55 Fletcher Drive
Palmyra, ME 04965
1-866-364-1366
hometownhealthcenter.org

Welcome to HOMETOWN Health Center

We are a Federally Qualified Health Center and your Patient Centered Medical Home. This means we care for the whole person and place *you*, the patient, at the center of everything we do. As your healthcare team, our role is to support you and encourage your active participation in your care plan. We want you to feel empowered to make informed decisions about your health. Together, we can build a strong partnership focused on your well-being.

What You Need to Do

Enclosed is your New Patient Packet. There are some forms you need to fill out and sign so we will have the most up-to-date information.

Here's what we need from you to serve you or your child better. Please review, complete and sign the following:

- **Registration Form**, so we know who you or your child is and what services are required
- **Patient Medical/Dental History**, so we understand your or your child's current health status
- **Authorization to Release Health Care Information**, so we can receive your or your child's health information from your previous provider
- **Consent to Treatment and Acknowledgment of Receipt of Notice of Privacy Practices**, so we have your permission to treat you or your child
- **Patient Acknowledgment of the Missed/Cancelled Appointment Policy,** to confirm your understanding of our appointment procedures

We understand this packet is a bit lengthy, but each section helps us provide you with the best care possible. **Please return the above documents to us by mail, fax (207-368-2451), or drop them off at our office.**

Need help filling out the forms? Call us—we're happy to assist!

What to Bring to Your Appointment

Please arrive 15 minutes before your scheduled appointment and bring the following items:

- Photo ID
- Insurance Card, if you have one
- If applicable, co-pay (we accept cash, check, or credit card)

Stay Connected

Please visit our website, www.hometownhealthcenter.org, to explore all that we offer. And if you're on Facebook, please follow us. We use Facebook to share important and fun information.

Thank you for choosing HOMETOWN Health Center.

Robin Winslow, CEO

HOMETOWN Health Center is a Federally Qualified Health Center that offers medical services, dental services, behavioral health services, prescription assistance, a sliding fee scale program and more. Offices in Dexter, Newport and School Based Health Center, Nokomis Regional High, Newport for RSU-19.

Hometown Health Center Registration Form

☐ **Dexter** ☐ **Palmyra** ☐ School Based Health Center

☐ **MEDICAL** ☐ **DENTAL** ☐ **BEHAVIORAL HEALTH** ☐ **SPECIALTY** __________

Patient Full Name: ______________________________ Preferred Name: ______________

Patients Date of Birth: ________________ Age: ______ Patient's Social Security #: ______________

Patient Phone Number: Day __________________ Evening: ______________________

Mother or Guardian's Name: ______________ Mother/Guardian Phone Number: __________

Father or Guardian's Name: ______________ Father/Guardian Phone Number: __________

Primary Address: ____

City: ________________________ State: ______________ Zip: ____________

Email Address: ______________________ Religion: __________________

Status (circle one): Married Widowed Single Separated Divorced Life Partner

Student Status (circle one): Full Time Part Time Not a Student GRADE: ____

Smoking Status (circle one): YES NO

Emergency Contact Name: ____________________ Relationship: ________ Contact number: ________

Support Person: ________________________ Relationship: ________ Contact number: ________

As a Federally Qualified Health Center, we are required to request the following information:

Gender:

__ **Male**
__ **Female**

Migrant Worker Status:

__ **Migrant**
__ **No**
__ **Not a Farm worker**
__ **Refused to Report**
__ **Yes**
__ **Seasonal**

Language Barrier:

__ **Yes**
__ **No**
__ **Primary Language Spoken:**

____

Homeless Status:

__ **Not homeless**
__ **Homeless**
__ **Doubling up**
__ **Shelter**
__ **Street**
__ **Transitional**
__ **Refuse to Report**

Veteran Status:

__ **Yes**
__ **No**

Race:

__ **Asian Indian**
__ **Chinese**
__ **Filipino**
__ **Japanese**
__ **Korean**
__ **Vietnamese**
__ **Other Asian**
__ **Native Hawaiian**
__ **Other Pacific Islander**
__ **Guamanian or Chamorro**
__ **Samoan**
__ **Black/African American**
__ **American Indian/Alaska Native**
__ **White**
__ **More than one race**
__ **Unreported/Choose not to disclose race**

Ethnicity:

