101 Boulder Point Drive, Suite 1
Plymouth, NH 03264
603-536-4000
www.midstatehealth.org

Welcome to Mid-State Health Center

Mid-State Health Center looks forward to working with you and your family. Your care and wellness are our primary goals.

We are pleased that you have selected us as your healthcare home. Enclosed are forms you must complete before arriving for your appointment. Please fill out these forms completely in blue or black ink.

In order to better serve you we ask that you bring a list of all your medications, insurance cards, completed forms, and other documents you feel are important to your visit. Please plan to arrive 15 minutes prior to appointment.

If you are unable to easily read or understand the required forms, please bring them with you to your appointment and one of our staff will assist you.

Our Promise to You

- You are the most important member of your healthcare team
- We are dedicated to providing coordinated, evidence-based care across all your healthcare systems
- Coordinating your care works best when patients provide their team with all of their healthcare information
- We want you to think of Mid-State as your healthcare HOME Team - where all your care comes together.

It takes coordination and good information to have a winning team. Think of Mid-State Health Center as the HOME team for your healthcare needs - it is where all your care comes together. If you see other healthcare providers outside of Mid-State it is important to share this information with your Mid-State Team. It gives us important information about your overall health and wellness.

Locations and Hours

MID-STATE'S PLYMOUTH OFFICE	MID-STATE'S BRISTOL OFFICE
101 Boulder Point Drive, Suite 1 Plymouth, NH 03264 (603) 536-4000 **OFFICE HOURS:** MON - THUR: 7:30am – 5:30pm FRI: 8am – 5pm SAT: 8am – 12pm **LAB HOURS:** MON – FRI: 7:30 – 11:45 am and 1:15 – 4:00 pm	100 Robie Road Bristol, NH 03222 (603) 744-6200 **OFFICE HOURS:** MON - WED: 7:30am – 5:30pm THUR & FRI: 8am – 5pm Saturday hours are available to all patients in our Plymouth Office 8am – 12pm. **LAB HOURS** MON – FRI: 7:30 - 11:45 am and 1:15 – 4:00 pm

After-Hours Access

To better serve our patients, one of our clinicians is always on-call, 24-hours a day, seven days a week. Our after-hours service gives our patients 24-hour advice on immediate and urgent health concerns. If you or someone in your family needs immediate attention after-hours or has an emergency, please call Mid-State Health at 603-536-4000 or 603-744-6200.

- Press Option 3 to page an on call medical provider
- Press Option 4 to page an on call psychologist

Selecting a Provider

Mid-State is dedicated to delivering individualized primary care to every patient. Our providers encourage all patients to play an active role in their healthcare planning and goals. Please feel free to visit our website for brief bios of our providers that include their photo, education, and special interest areas. Once you have decided, simply indicate your choice on your patient packet forms.

Appointments

Please call for appointments. We are dedicated to providing you with the best care possible. When you call, our staff will assess your needs in order to schedule you appropriately. Same day appointments are often available.

Please plan to arrive 15 minutes prior to your appointment to allow time for check-in process. Bring all documents you feel are important to your visit including a list of current medications and recent healthcare services received outside of Mid-State.

If an acute illness or emergency arises, we will make every effort to accommodate you. Depending on the situation, there could be times when you may be advised to go to the nearest Emergency Department instead of coming to the office.

Please notify our office immediately if you need to change or cancel your appointment.

Mid-State Health Center's Policy on Late Cancellation/Missed Appointments:
If you cannot keep a scheduled medical appointment, it is necessary that you notify us at least 4 hours in advance. If you cannot keep a scheduled behavioral health appointment, it is necessary that you notify us at least 24 hours in advance. To avoid charges for a late cancelled or missed appointment, please be sure and contact us according to our policy outlined above. Three or more late cancelled or missed appointments in one year, may result in termination from the practice.

Payment and Health Insurance Information

Mid-State accepts most insurance carriers that serve our region; visit midstatehealth.org for a complete list of carriers we accept. Claims will be submitted to all other insurance companies; however, we cannot guarantee coverage or payment.

You are responsible for informing Mid-State Health Center of any changes to your health insurance information. If the insurance company denies payment, you may be responsible for outstanding balances. Patients are responsible for all outstanding balances not covered by insurance.

If your insurance company is not on our list, please contact them to make sure your visit will be covered. If your insurance is not accepted, or does not pay for office visits; if you have a co-pay, deductible, or you are uninsured; we ask that these services be paid before leaving the office. We offer a 30 percent prompt pay discount to self-pay patients who pay in full on the day of service (discount is not available for dental services or sliding scale fees). Our office accepts: personal checks, cash, and most major credit cards.

***Prior Authorization for Behavioral Health*:** If you are scheduled with a Behavioral Health Provider, please contact your insurance company prior to your appointment to obtain authorization information. Please be aware that insurance companies typically do not cover educational testing. You will be responsible for all charges not covered by your insurance company.

