NASSON Health Care

MAILING ADDRESS
PO Box 72 Sanford, ME 04073

LOCATIONS
15 Oak St Springvale, ME 04083
207 490-6900 PHONE 207 459-2822 FAX

388 Somersworth Rd, N Berwick, ME 03906
207 676-2175

A division of York County
Community Action Corporation

PRE-APPOINTMENT FORMS CHECK LIST

Welcome to Nasson Health Care! In order to facilitate the registration process, and to save you time on the day of your appointment, we ask that you bring in or mail **all the completed forms** listed below.

Please mail or bring with you to: **Nasson Health Care**
PO Box 72, Sanford, ME 04073

When you come in for your first appointment, please bring all current medication bottles with you.

Pages 2 & 3 **REGISTRATION FORM**
Please fill out completely and remember to sign it.

Pages 4 & 5 **HEALTH HISTORY QUESTIONNAIRE**
Please fill out both front and back of the form.

Page 6 **HOUSEHOLD DATA**
When filling out this form, income needs to be included; this is confidential and does not affect sliding fee scale determination. This form needs to be filled out completely so we can continue to fulfill our grant requirements.

Pages 7 - 9 **NOTICE OF PRIVACY PRACTICES**
It explains how we use and/or disclose your medical information. Please read and sign.

Please read the forms carefully. If you should have any questions, please don't hesitate to call us at (207) 490-6900.

Our goal is to exceed your expectations each time you visit our office. In order to provide an efficient, productive patient experience, we prepare and review as much information as possible prior to your arrival.

Thank you!

REGISTRATION FORM

Please Print

Today's Date _____ Primary Care Physician _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____ ☐ Sr. ☐ Jr.

Date of Birth ___/___/___ **Patient's** Social Security Number _____

Marital Status (Check one) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered

Mother's Maiden name _____

Parent name (if minor patient) _____ Patients Sex ☐ Male ☐ Female

Street Address _____ City_____ State _____ Zip Code _____

PO Box _____ City_____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email address _____

I give **permission to release health information** regarding my treatment received at this facility to the below listed person(s)

Name _____ Relationship _____ Phone number _____

Name _____ Relationship _____ Phone number _____

INSURANCE INFORMATION

Subscriber's Name	Birth Date / /	Subscriber's Address (if different than patient's)		Home Phone	Cell Phone
Employer	Employer Address			Subscriber's Social Security No.	
Primary Insurance	Claims mailing address		Patient relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other (Please specify)		
Policy Number	Group Number	Co-Pay $	Deductible $	Insurance Phone #	
Secondary Insurance	Subscriber's Name	Date of Birth / /	Social Security No.	Home Phone	Cell Phone
Policy Number	Group Number	Co-Pay $	Deductible $	Insurance Phone #	
Claims mailing address			Other Insurance		
Patient relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other (Please specify)					

EMERGENCY CONTACT / SUPPORT ROLE

Please notify person listed below	Relationship to patient	Home phone No.	Home, Cell or Work phone

Please continue

DENTAL SERVICES

For minor patients:

1. Has your child seen a dentist regularly in the past 12 months? ☐ Yes ☐ No

2. If your child is without a dentist or it has been over 12 months since your child has seen a dentist, would you like to have your minor child receive dental services from Nasson Health Care? ☐ Yes ☐ No

CONSENT

- I am personally responsible for providing accurate and current insurance information.
- I authorize my insurance benefits to be paid directly to the physician at York County Community Action Corporation / Nasson Health Care
- I authorize release of all information necessary to secure payments of benefits.
- I understand that I am financially responsible for any remaining balance.
- I am aware of Maine's Minor's Rights to Confidential Health Care as how it pertains to mental health, substance abuse, and reproductive health services. A copy of this law will be mailed to me upon my request.
- I understand that signing this form permits my child to receive all services provided by Nasson Health Care. These services include diagnosis and treatment of acute illnesses, mental health services, and reproductive health services.

I certify that the above information is true and correct to the best of my knowledge.

_____ Date: _____

Patient, Parent or Guardian Signature

Guardian Documentation Received ☐ Yes ☐ No

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.	
Name (Last, First, M.I.): ☐ M ☐ F	DOB:

Primary Care Provider	**Date of last physical exam**

PERSONAL HEALTH HISTORY

List any medical problems that have been diagnosed, surgeries and hospitalizations
Have you been tested for TB in the past 6 months? ☐ Yes ☐ No If yes, were results positive or negative?
FEMALES: Are you pregnant or trying to get pregnant? ☐ Yes ☐ No Are you breast feeding? ☐ Yes ☐ No Are you taking oral contraceptives ☐ Yes ☐ No

TOBACCO	Do you use tobacco?		☐ Yes	☐ No
	☐ Cigarettes – packs per day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ Number of years		☐ Or year quit	
Substance Abuse	Do you have a history of substance abuse or do you currently have a substance abuse problem? (Drugs, alcohol, etc.)		☐ Yes	☐ No
Personal Safety	Have you ever been verbally, sexually, or physically hurt by anyone?		☐ Yes	☐ No
	Do you currently feel safe in your environment?		☐ Yes	☐ No

ALLERGIES: Including Acrylic, Metal, Latex and Local Anesthetics

Name the source:	**Reaction:**

Name: _____ DOB: _____

MEDICATIONS

Preferred Pharmacy:		
Name of Medication:	**Strength:**	**Frequency taken:**

FILL OUT THIS SECTION ONLY IF YOU WILL BE ESTABLISHING WITH A BEHAVIORAL HEALTH PROVIDER OR A DENTAL PROVIDER

FOR BEHAVIORAL HEALTH CARE

MENTAL HEALTH HISTORY

Please list mental health providers you have seen in the last five (5) years		
Provider Name	**How long you were seen**	**Reason you were seen**

FOR DENTAL HEALTH CARE

DENTAL HEALTH HISTORY

Do you have a current problem? (pain, swelling, sensitivity, broken tooth etc.) ☐ Yes ☐ No
If Yes, please describe:
When was your last dental visit? Dentist's Name:
What type of treatment was performed?

HOUSEHOLD and PERSONAL INFORMATION

The information in your medical record is confidential and is protected under Maine Revised Statutes Title 22, Section 1711-C. Your written consent will be required for release of information except in the case of a court order.

Nasson Health Care relies on federal funding to make our services available to everyone. Your answers to these questions help us continue to receive that funding. Thank you.

LEGAL NAME: _____ **DATE:** _____

Do you speak English? □ Yes □ No If no, what language do you speak? _____

Race:
□ American Indian/Alaska Native
□ Black or African American
□ Native Hawaiian
□ White
□ Asian
□ Multiracial
□ Other Pacific Islander
□ Other (Please specify) _____

Are you Hispanic or Latino? □ Yes □ No

Are you a migrant worker or seasonal farm worker? □ Yes □ No

Are you a Veteran? □ Yes □ No

Legal Sex: □ Male □ Female

While Nasson Health Care recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.

Do you think of yourself as:
□ Lesbian or gay
□ Straight (not lesbian or gay)
□ Bisexual
□ Something Else
□ Don't know

What is your gender?
□ Male
□ Female
□ Transgender - Female to Male
□ Transgender - Male to Female
□ Other

Housing Status:

Rent: □ Yes □ No Public Housing □ Yes □ No Is rent based on income? □ Yes □ No
Own Home: □ Yes □ No
Homeless Shelter: □ Yes □ No
Transitional Housing: □ Yes □ No
Doubling Up: □ Yes □ No
Other: _____

Household: List the people who live with you (List additional people on back of form)

Last Name	First Name	Initial	Date of Birth	Social Security#	Relationship to you

Household Income: You plus spouse.
$ _____ Check one: □ Weekly □ Monthly □ Yearly

Insurance: □ Yes □ No □ MaineCare □ Medicare A □ Medicare B □ Commercial □ Other

HIPAA NOTICE OF PRIVACY PRACTICES
USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your health facts and to provide you with the notice of our legal duties and privacy practices. We must follow the terms of the notice in effect right now, but we reserve the right to change the terms. If there is a change, we will provide you with a written, revised notice upon request.

As a client at the health center, facts about you must be used and disclosed to other parties, for treatment, payment and health care operations. These uses and disclosures require your consent, and include, but are not limited to the following information:

- A release of information contained in financial and or medical records;
- Diseases spread person to person, such as Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS);
- Drug and or alcohol abuse;
- Psychiatric diagnosis and treatment records;
- Laboratory test results;
- Medical history;
- Treatment progress;
- Any other related facts.

We may release the above to:

1. Your insurance company, Medicare, Mainecare (Medicaid), or any other person who will pay your bill for services or who will process your bill for services in order for us to receive payment;
2. Any person from a program or an insurance company, who performs billing, quality and risk management tasks, such as insurance auditors and state Risk Management;
3. Any hospital, nursing home, or other health care facility where you may have testing done or to which you may be admitted;
4. Any assisted living or personal care facility where you live;
5. Any doctor providing your care;
6. Family members and other people who are part of your plan for service, in such programs as CSHP, EPSDT, home health, hospice, etc.;
7. State and or Federal agencies acting on behalf of programs, Medicare and or Medicaid, including state surveyors or auditors for programs such as CSHP, EPSDT, PCS, WIC, STD/HIV, home health, hospice, etc.;
8. Other health care people to start treatment.

