’s name, credentials, and qualifications is available upon request.

Health services may include routine or specialized tests and procedures, such as x-rays, the administration or injection of medications, and blood draws for laboratory examinations, determined to be necessary for my care plan. I acknowledge that no guarantees have been made to me about the results or effectiveness of treatments or examinations performed by MSHC personnel.

I acknowledge that in cases where the patient discloses the intent to harm 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.

2. Telehealth Services

I understand that some services may be provided by telehealth (phone, video, or other secure technology). Telehealth follows the same standard of care as in-person visits. There are some risks which may include technical problems or limits to physical examination. If certain medications (like controlled substances) are prescribed through telehealth, my consent will be documented as required by New Hampshire law. Emergency services cannot be provided by telehealth. I understand that I may choose in-person visits or stop telehealth services at any time.

3. Communication with Me

I understand that MSHC may communicate with me by phone calls or voicemail, text messages, secure patient portal messages, and/or limited secure email (for certain situations). I understand that these communications may include reminders, instructions, or billing information. Texts and emails may not be fully secure, but the center will take reasonable steps to protect my privacy. I can opt out at any time.

4. Use of AI Scribe Technology

I understand that providers may use an AI-powered transcription or scribe tool to help document my visit. This tool listens during the visit and creates a medical note. My provider reviews, edits, and approves all notes for accuracy. The information is protected under HIPAA. No recordings are kept once the note is completed. I am aware I may opt out of the use of AI scribe technology at any time.

5. Photos/Video for Care Purposes

I understand that my health condition may require MSHC to obtain a photograph or image in certain situations (i.e., wound care). I agree to the use of this image and acknowledge that it may be necessary when providing quality healthcare services. I understand that the image will become part of my medical record. These will not be used for marketing or external purposes without my separate written permission.

6. Privacy and Information Sharing

I acknowledge that Mid-State Health Center (MSHC) can use and share my health information for the purpose of treatment, payment, and health care operations as allowed by law and explained in the Notice of Privacy Practices. MSHC may update this Notice at any time. I may request a copy in person or by writing to MSHC or view the latest version online at www.midstatehealth.org.

MSHC may access and store my treatment history through a secure health information exchange as permitted by law. I understand I can choose to opt out, following state rules.

I understand I may access my medical records through MSHC's Patient Portal and download copies for my own use. If I need official copies, I can request them by completing an Authorization to Release Protected Health Information form. This form is available at www.midstatehealth.org, by emailing medicalrecords@midstatehealth.org, or by calling (603) 536-4000.

I authorize MSHC to share my health information with government agencies, insurance companies, managed care organizations, or others responsible for paying for my care. These groups may review and request copies of records related to my treatment.

7. Fundraising Contact

The health center may contact me about fundraising to support its mission. Only PHI as allowed under the Health Insurance Portability and Accountability Act ("HIPAA"), HITECH, other applicable law, and by MSHC's Notice of Privacy Practices will be used for fundraising purposes. My diagnosis, treatment, or financial information will NOT be used for fundraising without my separate written permission. I can opt out of fundraising communications at any time.

8. Guarantee of Payment

I accept that I am financially responsible for all services given on my or the patient's behalf. I accept personal responsibility for all co-payments, deductibles, and non-covered services, plus any collection costs due to non-payment of amounts owed by me or the patient in addition to the amount of the bill. I acknowledge that there may be services provided by MSHC that may not be covered by my 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. 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.

I hereby assign 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 received. 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.

9. Patient Rights and Responsibilities

I understand that MSHC has a Patient Bill of Rights that explains my rights and responsibilities as a patient. I further understand that MSHC may update its Patient Bill of Rights at any time, and that I may receive an updated copy upon request, by submitting a request in writing to MSHC, or by accessing the most current Patient Bill of Rights online at www.midstatehealth.org.

10. Affirmation

I affirm that I have read, fully understand, and agree to the information included in this document and have been given the opportunity to ask questions and that all my questions have been answered to my satisfaction.

Patient/Parent/Guardian Name (Print): _____

Signature: _____ Date: _____