THE HEALTH CENTER – Plainfield, VT

LEGAL NAME:______________________________________ Date of Birth:_____________________

Preferred name: ____ (*This will be documented in your chart)*

SS#:____________________ Sex assigned at birth: Female Male ǁ Marital Status: (S) (M) (CU) (Sep) (D) (W)

Please remember that your name, date of birth, SS#, and sex in our system must match your insurance records. Please inform us of any inaccuracies. You may need to contact your insurance company to correct.

Mailing Address: ____

Physical Address: ____

E-Mail: ____ OK to send email message __yes ___no

Home Phone #: ___________________ Preferred? ___ Ok to leave voice mail __yes __no

Cell Phone #: ____________________ Preferred? ___ Ok to leave voice mail __yes __no

Work Phone #: __________________ Preferred? ___ Ok to leave voice mail __yes __no

Patient Employer:____

IF PATIENT IS A MINOR:

Parent/Guardian _______________________ Phone #: _______________Relationship:__________________

Parent/Guardian:_______________________ Phone #: _______________Relationship:__________________

LEGAL GUARDIAN:_______________________________________ Phone #:_____________________

We require documentation of legal guardianship.

EMERGENCY CONTACT:_____________________________________Phone #__________________

I GIVE PERMISSION TO DISCUSS MEDICAL AND DENTAL INFORMATION WITH:

Name:___________________________ Phone #:________________ Relationship:_____________________

Name:___________________________ Phone #:_______________ Relationship:_____________________

INSURANCE AND SUBSCRIBER INFORMATION: Please supply a copy of both sides of your insurance card(s). *Please check here if you do not have medical insurance:* ☐

Name of Ins:____ ID #:_______________________

Subscriber:___________________________ DOB:__________________ SS#__________________________

SECONDARY INSURANCE AND SUBSCRIBER INFORMATION: Please supply a copy of both sides of your insurance card(s).

Name of Ins:____ ID #:_______________________

Subscriber:___________________________ DOB:__________________ SS#__________________________

DENTAL INSURANCE AND SUBSCRIBER INFORMATION: Please supply a copy of both sides of your insurance card(s). *Please check here if you do not have dental insurance:* ☐

Name of Ins:____ ID #:_______________________

Subscriber:___________________________ DOB:__________________ SS#__________________________

PHARMACY INSURANCE INFORMATION:

Please check here if you do not have pharmacy insurance: ☐

Name of Ins:____ID#:________________________

<table>
<tr><td colspan="8">As a Federally Qualified Health Center, we are required to ask these questions.
The information will be kept confidential and will not impact your care.</td></tr>
<tr><td>Plese circle your race:</td><td>Caucasian (white)</td><td>Alaska Native or American Indian</td><td>Black/ African American</td><td>Asian</td><td>Native Hawaiian</td><td>Other Pacific Islander</td><td>Refuse to Report</td></tr>
<tr><td colspan="8">Are you of Latino/Hispanic Ethnicity? Yes No</td></tr>
<tr><td colspan="8">Do you require a translator to be better served in a language other than English? Yes No</td></tr>
<tr><td colspan="3">Do you think of yourself as:</td><td rowspan="3"></td><td colspan="4">What is your gender identity?</td></tr>
<tr><td>Straight or heterosexual</td><td>Lesbian, gay, or homosexual</td><td>Bisexual</td><td>Male</td><td>Transgender Male</td><td>Genderqueer</td><td>Choose Not to Disclose</td></tr>
<tr><td>Something else</td><td>Don't know</td><td>Choose not to disclose</td><td>Female</td><td>Transgender Female</td><td>Other</td><td></td></tr>
<tr><td colspan="5">Please circle if you are:</td><td colspan="3" rowspan="2">The Health Center will endeavor to refer to you as your preferred gender, but please remember that your sex in our system must match your insurance.</td></tr>
<tr><td>Military Veteran (non-active)</td><td>Homeless</td><td>Migrant Worker</td><td>Seasonal Agricultural Worker</td><td>Farmer</td></tr>
<tr><td colspan="8">Please circle how many people live in your home: 1 2 3 4 5 6 7 8 If larger: #______</td></tr>
<tr><td colspan="8">What is the combined annual income of all people living in your home? $________________________</td></tr>
</table>

IMMEDIATE FAMILY MEMBERS LIVING WITH YOU: (Spouse/Partner, Parent, Child, Other)

Name:________________________________DOB:___________________Relationship:_______________________
Name:________________________________DOB:___________________Relationship:_______________________
Name:________________________________DOB:___________________Relationship:_______________________

ACKNOWLEDGEMENTS:

I request The Health Center (THC) to provide me and/or my family with health care. THC will bill my insurance company directly. I authorize payment to THC for services provided.