I don't have insurance; can I still be a patient at Mid-State? Of course, we are happy to work with patients who are self-pay. For those who qualify, we offer sliding-fee scale. Contact us for more information.

In good health,

Your Team at Mid-State Health Center

Patient Services ________

COMMUNICATION DIRECTIVE, CONSENT FOR TREATMENT,
INSURANCE AUTHORIZATION AND ASSIGNMENT: (Must be signed and dated before treatment.)

Name: ____ **Date of Birth:** ______________

Please Check ☒ and enter information for preferred method of contact:

☐Home Phone ___________________
☐Work Phone ___________________
☐Cell Phone ___________________
☐Mail ___________________
☐MSHC Online (please provide email address) ___________________

Can messages be left at any of the above? Yes ☐ ***No*** ☐

Please list all individuals that may obtain your information, including *any* and *all* legal guardians if the patient is a minor or unable to consent.

Name_____________________ Relationship _____________ Phone # ________________
Name_____________________ Relationship _____________ Phone # ________________
Name_____________________ Relationship _____________ Phone # ________________
Name_____________________ Relationship _____________ Phone # ________________

1. CONSENT TO DIAGNOSTIC TESTS, PROCEDURES, AND TREATMENT:

I consent to care involving routine diagnostic tests, procedures, and treatment, including psychiatric care and the prescribing of medications as performed or ordered by the clinicians at Mid-State Health Center, including their assistants or designees, including testing for the human immunodeficiency virus (HIV) if a clinician is testing for diagnostic purposes or if there has been an exposure to health care personnel. No guarantee has been given to me as to the results that may be obtained from my care. If psychiatric medications are prescribed, I agree to discuss these medications with the psychiatrist to clearly understand their risks and potential benefits or alternatives.

2. NOTICE OF PRIVACY PRACTICES:

By my signature below, I acknowledge that I have read and/or received and agree to the terms of the Notice of Privacy Practices and Patient Rights and Responsibilities from Mid-State Health Center. I also acknowledge that I have read and/or received and agree to the terms of the treatment agreement.

3. FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS:

I agree that I am responsible for payment of bills from Mid-State Health Center and designees. I have read and/or received a copy of the Summary of Payment and Billing Policy for Mid-State Health Center. I understand that I am solely responsible for collecting insurance claims or negotiating a settlement on all disputed claims. I also understand that any unpaid account may be assigned to an agency or attorney for collection, agree to the assignment of all third party payor benefits to Mid-State Health Center, its clinicians or providers.

I agree that a copy of this consent, release and assignment of benefits may be used in place of the original. I understand that I am entitled to a copy of same if I make such a request and that this consent release, and assignment are valid until rescinded in writing or replaced by one of a later date.

Patient Signature: ______________________________________ **Today's Date:** ________________

The undersigned certifies that the patient is (unable to consent) (a minor) and the undersigned certifies that he/she has read and agrees to the above as the responsible party of the patient.

Responsible Party Signature ____________________________ **Today's Date** ________________________

Mid-State Health Center Patient Information Sheet

Patient Services ________

Patient Information

Today's Date:________

Last:________________________ First:________________________ M.I:____________

Gender: ☐M ☐F Date of Birth:_____/_____/_____ Social Security #:______________ Marital Status:__________

Mailing Address:________________________ | Street Address:________________________

City:______________ State:_____ Zip:________ | City:______________ State:_____ Zip:________

Home Phone:______________ Work Phone:______________ Cell Phone:______________

E-mail address:________________________ PCP (Primary Care Provider):________________________

Employer & Occupation:____

Insurance & Payment Information

Primary Insurance Company Name:________________________________ Phone#:____________

Policy Holder Name:________________________ Date of Birth:____/______/______ Social Security #:____________

Policy ID #:________________________________ Group #:________________________

Patient's Relationship to Policy Holder: (check one) ☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner

Secondary Insurance Company Name:________________________________ Phone#:____________

Policy Holder Name: ________________________ Date of Birth:____/______/______ Social Security #:____________

Policy ID #:________________________________ Group #:________________________

Patient's Relationship to Policy Holder: (check one) ☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner

Please complete this section *ONLY* if someone other than the patient is responsible for payment:

Party responsible for payment: (check one) ☐ Spouse ☐ Parent ☐ Domestic Partner

Last:________________________ First:________________________ Relationship:____________

Mailing Address:________________________ Street Address:________________________

City:______________ State:_____ Zip:________ City:______________ State:_____ Zip:________

Home Phone:______________ Work Phone:______________ Cell Phone:______________

Person's Date of Birth: _____/_____/______ Person's Social Security #:____________________

Emergency Contact

Name:____ Relationship:____________________

Mailing Address:________________________ Street Address:________________________

City:______________ State:_____ Zip:________ City:______________ State:_____ Zip:________

Home Phone:______________ Work Phone:______________ Cell Phone:______________

Information about the people we serve:

As a Federally Qualified Health Center, we are *required* by Federal Law to collect the following information for *statistical purposes only*. This is reported as an organization total for Mid-State. *Individual patient information is NOT reported or disclosed*. Thank you for your cooperation.

