



118 Moosehead Trail, Suite 5  
Newport, ME 04953  
1-866-364-1366  
hometownhealthcenter.org

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Welcome to HOMETOWN Health Center! We are pleased to have you as a patient and will make your health and well-being our top priority.

We are a Federally Qualified Health Center and your Patient Centered Medical Home. That means that we care for the whole person and we put you, the patient, at the center of the circle of care. Your voice matters at HOMETOWN Health Center. Our role as providers is to support you and help you become actively involved in your healthcare plan. We want you to have input in making decisions regarding your care. Together we make a strong team.

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 about you and your history. A self-addressed stamped envelope is enclosed for you to return these forms. If you need assistance completing the forms, please call our office and you will be directed to someone who can help.

Here's what we need from you to help us serve you better:

- Sign the Missed Appointment Policy
- Complete and sign the Authorization to Release Health Care Information
- Complete and sign the Registration form
- Complete the Medical/Dental History form
- **Return** the above documents to us, mail in the envelope provided, or drop off at our office.

Please arrive 15 minutes prior to your scheduled appointment and bring the following items with you:

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

You have completed the first step of becoming a patient of HOMETOWN Health Center. Please visit our website, [www.hometownhealthcenter.org](http://www.hometownhealthcenter.org), to get familiar with all that we offer. And if you are on Facebook, please "like" us. We use Facebook to distribute important and fun information.

Thank you for choosing HOMETOWN Health Center. Our promise to you is that we will provide the besthealth care possible.

A handwritten signature in black ink that reads 'Robin Winslow'.

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 & School Based Health Center, Nokomis Regional High, Newport for RSU-19.*



## Patient Acknowledgement of the Missed/Cancelled Appointment Policy

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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

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).

# HHC AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

## 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 (HIPAA), 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.

## HHC AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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

# HHC AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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: \_\_\_\_\_

Hometown Health Center  
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Newport, ME 04953  
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# Hometown Health Center Registration Form

- Dexter   
  Newport   
  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 identity:**

- Male
- Female
- Transgender – Female to Male
- Transgender - Male to Female
- Gender Queer
- Other
- Choose not to disclose

**Homeless Status:**

- Not homeless
- Homeless
- Doubling up
- Shelter
- Street
- Transitional
- Refuse to Report

**Race:**

- American Indian or Alaska Native
- Asian
- Black/African American
- Declined to specify
- Hawaiian
- More than one race
- Native American Indian
- Native Hawaiian or Other Pacific Islander
- Other Pacific Islander (Not Hawaiian)
- White

**Sexual Orientation:**

- Bisexual
- Lesbian, Gay, Homosexual
- Straight or Heterosexual
- Other
- Don't know
- Choose Not to Disclose

**Migrant Worker Status**

- Migrant
- No
- Not a Farm worker
- Refused to Report
- Yes
- Seasonal

**Ethnicity:**

- Hispanic/Latino
- Not Hispanic/Latino
- Other
- Decline to Specify
- Unknown

**Preferred Pronoun:**

- She, Her, Hers
- He, Him, His
- They, Them, Theirs
- Ze, Hir
- Decline to answer

**Language Barrier:**

- Yes
- No
- Primary Language Spoken: \_\_\_\_\_

**Veteran Status**

- Yes
- No

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									
<b>Living/Deceased</b>									

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 mail (in the postage paid envelope provided), drop off at one of our locations or fax to us prior to your appointment (fax # 207-368-2451).