__ **Mexican**
__ **Mexican American**
__ **Chicano/a**
__ **Puerto Rican**
__ **Cuban**
__ **Hispanic/Latino/a**
__ **Not Hispanic/Latino/a**
__ **Other**
__ **Decline to Specify**
__ **Unknown**

Primary Care Provider (PCP): ______________________ Primary Dentist: ______________________

Check here if you or your child does not have a PCP _____ Check here if you want HHC to be your PCP _____

Pharmacy Name and Location: ______________________________________

Primary Insurance Coverage: ______________________ ID:______________Group No:____________

Subscribers Name:______________________________ Subscribers Date of Birth: ___________________

Relationship to Patient: ________________________

Additional Insurance Coverage: ____

Residential Information:

I have trouble getting enough food to eat: YES ______ NO ______ My food needs are met: YES _____ NO _____

Smoke Detectors: YES _____ NO _____ Firearms in Home: YES _____ NO _____

Have you ever been a victim of abuse or domestic violence: YES _____ NO _____

Do you feel safe at home? YES _____ NO _____ Do you live alone? YES ______ NO ______

Hobbies/Interests: ____

How did you hear about Hometown Health Center? ____

We ask you for income information because we have programs that may help you!

*******State your household income in one of the following categories listed below********

Number in the household: _______

Household income (list amount): Weekly _______ Biweekly _______ Monthly _______ Yearly _______

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our Billing Department. Although we will compile the necessary forms to file with your insurance company, it is the responsibility of the patient to dispute any services not covered by the insurance company. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement.

We offer a sliding fee program. There is no cost to apply to the program. The medical visit fee ranges from $10-$45 per visit depending on your household size and income. You may also qualify for reduced charges for dental services.

I acknowledge that I am the legal decision maker as the parent/guardian.

Patient or Guardian Signature____ Date __________

Signature of guardian (if patient is under 18 years)______________________________ Date __________

***HOMETOWN Health Center** is a Federally Qualified Health Center that offers medical services, dental services, behavioral health services,prescription assistance, a sliding fee scale program, and more. Offices in Dexter, Newport and School Based Health Center, Nokomis Regional High-RSU19.*

Patient Medical /Dental History

Name: ______________________ DOB: ____________ Date: __________

Preferred Method of Communication: Phone:_____Mail:______Email:______Text: ______

Advanced Directive/Living Will: Yes________ No ______

Employer:______________________ Job Title:______________________

Pharmacy Name/Location:______________________ Phone Number: ____________

(Former) Dental Provider:______________________

City/State:______________________

(Former) Medical Provider:______________________City/State:)______________________

Date of last dental visit:______________________ Date of last dental x-ray(s): ____________

Habits: Please circle all that apply.

Smoking:	Never	Former	Presently	# of packs/day
Alcohol:	None	Rarely	Occasionally	Socially
Drug Use:	None	Former	Presently	Type:
Caffeine:	None	1-2 cups/day	3-4 cups/day	More than 5 cups/day
Exercise:	None	Intermittently	Regularly	

Current Medication List: Please include over-the-counter drugs, supplements, vitamins & birth control.

☐ No Current Medications

Medication	Dosage (mg)	Frequency	Prescribing Physician

Allergies: Please include food, drug, and environmental allergies.

☐ No Known Allergies

Allergy	Interaction	Allergy	Interaction

Previous Surgery History: Please list below.

☐ No Past Surgical History

Surgery	Year	Complications?

Relevant Family Medical History: Please check all that apply.

☐ No Relevant Family History

	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts/ Uncles
Cancer									
Diabetes									
High Blood Pressure									
Heart Attack									
Heart Disease									
Blood Clots/DVT									
Stroke									
Mental Illness									
Drug/Alcohol Addiction									
Other Diseases Not Mentioned									
Living/Deceased									

Medical Problems: Please check all that apply.

☐ No Medical Problems

	Abdominal discomfort		Headaches		Sinus trouble
	Acid reflux		Heart attack		Skin rash/disorders
	ADD		Heart disease		Special diet
	ADHD		Heart murmur		Stroke
	AIDS/HIV		Hepatitis: specify A, B, C		Swollen feet/ankles
	Alcohol/drug abuse		High blood pressure		Swollen neck glands
	Anemia		High cholesterol		Thyroid problems
	Anxiety		Kidney disease		Tonsillitis
	Asthma		Kidney stones		Tuberculosis
	Arthritis, Rheumatism		Liver disease		Tumor or growths
	Artificial heart valves		Low blood pressure		Ulcers