Initial________

I understand that I am responsible for any deductibles, co-payments, non-covered services, and/or charges not covered by the Sliding Scale Fee. I understand that failure to make payments may result in my account being submitted to collections, and termination of services from THC. I understand that in the event of collection action being taken against me, I will be responsible for paying all attorney fees (33% of balance owed) and court fees associated with such action.

Initial________

I acknowledge that I have received from THC:

1) Patient's Bill of Rights
2) HIPAA Notice of Privacy Practices
3) Credit and Collection Policy
4) Behavior Expectations Letter

These were provided to you in your initial registration packet and are posted in the waiting room.

Initial________

I certify that the information I have given is complete and accurate to the best of my knowledge.

Signature ____ **Date** __________________________

Guardian (if applicable) __________________________________

Version 20191205

The Health Center
New Patient Health History **Date:**

Name: **Date of Birth:**

These questions help us fully assess your health and wellness. This information is used to develop a treatment plan that meets your health and wellness needs. This form will be filed in your confidential medical record. Please let us know if we can help you complete this form.

- Have you ever been a patient at The Health Center before?

- Why would you like The Health Center to be your primary health care provider?

- What health care concerns are most important to you?

- What are your health care goals for the next year?

- During your first visit, The Health Center will review these forms with you and ask you questions about your medical history. We will develop a treatment plan for your future health care. What is your top concern to discuss during your first visit?

- Are you seeking care for a Workers Compensation issue? □ No □ Yes
  Please note, we refer management of all Workers Compensation claims to Occupational Medicine.
- Are there any religious or cultural considerations regarding your care? □ No □ Yes

  If yes, please explain ____

- Have you completed an Advance Directive or Living Will? □ No □ Yes

  If yes, please bring a copy to your first visit for our records

- From 1 to 10 how do you rate your overall health?

  Very Sick - 0 1 2 3 4 5 6 7 8 9 10 - *Very Healthy*

- What is your current pain level?

  No Pain - 0 1 2 3 4 5 6 7 8 9 10 - *Worse Pain*

  Location and type of pain ____

PATIENT HEALTH HISTORY - Have you ever, or do you now have any of the following?

- □ High Blood Pressure
- □ Digestive Issues
- □ Migraines
- □ Epilepsy or Seizures
- □ Heart Disease
- □ Other, please list:
- □ Anxiety
- □ Diabetes
- □ Eating Disorder
- □ COPD
- □ Substance misuse/abuse
- □ Skin Cancer
- □ Arthritis
- □ Depression
- □ Menstrual Problems
- □ Cancer, list type(s):
- □ Anemia
- □ Asthma
- □ High cholesterol
- □ Thyroid Problems

List any surgeries you have had:

Hospital	Reason	Year

FAMILY HEALTH HISTORY

	Mother	Father	Siblings	Children	Grandparents
Diabetes					
High Blood Pressure					
Heart Disease					
High Cholesterol					
Cancer (what kind)					
Drug/Alcohol Abuse					
Mental Health Concerns					
Genetic Disorder (what kind)					
Other health concerns					

Name:_________________________________ ***Date of Birth:_________________***

ALLERGIES

- Do you have any allergies to medications? □ No □ Yes
  If yes, list medication(s) and reaction:

- Do you have any of the following allergies?
  □ Food □ Latex □ Environmental □ Other ________________________

FUNCTIONAL ASSESSMENT

- Does your health limit you in any activities?

Working	□ No	□ Yes
Household Chores	□ No	□ Yes
Personal Hygiene or Grooming	□ No	□ Yes
Moderate Exercise	□ No	□ Yes
Vigorous Exercise	□ No	□ Yes

If yes to any of the above, please explain:

LEARNING NEEDS ASSESSMENT

- Highest education level completed _____________________________

- Do you have any of the following?

