Mountain Health Center

Patient Registration Form

PATIENT INFORMATION

PLEASE FILL OUT ENTIRE FORM IN BLUE OR BLACK PEN ONLY

LAST NAME	FIRST NAME	MIDDLE INITIAL	
911 ADDRESS	**CITY**	**STATE**	**ZIP**
MAILING ADDRESS	**CITY**	**STATE**	**ZIP**
HOME PHONE / **CELL PHONE**	**WORK PHONE**	**DATE OF BIRTH**	**SOCIAL SECURITY #**

SEX AT BIRTH ☐ Male ☐ Female

MARITAL STATUS ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

EMAIL ADDRESS

EMPLOYER NAME

EMPLOYER PHONE NUMBER

EMPLOYMENT STATUS
☐ Full Time ☐ Part Time ☐ Self Employed
☐ Seasonal ☐ Student ☐ Not Employed

EMERGENCY CONTACT NAME

RELATIONSHIP TO PATIENT

EMERGENCY CONTACT PHONE NUMBER

WOULD YOU LIKE PATIENT PORTAL ACCESS?

PHARMACY NAME & TOWN

PRIMARY CARE PROVIDER

PREFERRED CONTACT METHOD
☐ Home Phone ☐ Cell Phone
☐ Text Message

RACE (Check all that apply)
☐ African American ☐ Asian ☐ Native American/Alaska Native
☐ Native Hawaiian ☐ Other Pacific Islander ☐ White

ETHNICITY
☐ Non-Hispanic ☐ Hispanic

AGRICULTURAL WORKER
☐ Seasonal ☐ Migrant

ARE YOU A U.S. VETERAN?
☐ Yes ☐ No

ARE YOU HOMELESS?
☐ Yes ☐ No

PRIMARY LANGUAGE IF NOT ENGLISH _____
DO YOU NEED TRANSLATION SERVICES? ☐ Yes ☐ No

GENDER
☐ Male ☐ Female
☐ Transgender Male ☐ Transgender Female
☐ Other ☐ Do Not Wish to Report

SEXUAL ORIENTATION
☐ Bisexual
☐ Lesbian or Gay
☐ Straight/Heterosexual
☐ Something Else
☐ Don't Know
☐ Do Not Wish to Report

FAMILY FINANCIAL INFORMATION
Family/Household size: _____
Household Income: _____
☐ Weekly ☐ Bi-Weekly
☐ Monthly ☐ Annually

HOW DID YOU HEAR ABOUT US?
☐ Current Patient
☐ Live Nearby/Locally
☐ Family/Friend
☐ Newspaper Online
☐ Other: _____ (Please specify)

RESPONSIBLE PARTY INFORMATION

ANY PATIENT UNDER 18 MUST HAVE A RESPONSIBLE PARTY

☐ **PATIENT** (18 Years or older) ☐ **CUSTODIAL PARENT** ☐ **GUARDIAN** (Proof of legal status required for treatment)

LAST NAME	FIRST NAME	MIDDLE INITIAL	
STREET ADDRESS	**CITY**	**STATE**	**ZIP**
DATE OF BIRTH	**HOME PHONE**		

MEDICAL INSURANCE

☐ I currently have **MEDICAL** insurance (see below)

☐ I currently **DO NOT** have **MEDICAL** insurance

☐ I would like to apply for the **SLIDING-FEE SCALE DISCOUNT**

Primary Insurance Name: _____
Policy Number: _____
Group Number: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____

Secondary Insurance Name: _____
Policy Number: _____
Group Number: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____

☐ I have read the ***Notice of Privacy Practices*** for Mountain Health Center.

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

_____ _____ _____

Signature of Patient or Guardian *Printed Name* *Date*

Five-Town Health Alliance, Inc
Mountain Health Center/Red Clover Family Dentistry
Patient Registration Consent Form

CONSENT TO RELEASE OF INFORMATION

I authorize Mountain Health Center/Red Clover Family Dentistry to give copies of my medical or dental records for services provided by Mountain Health Center/Red Clover Family Dentistry providers to any of the following: (a) my insurance company or any other third party reimburser (including Medicaid), (b) my continuing care facility, (c) any organization involved in planning my discharge from Mountain Health Center, (d) any organization performing utilization review pursuant to state or federal law, and (e) any health care agency authorized by law. Patient acknowledges that the medical or dental records covered by this consent may include information concerning conditions of mental illness, substance or alcohol abuse and worker's compensation.

AUTHORIZATION TO ASSIGN INSURANCE BENEFITS

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 Patient under the terms of any applicable insurance policy, be paid directly to the providers affiliated with Mountain Health Center/Red Clover Family Dentistry. Patients agree to sign any additional assignment of benefits form requested by Mountain Health Center/Red Clover Family Dentistry or any insurance company from time to time. Patients understand that he/she is liable to providers at Mountain Health Center/Red Clover Family Dentistry for all related charges, whether or not covered by insurance.