	Artificial joints		Diabetes		Nervous problems
	Autism		Depression		Nausea
	Back problems		Emphysema		Osteoporosis
	Bleeding abnormally with extractions or surgery		Epilepsy		Pacemaker
	Blood disease		Fainting or dizziness		Psychiatric care
	Bronchitis		Glaucoma		Palpitations
	Cancer		Jaundice		Pneumonia
	Chemical dependency		Joint replacement		Radiation treatment
	Circulatory problems		Migraines		Respiratory disease
	Congenital heart lesions		Light-headedness		Recent surgery
	Cortisone treatments		Lung disease		Rheumatic fever
	Cough, persistent or bloody		Mitral valve prolapsed		Scarlet fever
	Cortisone treatments		Muscular Dystrophy		Shortness of breath
	Colitis				

Dental History: Please check all that apply.

	Bad breath		Dry mouth		Mouth pain/brushing
	Bleeding gums		Fingernail biting		Pain around ear
	Blisters on lips/mouth		Food collection in teeth		Periodontal treatment
	Burning sensation on tongue		Grinding teeth		Sensitive to hot/cold/sweets
	Chew on side of mouth		Jaw pain		Sensitive when biting
	Cigarette, or other, smoking		Loose teeth/broken fillings		Sores/growths in mouth
	Clicking or popping jaw		Orthodontic treatment		Bubble/pimple on gum

Frequency of flossing: ______________________________

Frequency of brushing: ______________________________

Health Maintenance Screenings: Please circle all that apply.

Colonoscopy	Yes No	Date:	Results:	Normal Abnormal
FIT/Stool Test	Yes No	Date:	Results:	Normal Abnormal
Mammogram	Yes No	Date:	Results:	Normal Abnormal
PAP Smear	Yes No	Date:	Results:	Normal Abnormal

Immunization History: Have you had:

Hepatitis B Series	Yes No	Date:	# of Doses if Known:	
TDaP/Tetanus	Yes No	Date:		
Pneumovax 23	Yes No	Date:		
Prevnar (Pneumo 13)	Yes No	Date:		
Flu	Yes No	Date:		
Shingles	Yes No	Date:		
COVID-19	Yes No	Date:		

Women:

Are you pregnant? Yes __________ Due Date: ______________________________

No __________ Form of birth control: ____________________

Are you breast feeding? Yes __________ No _____________

Please complete these forms and return by mail, fax (207-368-2451), or drop them off at our office.

Thank you for your cooperation and we look forward to having you as a patient!

Authorization for Release of Health Information

Patient Name: ______________________________ Date of Birth: __________

Patient's Former Name or Alias: ______________________________

Patient Address: ______________________________

Phone/Contact Number: ______________________________

By signing below, I authorize HOMETOWN Health Center (HHC) and its staff (check applicable box(es):

☐ To DISCLOSE my health information below TO:

☐ To OBTAIN my health information below FROM:

Name of Person or Organization: ______________________________

City/State/Zip Code: ______________________________

Phone: ______________________ Fax: ______________________

By: ☐ Mail* ☐ Fax ☐ Email **(specify recipient's email address): ______________________

☐ Verbal Communication ☐ Other (specify instructions): ______________________

****Records provided by email will be provided in files that will be accessible to the email recipient via HHC's patient portal.**

Health Information to be Disclosed

☐ My entire medical record (complete "sensitive medical information" section below if you wish sensitive types of health disclosed)

☐ My medical records for the following dates: __/__/___ to __/__/__

☐ Only the following specific types of medical records or information for the following dates:

___/___/___ to ___/___/___

☐ Clinical Records ☐ Immunization Records ☐ Lab Reports ☐ Hospital Records

☐ Radiology Reports ☐ Summary Records ☐ Dental Only ☐ Other Records: Specify below

____

____

********IMPORTANT*******

Unless I strike out this sentence, I intend this authorization to include disclosure of records and information above disclosing person or organization has received from other healthcare providers, facilities or persons, unless such information may be withheld by law (see note below).

Sensitive Health Information

I specifically intend this authorization to include the disclosure of (initial all that apply):
_____ Mental and behavioral health records and information, including (i) records and information maintained by licensing mental health facilities, programs and agencies, and (ii) records and information related to mental health services provided by licensed mental health professionals. I understand that I have the right to review any mental and behavioral health records maintained by licensed mental health facilities, programs or agencies at any reasonable time before deciding to authorize their disclosure on this form. (Note: licensed mental health facilities, programs and agencies may refuse to disclose information or records they have obtained from another individual or facility through an assurance of confidentiality, though you have the right to receive a summary description of such information.)