Learning Disability	□ No	□ Yes
Visual Limitation	□ No	□ Yes
Hearing Limitation	□ No	□ Yes

If yes to any of the above, please explain:

SOCIAL HISTORY

- □ Employed □ Unemployed □ Retired □ Disabled □ Leave of Absence

- Occupation or prior occupation ____

- Relationship status: □ Single □ Partnered □ Married
  □ Divorced □ Widowed □ Other __________

- Total number of children ________ Number of children under 18 ________

- Who lives at home with you? ____

Name:___________________________________ ***Date of Birth:***__________________

WOMEN'S HEALTH

- Total number of pregnancies ______ Number of live births _____
- Age when you had your first menstrual period ______
- Age when you stopped having menstrual periods ______
- Type of contraception used ________________________

ADDITIONAL INFORMATION

- Is there anything we haven't asked that you believe is important for your health care provider to know about your health and wellness?

Name:___________________________________ Date of Birth:__________________

New Patient Medication List

Name: ____ **Date of Birth:** ______________________

Below please list all medications you take. It is important to include:

- Prescribed Medications
- Inhalers/Nebulizers
- Patches
- Over the Counter Medications
- Creams/Ointments
- Dietary and Herbal Supplements
- Eye Drops
- Oxygen
- Medical Equipment

☐ **Please check this box if you do not take any medications.**

Medication	**What is it taken for?**	**Dose (how much)**	**Frequency (how often)**	**Comments**

If you need more space, please continue on the back of this page.

The Health Center Medical Staff is very cautious prescribing certain medications used to treat pain, anxiety, addiction, and Attention Deficit Disorder. Due to potential side effects and the risk of abuse and addiction, it is our practice *not* to prescribe these medications to new patients. We thoroughly review all past medical records and try treatment approaches with a lower risk of side effects associated with addictive medications before we consider the use of any of these medications. Please sign below indicating that you have read and understand this policy.

____ ___________

Signature of Patient or Representative Date

Name: ____ **Date of Birth: ______________________**

Please list any other medications that did not fit on the last page:

Medication	What is it taken for?	Dose (how much)	Frequency (how often)	Comments

Medication Comments:

CREDIT AND COLLECTION POLICY

The Health Center's Credit and Collection Policy is necessary to insure that the necessary financial resources are available to maintain our services and ability to care for our patients and our community.

- Charges for services are due and payable at the time services are rendered. Unless you have insurance to cover the cost of services provided by The Health Center, we expect payment of the full bill at the time of service, unless other arrangements are worked out in advance. Everyone is expected to pay their co-pays not covered by insurance at the time of service. We bill most insurance companies directly; however, we do not participate in all insurance. It is your responsibility to know what your insurance covers and whether or not they participate with our practice.

- Your insurance company will notify you of their actions. It is your responsibility to keep up with what is paid or not paid and to deal with the insurance company concerning any inquiries. Insurance companies will often send letters to you requesting additional information before a claim is paid. Please make sure you respond to these in a timely manner.

- When you check out after a visit, you will be given a copy of the encounter form (record of services), which records the services you received. We will not ordinarily send you another printed claim form after you are given this form, so you should retain your encounter form for your records. We expect payment in full on your account(s) within 30 days after your insurance pays or denies a claim.

- If you are unable to pay in full at the time of service, please make arrangements with the Patient Financial Services Representative to pay as much as you can and plan to pay any remaining balance owed in a timely manner.

- Please be advised that if your check is returned due to insufficient funds, you will be charged $25 per returned check. If you have a history of returned checks with us, you must pay by cash or credit card only.

- Once your insurance pays or denies, we consider you to have a personal balance pending. If a personal balance is not entirely paid within 60 days of service and you do not have an acceptable payment plan, the account is handled on a cash only basis thereafter. If your account is not paid in full or satisfactory arrangements are not made after 90 days, you will receive a notice stating we will provide no further health or dental care services to you or your family, and collection proceedings will begin. The attorney fee, which is 33% of your balance owed, as well as court and sheriff fees, will be your responsibility and added to your balance owed.

- If unusual circumstances should make it impossible for you to make payment within 30 days, we invite you to call or personally discuss the matter with our Patient Financial Services Representative at (802) 322-0705. This will help avoid misunderstandings and enable you to keep your account in good standing.

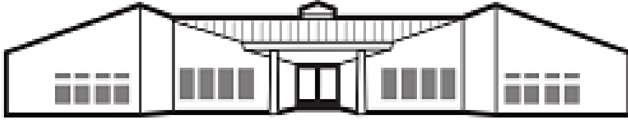
- If you need assistance applying for insurance or feel you may qualify for our sliding scale, please ask to speak to our Patient Financial Services Representative. We wish to help you in any way we can, so that your medical bills do not become burdensome.

Signature: ____________________________________ Date: _____________________

Print Name: ___________________________________

Guardian, if applicable: ____

20191205



The Health Center
P.O. Box 320, Plainfield, VT 05667
(802)454-8336/Phone (802)454-8339/Fax

Behavior Expectations for Patients

The Health Center proudly serves the medical, dental and behavioral health needs of several thousand patients in Central Vermont. You should expect to be treated by our staff with courtesy and respect and we ask the same in return.

Our behavior expectations are outlined below. Please review and acknowledge that you have read and understand them. These guidelines apply to all Health Center buildings and clinic sites and include the parking lots and grounds.

- Behavior, verbal or physical, that causes staff to feel uncomfortable, threatened or embarrassed, is unacceptable.
- Any aggression or threats made in person, over the telephone or in written communication are unacceptable. The practice considers threatening behavior to be:
    - Attempted or actual aggressive, threatening physical actions made toward any staff member.
    - Aggressive, threatening or abusive language (including raised voice, swearing, cursing and shouting) which threatens or intimidates staff.
    - Inappropriate, aggressive or forceful demands.
    - Loud or otherwise disruptive behavior that interferes with staff, operations or other patients comfort.
- Threats of legal action inevitably harm the doctor-patient relationship and can result in termination of care at The Health Center. We prefer that patients and providers develop a healthy, trusting relationship and discuss any differences, questions or concerns in a civil manner.
- Any instance or threat of physical abuse will be reported to the police. The offender will be dismissed from our practice and the incident will be documented and kept on file.

Any medical concerns or complaints can be addressed by submitting a written statement to the Medical Director for consideration.

I have read and understand the behavior policy of The Health Center.

Name:____
Please print

Signature____ **Date**___________________

Protected Health Information Release Authorization

The Health Center
PO Box 320
Plainfield, VT 05667
802-454-8336 fax 802-454-8339

This will allow your previous primary care and specialty providers to send us a copy of your records.

Full Name:____

Date of Birth:___________________________

Address: ______________________________

____

This will authorize: ______________________________________
(previous providers) ______________________________________

____

____

to exchange/disclose my protected health information with/to:

The Health Center
PO Box 320
Plainfield, VT 05667

as described below for the following purpose: continuity of care

_____Complete copy of medical records _____Complete copy of dental records & xrays

_____Complete copy of mental health records _____Other (describe): ________________________

The information authorized for disclosure may relate to: (check all that apply):

_____HIV related illness_____AIDS_____Drug or alcohol treatment

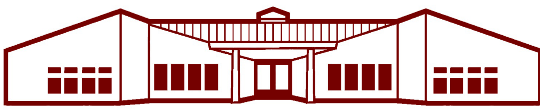
(further redisclosure prohibited or governed by 42 CFR part 2)

- I understand that I may inspect or copy the protected health information described by this authorization.
- I understand that this authorization may be revoked in writing and delivered to The Health Center at the above address at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on my authorization I have signed.
- I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- I understand that The Health Center shall not condition treatment on my providing authorization for the requested use or disclosure and that I may refuse to sign this authorization.

Date: ___________________ ____
Signature of patient or representative

____
Relationship to patient

This authorization will automatically expire three years from the date the patient transfers his/her care to another provider.



The Health Center

Application for Sliding-Fee Scale Discount Program

Phone: (802) 322-0704 Fax: (802) 454-8339 www.thcplainfield.org

1. Applicant

Name (Last)________________ (First)________________ (MI) ________

Street Address ________________ City________ State _____ Zip________

Home Phone ________________ Date of Birth________ ________________

Single________ Married________ Divorced________ Separated________ Widowed________

2. Tax Household Members *(Who would be listed on your tax return documents. Please include all household members on one form.)*

Name	Relationship on Taxes	THC Patient? (Y/N)	Birth Date
1.			
2.			
3.			
4.			
5.			

