Mountain Community Health

61 Pine Street
Bristol, VT
Phone (802) 453-3911 - Medical Fax (802) 453-6105 - Dental Fax (802) 453-3983

Patient Registration Consent Form

1. CONSENT TO TREAT

I (or my legal guardian or parents) authorize Mountain Community Health (MCH), the providers and healthcare team members to perform therapeutic medical or dental care reasonable by today's standards. I understand that I have the right to refuse any procedure or treatment. I have the right to discuss all medical treatments with my provider.

2. AUTHORIZATION TO ASSIGN INSURANCE BENEFITS

I, the patient (or the policyholder if the patient is not the policyholder), authorizes and directs that all medical or dental benefits payable to or for the benefit of the Patient under the terms of any applicable insurance policy, be paid directly to the providers affiliated with MCH. Patients agree to sign any additional assignment of benefits form requested by MCH or any insurance company from time to time. Patients understand that they are liable to providers at MCH for all related charges, whether or not covered by insurance.

3. ASSIGNMENT OF MEDICARE BENEFITS

I certify that the information provided by me in applying for payment under Title XVII of the Social Security Act is correct and request payment on my behalf of all authorized benefits.

4. AGREEMENT TO PAY CHARGES

I, the patient/guarantor (where applicable), agree to pay my share of costs for the services to be rendered by or through MCH providers in accordance with regular rates and terms. In the event of non-payment, patient, and guarantor (where applicable) understand that such non-payment will be reported to credit reporting agencies and agree to pay all reasonable costs of collection including attorney fees. I understand that I may get bills from other outside third parties such as Quest Diagnostic, UVMHN, Dominion, Indivior etc. for services provided on my behalf like lab specimens, diagnostics, or medications.

5. CONSENT TO RETRIEVE EXTERNAL PRESCRIPTION HISTORY

I authorize MCH to obtain and use my external prescription history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

6. RELEASE OF INFORMATION

I acknowledge and understand that MCH may share my health information and records with other providers that are treating me for medical or dental services provided by MCH providers to any of the following: (a) my insurance company or any other third party insurance payer (b) my continuing care facility, (c) any organization involved in planning my discharge from MCH, (d) any organization performing utilization review pursuant to state or federal law, and (e) any health care agency authorized by law. I, the patient, acknowledges that the medical or dental records covered above may include information concerning conditions of mental illness, substance or alcohol abuse and worker's compensation.

The confidentiality of substance-use disorder records received by MCH from certain Substance Use Disorder Treatment Programs are protected under federal regulations (42 CFR Part 2) which prohibit any person or entity, including MCH, from making further disclosure of this information unless such disclosure is expressly permitted by my separate written consent or as otherwise permitted by 42 CFR Part 2.

7. CONSENT TO WIRELESS CALLS, TEXTS, AND E-MAILS

I consent to receive calls, texts, and emails from MCH, its agents or its representatives at the numbers and email addresses I provided during registration for the following purposes: appointment reminders, general health reminders, billing, and patient experience surveys. Messages may be generated and sent using an automated notification. I understand that I am not required to provide this consent in order to receive healthcare services. I understand that message data rates may apply depending on my contract with my carrier. I understand that I have the right to revoke this consent orally or in writing.

_____ _____

Signature of Patient (if older than 12 years old), Parent or Authorized Representative **Date**

_____ _____

Print Name **Date**

Relationship to Patient: _____

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Patient Registration Form

Name: (First) _____(Middle)_____(Last)_____

Date of Birth: _____/_____/_____ **Previous Name** (if applicable): _____

Mailing Address: _____

Physical Address (if different than above): _____

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

How would you like us to remind you of appointments: ☐ Phone (preferred #) _____ ☐ Text

Social Security # _____-_____-_____ **E-mail**:_____

Would you like access to our online Patient Portal: ☐ Yes ☐No **Primary Care Provider:** _____

Emergency Contact: _____**Phone**: _____**Relationship:** _____

Sexual Orientation: ☐ Lesbian ☐ Gay ☐ Straight ☐ Bi-sexual ☐ Other_____ ☐ Chose not to disclose Sexual Orientation