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



# HHC School Based Health Center

## Consent to Treatment and Acknowledgement of Receipt of Notice of Privacy

Name of Student: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

- I give permission for my child to utilize the services at the School Based Health Center (SBHC) at RSU 19 and bill insurance.
- I understand that all consent forms remain part of the child's medical record. The consent is valid for the duration of the student's eligibility at the SBHC. If a subsequent consent form is submitted, it supersedes all prior consent forms.
- I understand that my signature gives permission for the SBHC staff to access my child's school health record, share health information with my child's doctor and/or dentist and share information with the school nurse and school social worker/guidance counselors when it is deemed appropriate for treatment purposes. I understand that more complete information concerning the SBHC's right to share my child's medical treatment can be found in Hometown Health Center's Notice of Privacy Practices, which has been offered to me and available on our website at [hometownhealthcenter.org](http://hometownhealthcenter.org)
- I understand that the SBHC provides services that complement (but do not replace) those provided by my child's primary health care provider (PCP). If my child needs a service that the SBHC is unable to provide, I understand that the health center staff will refer to my child's primary health care provider (PCP) or to an appropriate specialist for that service.
- As a recipient of state funding, we are required to administer a rapid assessment for adolescent preventative services (RAPPS). I understand that when I enroll my child, children in the 5th through 12th grades may be scheduled for an annual appointment with the clinic to administer a standardized health questionnaire. My insurance may be charged for this visit, but I will not be responsible for any out of pocket expense.
- Medical records will be maintained in a confidential manner; however, I acknowledge that the SBHC may release information regarding treatment to third party payers, such as Mainecare, Medicare or other health insurance companies for the purpose of billing and for any reason in accordance with acceptable medical practice and pursuant to law. We participate in HealthInfoNet and Community Care Partnership of Maine. For more information on this visit our website: [www.hometownhealthcenter.org](http://www.hometownhealthcenter.org) or see the HIPAA Notice of Privacy Practices.
- I understand that under Maine State Law, my child may consent for certain behavioral health care services without parental permission and unless failure to notify parent or guardian would seriously jeopardize the health of the minor, the practitioner will honor the confidentiality of the student.
- In case of accident or serious illness while a child is receiving care at the SBHC, I request the SBHC to contact me. If the SBHC is unable to reach me, I hereby authorize the SBHC to make whatever arrangements are deemed necessary.  
**If you consent to this, please initial here:** \_\_\_\_\_

### Assignment of Benefits and Release of Information:

I assign all payments due from my insurance companies to HOMETOWN Health Center, which would otherwise be payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not they are paid by insurance. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

### HIPAA Notice of Privacy Practices:

- You and your child have privacy rights under the Federal Health Insurance Portability and Accountability Act (HIPAA). These laws protect the privacy of your child, but also allow us give information to others if the law requires or permits it. We will use or disclose your child's personal health information for treatment, to receive payment of services provided, or for healthcare operations. We may also disclose your child's personal health information for certain other purposes, which are described in more detail in our Notice of Privacy Practices. By signing, I acknowledge that I have been offered the Notice of Privacy Practices.
- A copy of our HIPAA NOTICE OF PRIVACY PRACTICES is also available on our website [hometownhealthcenter.org](http://hometownhealthcenter.org)

I, (print parent/guardian name) \_\_\_\_\_ acknowledge I am the legal decision maker as the parent or guardian and understand and agree to all the above statements .

\_\_\_\_\_  
Signature of parent/guardian or student (age 18 and older)

\_\_\_\_\_  
Date:

Even if your child has a primary care provider elsewhere, he/she can receive on-site medical, dental, and behavioral health care at the School Based Health Center (SBHC) at Nokomis Regional High. Hometown Health Center will coordinate care and insurance payment with your child's provider during clinic hours.

## **Enroll Your Child Today**

- Asthma
- Strep Throat
- Cough
- Fever or Cold
- Acne or Rashes
- Sprains and Strains
- Dental Services
- COVID-19 Testing
- Well-Child/Annual Exams
- Immunizations
- Vomiting or Diarrhea
- Sports Injuries
- Behavioral Health Counseling
- Flu Shot

After enrolling at the SBHC, your child can access care at Nokomis Regional High school during clinic hours.

This saves time driving to/from appointments.  
Your child is able to return to class more quickly.

**Your child does not need to be a HOMETOWN Health Center patient to enroll in this program.**

PLEASE NOTE: COVID-19 testing may be done outside of the building as "parking lot" visits.

All patients will be screened before entering the health center.

### **Sign up today!**

Call Penny Townsend, Chief Program Officer, HHC,  
at 207-368-5189 or 1-866-364-1366, email  
penny.townsend@hhcme.org with any questions.

**Visit [hometownhealthcenter.org](http://hometownhealthcenter.org)**

Hometown Health Center, 118 Moosehead Trail, Suite 5, Newport,  
29 Church Street, Dexter  
and School Based Health Center at RSU-19