Primary Language: ☐ English ☐ French ☐ Spanish ☐ Other: ____________________

Are translation services needed for your visits? ☐ Yes ☐ No

Are you a Veteran? ☐ Yes ☐ No

Income: ☐ 0-$24,999 ☐ $25,000-$49,999 ☐ $50,000-$74,999 ☐ $75,000- $99,999 ☐ Over $100,000

Household Size: Number of people in household this income supports: ____________

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Other Pacific Islander ☐ Native Hawaiian ☐ Native American/Native Alaskan ☐ Multi Racial ☐ Other ________________

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Declined to Provide

Other: ☐ Homeless ☐ Migrant/Seasonal Worker ☐ Declined to provide

How did you hear about Mid-State: ☐ Friend/Relative ☐ Website ☐ Direct Mail ☐ Newspaper ☐ Facebook ☐ Online Search

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SUMMARY OF PAYMENT & BILLING POLICIES

General

- ✓ Please be sure to bring your Insurance card(s) with you to each visit.
- ✓ MSHC will request payment of all co-payments and charges not covered by a third party (insurance) at the time of your visit.
- ✓ Payment for dental service is due in-full, at the time of service. Outstanding balances for medical and behavioral health visits are due within 30 days of your visit.
- ✓ Self-pay patients not eligible for a sliding fee discount will be afforded a 30% prompt pay discount when full payment for services is received at the time of the visit. Prompt pay discount is not available for dental services or sliding scale fees.
- ✓ No Show/Late Cancels will be charged $50 for medical & dental visits and $50-$100 for behavioral health visits.

Sliding Fee Discounts

- ✓ Sliding fee discounts apply only to services provided by MSHC. It is your responsibility to renew your application before it expires.
- ✓ The discount is ***not insurance*** and will not pay for services provided by other doctors, labs or hospitals. You will need to make arrangements with these organizations directly.
- ✓ For your convenience, if we refer you, ConVerge Diagnostic Services and Quest labs are willing to honor the MSHC discount for their own discount programs. Speare Memorial Hospital and Speare Memorial Hospital Lab may or may not honor our sliding scale and if they do honor the discount it may be at a different percentage.

Unpaid Balances

- ✓ You will receive a monthly billing statement from us until your balance is paid in full.
- ✓ Mid-State reserves the right to charge interest and collection fees.
- ✓ Payment plans for medical and behavioral health services are available for those unable to make payment in full. If you would like to set up a payment plan, please speak with the cashier or contact Patient Accounts at 603-536-4000 opt 4.
- ✓ We understand that many patients face financial pressures that prevent them from being able to pay their balance in full. We are willing to accommodate individual situations so long as you:
    - o Are forthright and honest about your situation
    - o Remain in contact with us about your account and comply with payment plans
    - o Complete paperwork and follow up with case workers in a timely manner
    - o Stay current with payment plans
- ✓ In the event that your account balance remains outstanding for more than 120 days and you have not met these criteria, MSHC may choose to place your account with a collections agent.
- ✓ If your account is placed with a collection agent, you may no longer be able to access care at MSHC. All further payment arrangements will need to be made with the collection agent directly. If MSHC suspends your eligibility for services due to unpaid bills, once your balance has been paid, you may then re-access care through the next available new patient appointment.

Mid-State Health Center

Pain Management Philosophy and Policy

If you have chronic pain, you know how it affects every area of your health and your life in negative ways. Having the pain go away entirely is not usually possible, but finding ways to manage the pain and live with it is possible. Mid-State Health Center's goal is to help you reach your highest level of functioning and quality of life, even if you have chronic pain.

Successful pain management depends on a treatment plan that:

1. is designed especially for you, based on your own special situation, AND
2. has the right balance between the risks of treatment (especially medications) and your overall health and function.

To create this type of plan, Mid-State will start with a complete evaluation of your pain problem. We will obtain a complete history, do a physical exam, obtain and review previous records, and order and review any additional lab tests and/or x-rays that may help define the problem. What you want to get out of treatment will also play an important part of this evaluation. Along with your clinician's guidance, your treatment goals will become part of your overall plan.

You and your clinician will measure the success of the treatment plan against these goals. It will be important for you to follow-up with your clinician when scheduled to make decisions about treatment success and to refine your plan, if needed.

