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 Identity:

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

Sexual Orientation:

__ Bisexual
__ Lesbian, Gay, Homosexual
__ Straight or Heterosexual
__ Other
__ Choose not to disclose

Sexual Orientation:

__ She, Her, Hers
__ He, Him, His
__ They, Them, Theirs
__ Ze, Hir
__ Declined to answer

Homeless Status:

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

Migrant Worker Status:

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

Language Barrier:

__ Yes
__ No
__ Primary Language Spoken:

_____

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

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.*

HOMETOWN
Health Center

Advance Directive Authorizing Consent to Treatment for Child

Child's Name: _____ Date of Birth: _____

I, _____ (name of parent), authorize the following person(s) to act as agent(s) on my behalf if I am not able to be present during the treatment of the child named above for purposes of making decisions with respect to my child's dental or mental care, except in situations where sedation or general anesthesia will be utilized, in which case my presence will be required.

If the person I have named as Agent #1 is not willing, reasonably available or able to make decisions for me, I choose the person I have named as Agent #2.

Name of Agent #1_____**Name of Agent #2**_____

Title or relationship to me _____ Title or Relationship to me_____

Address _____ Address _____

_____ _____

Home Phone _____ Home Phone _____

Cell Phone _____ Cell Phone _____

This Advance Directive is effective:

_____ (parent's initials) Immediately

_____ (parent's initials) If and when my doctor or a court determines that I lack capacity to consent

_____ (parent's initials) I understand that I can end my agent's right to make decisions for me or change my agent at any time, and that to do so I must inform HHC in writing, signed and dated by me.

_____ (parent's initials) I have read and understand this Advance Directive Authorizing Consent to Treatment for Child. I have had an opportunity to ask questions about it before signing.

Signature of Parent: _____ Date:_____

Signature of Witness #1: _____ Date: _____

Printed Name of Witness #1: _____Date: _____

Signature of Witness #2: _____ Date: _____

Printed Name of Witness #2: _____ Date: _____

HOMETOWN Health Center

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
- 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 (RAAPS). 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 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

☐ 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: