HOMETOWN Health Center

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1-866-364-1366
hometownhealthcenter.org

Welcome to HOMETOWN Health Center's School Based Health Center
We are a Federally Qualified Health Center and your Patient Centered Medical Home. This means we care for the whole person and prioritize the patient in our care. Even if your child has a primary care provider elsewhere, RSU19 students, families and staff can access on-site medical, dental and behavioral health services at the School Based Health Center (SBHC) at Nokomis Regional High. HOMETOWN Health Center will coordinate care and insurance payments with your child's provider.

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
- **School Based Health Center Dental Program,** for those signing up for dental services at the school
- **Patient Medical/Dental History**, so we understand your or your child's current health status
- **School Based Health Center Consent to Treatment and Acknowledgment of Receipt of Notice of Privacy Practices**, so we have your permission to treat your child at the SBHC
- **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 (such as Student ID)
- Insurance Card, if you have one (please send it with your child for their first appointment)
- 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.

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.

HOMETOWN Health Center

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:

__ 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.*

HOMETOWN Health Center

School Based Health Center Dental Program
1-866-364-1366

Name of Child: _____ Child's Date of Birth:_____

Parent's Name: _____

Address: _____

City:_____ State: _____ Zip: _____ Phone number:_____

Please complete and sign this form so that a dentist/dental hygienist can see your child at the school.

_____ YES, I would like my child to participate in the School Based Dental Program

(Please complete the medical questionnaire below)

_____ My child is a current dental patient at HOMETOWN Health Center

Please answer the following questions to help us learn more about your child

My child's most recent dental visit was within the last: (please check one)

____ 6 months ____12 months _____ 3 years ____ 5 years ____Never

Is your child's dental care paid for by:

_____ Self-pay (out-of-pocket) _____ Private Dental Insurance(s) _____
Name(s) of insurance

_____ MaineCare (Medicaid)

If applicable, please provide the ID number of your dental insurance or MaineCare

Number: _____

Medical Questionnaire: Child's medical history – Has the child had any of the following? **(Please check all that apply)**

__Diabetes
__Anemia
__Blood Disease
__Hemophilia
__Heart Disease/Murmur
__Hay Fever
__Chicken Pox
__Convulsions Epilepsy
__Kidney Problems
__Asthma
__Tuberculosis
__Hearing Problems
__Vision Problems
__Hepatitis
__Liver Disease
__(Rupture) Hernia
__Skin Problems/Rashes
__Thyroid Problems
__Rheumatic Fever
__Sickle Cell Anemia
__Venereal Disease
__HIV (AIDS)

Does this child have any allergies? _____ YES _____ NO If YES, please explain:

_____

Has this child ever had surgery? _____YES _____ NO If YES, please explain:

_____

Any other illnesses? _____ YES _____ NO If YES, please explain:

_____

_____

Has this child ever been hospitalized? _____ YES _____ NO If YES, when Month: _____ Year: _____
Please explain:

_____

Signature of parent/guardian: _____ Date: _____

HOMETOWN Health Center

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!

HOMETOWN Health Center

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
- I understand that the SBHC provides services that compliment (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. 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 or see the HIPAA Notice of Privacy Practices.
- I understand that under Maine State Law, my child may consent for certain medical and 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 to 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

☐ 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:

HOMETOWN
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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: _____

HOMETOWN
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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