_____ HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome) information, including HIV test results, HIV/AIDS status, and medical records containing HIV/AIDS information. I understand that authorizing the disclosure of HIV/AIDS records and information could have adverse consequences, including the loss or denial of employment, health insurance benefits, or life insurance benefits, and other forms of discriminatory treatment, whether lawful or unlawful.

_____ Substance use disorder program records and information (subject to protection under 42 C.F.R. Part 2).

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F.R. Pts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. 42 CFR (Code of Federal Regulations) applies to all records relating to the identity, diagnosis, prognosis, or treatment of any patient in a substance abuse program that is conducted, regulated directly or indirectly, assisted by any department or agency of the United States.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. If not earlier revoked, this consent to disclose alcohol and/or drug treatment records expires automatically on ______________________________.

I understand that generally my treatment provider may not condition my treatment on whether I sign this consent form, but in certain limited circumstances I may be denied treatment and/or services if I do not sign the consent form.

Patient Signature: ______________________________ Date: ____________________

Parent or Guardian Signature: ____________________ Date: ____________________
(If the patient lacks capacity to sign)

I REVOKE CONSENT:

____ Date: ____________________
Patient Signature

*******IMPORTANT*******

Authorization of Continuing Communications and Subsequent Disclosures

Unless I strike out any of the following, I intend to allow continuing communications and subsequent disclosures of information within the scope of this authorization – i.e., the disclosing and recipient parties of my health care information may have continuing communications concerning the health care information authorized to be disclosed by this form, and to disclose information covered by this authorization that was created or related to clinical encounters occurring after the date of my signature below.

I authorize the disclosure of the above information for the following purpose(s) (check applicable box(es)):

___ Treatment or Coordination of Medical Care ____ Transfer of medical care

___Legal Matter or Proceeding ____ Insurance coverage or payment purposes

___ Other (specify): ____

Duration of Authorization:

- To the extent that this authorization authorizes disclosure of alcohol and/or drug treatment records, that part of the authorization will expire on the date I have entered on page 2, unless it is earlier revoked by me.
- In all other respects, this authorization will expire twelve (12) months from the date of my signature below, unless earlier revoked by me or unless I have entered a different expiration date or event HERE:

  ____
  [may not exceed thirty (30) months].

By signing below, I acknowledge that I have read this authorization and understand that:

- I may refuse to authorize the disclosure of some or all the above healthcare information, but my refusal may result in improper diagnosis or treatment, denial of a claim for health benefits or other insurance, or other adverse consequences.
- I may revoke this authorization at any time, either orally or in writing, by notifying HHC in the manner described in HHC's Notice of Privacy Practices (except to the extent that HHC or any other person has already acted in reliance on it), but that my revocation may result in the denial of health insurance or other insurance coverage or benefits.
- HHC will not condition services or treatment on whether I sign this authorization, unless authorized to do so by law.
- There is the potential that information disclosed pursuant to this authorization may be redisclosed by persons or entities receiving the information and that, as a result, the information may no longer be protected.
- I have the right to a copy of this signed authorization.

____ ____________
Signature of Patient or Patient's Authorized Representative** Date:

____
Printed Name

Authorized Representative's legal authority

________ Legal Guardian ________ Healthcare power of attorney agent

________ Health Care surrogate ________ Parent of a minor

*****Signature by an authorized representative certifies to HHC that such person has the legal authority indicated to authorize disclosure of the patient's information and records.**

FOR OFFICE USE ONLY

If the disclosure is by HHC and the disclosure is partial or incomplete as compared to the patient's request, HHC must notify the patient and recipient of the information that the disclosure is partial or incomplete by checking this box ___

If this authorization authorizes disclosure of substance use disorder program information protected by 42 C.F.R. Part 2:

Notice to Recipient of Prohibition on Redisclosure: This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is behind disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute a crime by any patient with a substance use disorder, except as provided at § 2.12 (c) (5) and §2.65.