Gender: ☐ Male ☐ Female ☐ Transgender Male/Female to Male ☐ Transgender Female/Male to Female

☐ Choose not to disclose Gender

Sex at Birth: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Partner ☐ Widowed ☐ Legally Separated

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐Military ☐ Unemployed/Retired

Student Status: ☐ Full-time Student ☐ Part-time Student ☐ Not a Student

Employer Name and Address: _____

Pharmacy Name and Location: _____ **Mail Order Pharmacy:** _____

Responsible Party Information (Who is Responsible for Paying the Bill) – Complete Only if Not Same as Patient:

☐ Patient ☐ Spouse ☐ Parent ☐ Guardian (Proof of legal status required for treatment)

Name: (First) _____(Middle)_____(Last)_____

Date of Birth: _____/_____/_____ **Previous Name** (if applicable): _____

Mailing Address: _____

Physical Address (if different than above): _____

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

☐ **I do not have Medical Insurance** ☐ **I would like to apply for the Sliding Fee Scale Discount**

<u>Primary Medical Insurance Information:</u>

Plan Name: _____

TURN THE PAGE

Policy Number: _____**Group Number**: _____ **Effective Date**: _____/_____/_____

Policy Holder's Name: _____ **Policy Holder's Date of Birth**: _____/_____/_____

Secondary Medical Insurance Information:

Plan Name: _____

Policy Number: _____**Group Number**: _____ **Effective Date**: _____/_____/_____

Policy Holder's Name: _____ **Policy Holder's Date of Birth**: _____/_____/_____

Primary Dental Insurance Information:

Plan Name: _____

Policy Number: _____**Group Number**: _____ **Effective Date**: _____/_____/_____

Policy Holder's Name: _____ **Policy Holder's Date of Birth**: _____/_____/_____

Secondary Dental Insurance Information:

Plan Name: _____

Policy Number: _____**Group Number**: _____ **Effective Date**: _____/_____/_____

Policy Holder's Name: _____ **Policy Holder's Date of Birth**: _____/_____/_____

MCH is a Federally Qualified Health Center, and we are required to collect the following information:

Are you a Seasonal Worker? ☐ Yes ☐ No

Are you a Migrant Worker? ☐ Yes ☐ No

Are you a United States Veteran? ☐ Yes ☐ No

Are you Homeless? ☐ Yes ☐ No

If yes, ☐ Homeless ☐ Shelter ☐ Transitional ☐ Double up ☐ Street ☐ Other _____

How many people currently live in your household (including yourself): _____

Annual Household Income:_____ ☐ Choose to not disclose Income

Primary Language Spoken: ☐ English ☐ Spanish ☐ Other _____ **Interpreter Needed?** ☐ Yes ☐ No

Race:
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese
☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian
☐ Other Pacific Islander ☐ Guamanian/Chamorro ☐ Samoan ☐ Black/African American
☐ American Indian/Alaska Native ☐ White ☐ More than one Race ☐ Choose not to disclose Race

Ethnicity: ☐ Mexican/Mexican American/Chicano ☐ Puerto Rican ☐ Another Hispanic Latino/a or Spanish
☐ Not-Hispanic/Latino/a or Spanish ☐ Choose not to Disclose Ethnicity

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☐ I have read the Notice of Privacy Practices for Mountain Community Health

☐ I have declined to read the Notice of Privacy Practices for Mountain Community Health. I am aware that there is a copy posted in the office.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Print Patient/Guardian Name Relationship to Patient

Mountain Community Health
61 Pine Street, Bristol, VT 05443
Phone (802) 453-3911 - Medical Fax (802) 453-6105 - Dental Fax (802) 453-3983

Release of Information Authorization

Name: (First) _____(Middle)_____(Last)_____

Date of Birth: _____/_____/_____ **Previous Name** (if applicable): _____

Mailing Address: _____

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

- I understand that Mountain Community Health (MCH) may share my Protected Health Information (PHI) with other healthcare providers and entities for purposes of treatment, coordination of my care, referral to other treatment facilities, practice operations, processing, and payment of a claim, obtaining prior authorization for services, or resolving any legal or administrative issues as directed by me.
- I understand that I may revoke this authorization at any time by notifying MCH in writing. I understand that any revocation shall not be effective to the extent that action has already been taken in reliance on this Consent.
- I understand that all releases will expire when I am no longer an MCH patient.
- I understand that any information disclosed per this Authorization is subject to State and Federal Laws.
- I understand that any information disclosed per this Authorization may be re-disclosed by a recipient and no longer protected by Vermont or federal law.
- I understand that My treatment or payment for my treatment cannot be conditioned on the signing of this Authorization.