3. Are you a College/University student? ☐ Yes ☐ No (If "Yes" you will need to supply a copy of your FAFSA to apply.)

Can you be claimed as a dependent on someone else's tax return? ☐ Yes ☐ No

(If yes, additional income verification is required)

3a) Are you homeless? ☐ Yes ☐ No ☐ Transitional Housing

3b) If yes, please describe: ________________________

3c) Where are you staying?: ________________________

3d) How long will you be staying there?: ________________________

3e) Are you aware of homeless services in our community? ☐ Yes ☐ No

4. Total Tax Household Income

(Tax filers and all dependents)

Total Household Members

From Sections 1 & 2 ____________

Income Calculation

Wages/Salary $________ per________ = $________

Self-employment $________ per________ = $________

Unearned (ex:Social Security)$________ per________ = $________

Total Annual Gross Income $____________ (Specify type) ________________

5. Insurance

Do you or your spouse have dental insurance coverage? ☐ Yes ☐ No Company ____________

Do you or your spouse have health insurance benefits? ☐ Yes ☐ No Company ____________

If yes, is it a Vermont Health Connect Policy? ☐ Yes ☐ No

☐ Insured - Insurance Provider:

☐ Uninsured

☐ Filled out State Insurance Application (Green Mountain Care/Medicaid)

☐ Application pending/Called GMC with patient to check application status

Do you have a medical and dental provider?

☐ Yes Medical Provider Name: ____________________

☐ No

☐ Yes Dental Provider Name: ____________________

☐ No Dental Provider

Are you interested receiving information about any of the following community services?

☐ Medical

☐ Dental

☐ Counseling ☐ Food Shelf ☐ Housing

Would you like us to connect you with services? ☐ Yes ☐ No

6. Signature

To the best of my knowledge, the above information is true and correct. I agree to inform the Center of any changes in my employment, financial status or housing. If the above information proves to be incorrect, I understand that the discount provided to me will be terminated. (I also give permission for the Health Center staff to contact my employer or any other source to verify income.)

It is expected that all patients will be forthright and honest about their medical coverage and financial information. Intention-al omission or falsification of identity, financial, or demographic information is fraud and may result in dismissal from the practice for up to one year. In the event of falsification, the patient will be responsible for the full payment of services.

____

Signature of Applicant **Date**

FOR HEALTH CENTER USE ONLY

Auth. Initials ______________ Slide Level ______________ Approval/Denial Date ______________ Renewal Date ______________

Please return this form with one of the following forms of income verification to The Health Center, PO Box 320, Plainfield, VT 05667:

- 2 consecutive paystubs from the last 30 days
- Social Security, disability or pension benefits statements
- IRS Form W2 or 1099
- FAFSA form
- Most recently filed tax return (form 1040)

158 Brentwood Drive, Suite #6 • Colchester, Vermont • Fax: (877) 899-2622

PATIENT INFORMATION

◯ Check here if your patient information is already on file with Community Health Pharmacy.

Social Security Number: ______________________

Name: ______________________ Date of Birth: ______________ Sex: ◯ Male ◯ Female

Billing Address: ______________________ E-mail Address: ______________________

City: ____________ State: ______ Zip: ________ Daytime Phone: ______________________

◯ Check here if shipping address is the same as billing address Evening Phone: ______________________

Shipping Address*: ______________________ Physician Name: ______________________

City: ____________ State: ______ Zip: ________ Clinic: ◯ CHCB ◯ CHSLV ◯ THC ◯ LVMC ◯ NoTCH ◯ NCHC ◯ MHC

*Your prescription will be mailed to the shipping address on file.

◯ **If you would like autofill, please check here** Date of Last Office Visit: ______________________

Medications being filled at other pharmacies: ______________________

OTC items currently taking: ______________________

DRUG ALLERGIES

Drug Allergies: ◯ None ◯ Aspirin ◯ Codeine ◯ Penicillin ◯ Sulfa ◯ Other: ____________

Severity: ◯ Mild ◯ Moderate ◯ Severe ◯ Anaphylaxis

DRUG REACTIONS

CHRONIC CONDITIONS

DISEASE STATES

INSURANCE AND BILLING INFORMATION

◯ I have no prescription drug coverage through my medical insurance.

◯ I have Medicare Part D.

◯ I have Medicaid

◯ I have insurance. My prescription drug carrier is: ______________________ Rx BIN: ________ Rx PGN: ________

Cardholder ID: ____________ Group ID: ______________ Relationship to Cardholder: ◯ Self ◯ Spouse ◯ Child ◯ Other

PAYMENT INFORMATION

To process your prescriptions quickly, please provide a payment method.

◯ I will pay by check ◯ I will pay by money order ◯ I will pay by credit card

Please complete credit card information below:

◯ Visa ◯ Mastercard ◯ Discover ◯ American Express

____
Name of Responsible Party

Credit Card Number: ______________________ Expiration Date: ____________ MM/YYYY

X ______________________
Signature of Card Holder

◯ Check here to decline keeping credit card number on file.