Received by: ____________________ **Location:** ____________ **Date:** ______________

Consent to Treatment & Acknowledgement of Receipt of Notice of Privacy Practices

HOMETOWN Health Center (HHC) is a Federally Qualified Health Center that provides patient-centered integrated medical care for physical and mental health, including dental services, to patients regardless of age, sex, sexual orientation, gender identity, color, rate, ethnicity, creed, national origin, religion, physical or mental disability or veteran status. HHC uses an electronic medical record that includes all of your medical information in one place. In order to give you the best care possible, your HHC providers may view any portion of your medical record relevant to your treatment, which may include your physical or mental health records or your dental records.

1. General Consent to Treatment: By signing below, I authorize health care providers at HHC to conduct examinations, diagnostic tests and procedures to assess my health care conditions, and to provide care (including emergency treatment), services or therapies necessary to effectively diagnose and treat me. I understand that it is the responsibility of my treating provider(s) to explain to me the nature of proposed care, treatment, services, prescribed medications, suggested interventions, or procedures. Before I undergo any procedure or test, my provider (s) will explain the test or procedure, including the most frequent risks and side effects; the likelihood of success; other options, including the risks and side effects of those alternatives; and information about the risks and benefits of refusing the recommended treatment.

2. Right to Refuse Treatment: In giving my general consent to treatment, I understand that I may refuse any examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my health care provider(s) and that I remain responsible for decision about my own healthcare and the consequences of those decisions.

3. Responsibility of Payment: I understand that I must pay HHC for any charges resulting from my treatment. I request that payment of authorized covered benefits be made on my behalf to HHC for such services. I understand that in order to verify those benefits HHC may release to my health insurance carrier(s) health information about me, including information related to HIV/AIDS, substance abuse (except information limited by law), and mental health treatment.

4. Release of Health Care Information: I understand that, subject to certain conditions, I may ask to limit disclosures, receive confidential information by giving HHC an address, phone number or other means of receiving the information, see or obtain copies of protected health information upon written request, and that I have other rights with respect to my health information as set forth in the Notice of Privacy Practices and listed in HHC's "Authorization for Release of Health Care Information"

5. Notice of Privacy Practices: I understand that HHC must keep my health information confidential, but legally may share information concerning my diagnosis and treatment with other healthcare practitioners and facilities involved in my ongoing care and treatment, and may use my information for other purposes including getting paid for services provided to me, coordinating care for me, or for HHC's necessary business operations. I understand that detailed list of allowed uses and disclosures is included in HHC's Notice of Privacy Practices. I have been offered a copy of HHC's Notice of Privacy Practices and I

   ______ TOOK A COPY _____CHOSE NOT TO TAKE COPY (please check one)

6. Signature: By signing below I agree that I have read and understand the information provided above. If I have any questions regarding my consent I will ask my provider before signing this form.

Patient Signature: ____ Date: ________________
(If under 18, a parent or legal guardian must sign)

Witness Signature ____ Date: ________________

Patient Acknowledgement of the Missed/Cancelled Appointment Policy

Hometown Health Center (HHC) will work actively with patients and families to reduce no-show, late arrival, and frequently cancelled appointment activity in an effort to improve access for patients. As a Patient Centered Medical Home, we aim to provide the best quality of care for medical, dental, behavioral health and specialty services.

To ensure that our patients do not miss their appointments, HHC utilizes an automated appointment reminder system that sends out alerts through phone calls, emails, and text messaging.

Please make sure that all of your contact information is updated each time you check-in for an appointment.

Please notify HHC of any cancellations at least 24 hours in advance of your scheduled appointment time. This will allow our office enough time to fill the appointment slot with another patient in need. If you cancel less than 24 hours before your scheduled appointment, it will count as a missed appointment.

HHC understands that emergencies and unforeseen circumstances may cause our patients to miss an appointment. For this reason, after the first missed appointment, HHC will give you an opportunity to reschedule.

If two missed appointments occur, you will receive a letter alerting you to the missed appointment and reminding you of this policy. We will assist you in addressing any barriers you may have attending your healthcare appointments.

Please be aware, if a third missed appointment occurs, you will only be allowed to be seen for Same Day Appointments. This means that you will only be able to be seen the same day you request an appointment, and only if there are appointments available. We will send a letter to your last recorded address alerting you of this change. We hope we can work with you to prevent this restriction from happening. If you have barriers that are preventing you from attending appointments, please reach out to our Care Coordination Team as they are here to help.

I understand this policy and have had any questions answered:

______________________________	__________
Patient Name (Printed)	Date of Birth
______________________________	__________
Patient/ Guardian Signature	Date
______________________________	__________
Witness Signature	Date