By signing this release, I acknowledge my permission to release the below information to and/or from the individual or agency I have named which may include drug abuse, alcohol abuse, behavioral health, and HIV information.

□ **All**
□ Office Notes
□ Treatment Plan
□ Immunizations
□ Only those items which are pertinent to _____referral
□ Test Results
□ Medications
□ Other_____

The date range of records to release (check one): □ Only documents from _____to_____ □ All dates

Reason for Request: _____ □ Transfer Out of MCH

Release of Information **TO**: _____

_____

I give permission to MCH to obtain copies of my PHI **FROM** the previous healthcare provider(s) listed below (address, phone, fax): _____

_____

The following family members, guardians, power of attorney, or executor (list name, address, relationship) may have access to my PHI (list medical and/or financial):_____

_____

_____ _____ _____
Signature of Patient or Patient's Representative | Date | Rep. Relationship

Witness Signature: _____ Date:_____

The confidentiality of substance use disorder patient records is protected by Federal regulations (42 CFR Part 2), which prohibit any person or entity named above from making further disclosure of this information unless such disclosure is expressly permitted by my written consent or as otherwise permitted by 42 CFR Part 2.

Mountain Community Health

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Consent to Treat Minor Children

Name of Minor: (First) _____(Middle)_____(Last)_____

Date of Birth: _____/_____/_____ Social Security # _____-_____-_____ Phone if applicable: ( )_____

Mailing Address: _____

Physical Address (if different than above): _____

- **Minor is authorized to come alone to office visits to see providers at MCH.** ☐ Yes ☐ No

Release of Protected Health Information:

_____By completing this form, I certify that I am the parent/legal guardian of the Minor listed above and that MCH is authorized to disclose protected health information (PHI) as directed. Please check the specific information that is to be released for each contact listed below. This authorization will be in effect until revoked by the patient or authorized representative. If you are the parent/guardian, you must fill in your information below for our office to release information to you. This document will be considered Null and Void when child reaches the age of 18 years.

Parent Name: _____ Phone: ( )_____

Legal Guardian: ☐ Yes ☐ No Emergency Contact: ☐ Yes ☐ No PHI: ☐ Yes ☐ No Financial: ☐ Yes ☐ No

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Parent Name: _____ Phone: ( )_____

Legal Guardian: ☐ Yes ☐ No Emergency Contact: ☐ Yes ☐ No PHI: ☐ Yes ☐ No Financial: ☐ Yes ☐ No

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Other Name: _____ Phone: ( )_____

Legal Guardian: ☐ Yes ☐ No Emergency Contact: ☐ Yes ☐ No PHI: ☐ Yes ☐ No Financial: ☐ Yes ☐ No

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Additionally, the persons listed below may accompany my child to appointments at MCH. I understand that unless the accompanying person's name is listed below, my child will not be seen. I further understand that it is my responsibility to keep these names up to date.

_____ _____

Name **Relationship**

_____This person is authorized to give consent for all medical, immunizations and/or surgical treatment that may be required for our child during our absence.

_____I further give permission for the staff/providers of MCH to speak with the named individual above relating to the history, diagnosis, and treatment or service rendered to this Minor.

_____ _____

Name **Relationship**

_____This person is authorized to give consent for all medical, immunizations and/or surgical treatment that may be required for our child during our absence.

_____I further give permission for the staff/providers of MCH to speak with the named individual above relating to the history, diagnosis, and treatment or service rendered to this Minor.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Print Parent/Guardian Name Relationship to Patient