We may contact you to:

1. Provide appointment reminders or news about other health programs we provide;
2. Raise funds or donate items for our business.

We are allowed to use or disclose facts about you without consent in the following situations:

1. In emergency treatment situations, if we try to obtain consent as soon as possible after treatment;
2. Where significant barriers to communicating with you exist and we determine that the consent is clearly inferred from the situation;
3. Where we are required by law to provide treatment and we are unable to obtain consent;
4. Where the use or disclosure is required by law;
5. For certain public health activities, such as reporting births, deaths, injuries, diseases, etc.;
6. Where we reasonably believe you are a victim of abuse, neglect, or domestic violence to a government agency authorized to receive abuse, neglect or domestic violence reports;
7. Health care oversight activities;
8. Certain legal administrative proceedings;
9. Certain law enforcement purposes;
10. To coroners, medical examiners and funeral directors in certain situations;
11. For organ, eye or tissue donation purpose;
12. For certain research purposes;

13. To avoid a serious threat to health and safety;
14. For specialized government functions, including military and veterans' activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institution and custodial situations;
15. For Workers' Compensation purposes.
16. For Organized Health Care Arrangement purposes:
    Nasson Health Care is a member of Community Care Partnership of Maine ("CCPM"), an "Organized Health Care Arrangement" focused on improving the health of the communities it serves. The members of CCPM, in collaboration with insurance companies, use population health analytics, utilization review, quality assessment and improvement activities, and other evidence-based strategies to improve your healthcare. Members are mutually accountable for the health of all patients served by CCPM.
    The entities that that make up this Organized Health Care Arrangement include the following community health centers and hospitals:
    - Cary Medical Center
    - DFD Russell Medical Center
    - Fish River Rural Health
    - Greater Portland Health
    - Katahdin Valley Health Center
    - Mayo Regional Hospital
    - Millinocket Regional Hospital
    - Nasson Health Care
    - Penobscot Community Health Care
    - Pines Health Services
    - Sebasticook Family Doctors
    - St. Joseph Healthcare

    CCPM's Organized Health Care Arrangement permits these separate covered entities, including Nasson Health Care, to share PHI with each other as necessary to carry out permissible treatment, payment or health care operations relating to the work of the Organized Health Care Arrangement, unless otherwise limited by law, rule or regulation. The list of entities may be updated to apply to new entities in the future. You can access the most current list at www.ccpmmaine.org/members or call CCPM at 207-992-9200.

We are allowed to use or disclose facts about you without consent or authorization provided you are informed in advance and given the chance to agree to, restrict or forbid the disclosure in the following situations:

1. The use of a directory of people served by us (clinic schedules, patient schedules);
2. To a family member, friend or other person you choose who may assist in your care or payment for care.

Other uses and disclosures will be made only with your written approval. That approval may be withdrawn in writing at any time, except in limited situations.

YOUR RIGHTS

You have the right, subject to certain conditions, to:

1. Request restrictions on certain uses and disclosures of facts about you by filling out our Request form. However, we are not required to agree to the requested restrictions.
2. Receive confidential communication of protected health data by giving us another address or means of receiving health data.
3. Inspect and copy protected health data by filling out our request form.
4. Amend protected health data by filling out our form.
5. Receive a list of disclosures made of your protected health data by filling out our request form.
6. Obtain a paper copy of this notice upon request, if you agreed to receive this notice by e-mail, fax, or website.

COMPLAINTS

You may file a complaint with us and the Secretary of the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. There will be no retaliation against you for filing a complaint. The complaint must be filed in writing with us and must state the specific incident(s) including the date, what happened and details of the incident. For details about filing a complaint with us, please contact:
Jami Kelly, HIPAA Compliance Officer, at 207-324-5762.

ACKNOWLEDGMENT

I have read this Notice or have had it explained to me. I understand this Notice and have had the chance to ask questions about any matters I do not understand.

Signature _____ Date _____

PLEASE PRINT NAME _____ _____

For Staff Use Only

The following good faith efforts were made to obtain acknowledgement: _____

_____

However, acknowledgement was not obtained because: _____

_____

_____ Signature: _____ Date: _____