AUTHORIZATION OF MEDICARE BENEFITS

I request payment of authorized Medicare benefits for me or on my behalf for any services furnished me by the providers of Mountain Health Center including non-physician services. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

AGREEMENT TO PAY MOUNTAIN HEALTH CENTER/RED CLOVER FAMILY DENTISTRY CHARGES

Patient and guarantor (where applicable) agree that in consideration of the services to be rendered by or through Mountain Health Center/Red Clover Family Dentistry providers, each personally promises and obligates himself/herself to pay the amount of Mountain Health Center/Red Clover Family Dentistry charges in accordance with its 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.

CONSENT TO TREAT

I (or my legal guardian or parents) authorize Mountain Health Center/Red Clover Family Dentistry to provide medical or dental care reasonable by today's standards. I also authorize Mountain Health Center/Red Clover Family Dentistry to share my health information with other providers that are treating me.

Signature of Patient or Guardian: _____Relationship to Patient:_____

Print Patient Name: _____ Date:_____

FIVE-TOWN HEALTH ALLIANCE, Inc.
DBA Mountain Health Center/Red Clover Family Dentistry
61 Pine St, Building #4
Bristol, VT 05443
Phone: 802-453-5028 Fax 802-453-6105

UNIFORM CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient:_____ Date of Birth:_____
(First name) (Middle Initial) (Last Name)
Address:_____ City:_____ State_____ Zip_____

I understand that it may be necessary for Mountain Health Center or Red Clover Family Dentistry (MHC/RCFD) to share my Protected Health Information (PHI) with other healthcare professionals and other individuals and entities for the purposes of my treatment, coordination of my care, referral to other treatment facilities, practice operations, processing and payment of claims, obtaining prior authorization for services, or resolving any legal or administrative issues as directed by me.

I agree that my PHI may include all of the following: My complete medical history, diagnoses, medications, progress notes, counseling notes, psychologic assessments, diagnostic test results (including drug testing), nursing notes, internal and external correspondence regarding my medical conditions, notes from other healthcare professionals to whom I may be referred, any of my prior medical records in MHC/RCFD's possession, and all information on mental health conditions, drug and alcohol substance use disorders, and AIDS/HIV status.

I give permission to MHC/RCFD to share my PHI, including all information listed under Paragraph 2 above, with me and with:

1. All clinical and administrative staff employed by MHC/RCFD who need to have access to my medical records.
2. My health insurance company for claims payment purposes.
3. The following family members, guardian, power of attorney, or executor (name, address, relationship):_____
   _____
4. The following healthcare professionals with whom I have an existing relationship or to whom I may be referred for treatment: University of Vermont Health Network and its affiliated medical practices, Addison County Home Health and Hospice, Counseling Services of Addison County, Rutland Mental Health Services, Dartmouth-Hitchcock Medical Ctr., Rutland Regional Medical Ctr., the assisted-living facility or nursing home where I reside, my pharmacy, my school nurse, VT Sleep Ctr., VT Gastroenterology, 4 Seasons Derm., my physical therapist and my chiropractor.
5. Any other individual or entity (identify individual recipient when possible) designated by me here (name, address, phone number):_____
   If #5 above is filled in, are you transferring care out of MHC/RCFD? Yes or No

I give permission to MHC/RCFD to obtain copies of my PHI from my previous healthcare providers, including all information listed under Paragraph 2 above (name, address, phone number):_____

I understand that this Consent is voluntary and can be revoked by me in writing at any time. 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 this Consent shall expire when I am no longer a MHC/RCFD patient, unless I elect to revoke it at an earlier date. I understand the terms of this Consent.

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.

Patient Signature:_____ Date:_____

Guardian or Legal Representative's Signature:_____

Print Representative's Name:_____ Relationship to Patient:_____ Phone_____

I:\Forms – Letterhead\Uniform Consent

Mountain Health Center

Mountain Health Center

Consent to Wireless Calls, Texts and E-Mails

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

I consent to receive calls, texts and e-mails from the Mountain Health Center, its agents or its representatives at the numbers and e-mail address I provided during registration for the following purposes: appointment reminders, general health reminders, and patient experience surveys. Messages may be generated and sent using an automated notification system and messaging may be prerecorded and delivered. I understand that I am not required to provide this consent in order to receive healthcare services. I understand that message and data rates may apply.

I understand that I have the right to revoke this consent using any reasonable method including orally or in writing. I further understand that text messaging is not a secure means of communication.

I certify that I have read the foregoing, received a copy of this document if requested, and I am the patient or the patient's legal representative.

_____ _____

Patient Signature (or Legal Representative) Date

_____ _____

Printed Name If Legal Representative – Relationship to Patient