Narcotic medications can be part of the treatment plan, but only after all other treatment options have been tried. If narcotics are prescribed as part of your treatment plan, you will be required to participate in the following, special monitoring activities, to ensure safe use of the medication:

1. evaluation for addiction risk by the Mid-State Behavioral Health staff, prior to the time of the initial prescription,
2. urine drug screening prior to the initial prescription, and
3. urine drug screening at subsequent visits, as determined by your clinician.

Narcotics will not be continued unless there is an improvement in function and pain noted by you or your clinician.

Medical History Form

M.A. Entry ________

________________ Date

________________ Mid-State Primary Care Clinician

________________ Name

________________ Date of Birth

Occupation: ________________ Retired: ☐ Yes ☐ No

Education: ________________

Primary Support: ☐ Spouse ☐ Parents ☐ Other ________________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/Widower

Pediatric/Adolescent
Parents Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

I live with: ________________

Number of children: Son(s) ________ Daughter(s) ________

Do you have a living will? ☐ Yes ☐ No Do you have an organ donor card? ☐ Yes ☐ No

Allergies ☐ None known

Medication	Reaction

Current Medications

Medication Name	Dose	Frequency

Hospitalization (Non-Surgical)

Date	Diagnosis	Hospital	Attending Physician

Surgical History

Date	Procedure	Hospital

____ ________________________

Name Date of Birth

Past Medical Diseases ☐ None known

Condition	Yes	No	Condition	Yes	No
Abdominal Pain	☐ Yes	☐ No	Hearing Difficulty	☐ Yes	☐ No
Alcohol/Drug Problems	☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Hemorrhoids	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Hepatitis/Yellow Jaundice	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Bleeding Problems	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Cancer of ___________	☐ Yes	☐ No	Kidney Stones	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Chronic Bronchitis	☐ Yes	☐ No	Reaction to Anesthesia	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Skin Disease/Dermatitis	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Stomach Ulcers	☐ Yes	☐ No
Gall Bladder Disease/Stones	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Tuberculosis/Positive PPD	☐ Yes	☐ No
Gout	☐ Yes	☐ No	Vision Problems	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Other: ____________	☐ Yes	☐ No
Head or Neck Radiation	☐ Yes	☐ No	Other: ____________	☐ Yes	☐ No

Family History

List any diseases that your relatives have

Father ____

Mother ____

Brother(s) ____

Sister(s) ____

Son(s) ____

Daughter(s) ____

Immunizations (include dates)

Hepatitis B: _________ Influenza: _________ TB test/results__________

DPT/Td (tetanus): __________ OPV (Polio):__________ MMR (measles, mumps, rubella)__________

Varicella__________ Other__________

Health Screening

When was your most recent?

	Date		Date
Pap Smear …………………..	____________	Stool Check for Blood …….	______________
Mammogram …………….…	____________	Cholesterol Check ………….	______________
Breast Exam …………….…	_____________	Fasting Blood Sugar ……….	_______________
Prostate Exam ……………..	_____________	Sigmoidoscopy/Colonoscopy	_______________

Mid-State Health Center

Authorization to Release Patient information **TO** Mid-State Health Center

Patient Name:____ Date of Birth:_______________

Release Previous Medical Records From (Organization/Provider):

Name of Organization/Provider: ____

____
Address City State Zip

Telephone Number:____________________________ Fax Number:______________________________

to disclose the above named individual's health information as described below: ☐ VERBAL ONLY ☐ RECORDS ONLY ☐ BOTH

Date(s) of Service Requested (if known):______________________________________

Description of Information to be released: (check all that apply)

☐ Entire medical record	☐ Verbal exchange of information	☐ Progress notes
☐ Immunization record	☐ Most recent history and physical	☐ Behavioral Health treatment & evaluation records
☐ Laboratory reports	☐ Consultations	☐ Copy of dental chart
☐ Radiology/Imaging reports		☐ Copy of dental x-rays
	☐ Other ______________________________________	

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome ("AIDS"), or Human Immunodeficiency Virus ("HIV"), or genetic testing. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization:

Mid-State Health Center
101 Boulder Point Drive Suite 1
Plymouth, NH 03264
Phone Number (603) 536-4000 Fax Number (603) 536-4001

******If there are fees associated with this request, please contact our office prior to processing***.

Description of purpose of the use and/or disclosure:

☐ Continuing care	☐ Second opinion	☐ Personal Use
☐ Consultation	☐ Insurance	☐ ARCHIVE FILES
☐ Legal purposes	☐ Social Security/Disability	
☐ Other: Please describe______________________________________		

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify.
This authorization will be in effect until ____________________ (date or event).

I understand that I may revoke this authorization at any time by notifying the facility from which I am requesting my health information. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_______________________________________ _______________________________
Signature of Patient or Patient's Representative Date

____
Printed Name of Patient or Patient's Representative

_______________________________________ or _______________________________
Relationship to Patient Legal Authority (attach supporting documents)