



Welcome to Avis Goodwin Community Health Center, and thank you for allowing us to care for all of your health care needs. It is our goal to make your transition to our practice smooth and efficient. You are now part of a practice that has state of the art electronic medical records, dental, medical and mental health services and dedicated support staff to meet your needs. We are experts in providing care to all ages.

In order for us to better serve you, please make note of the following:

Enclosed in this packet is your **patient handbook**. This is an important resource containing information that allows us to be your health care partner effectively. Please familiarize yourself with this information as we have much to offer.

As a new patient to our practice, we ask that you complete and mail back to our office the forms enclosed. A stamped envelope has been provided. It is preferred that we obtain your past medical records prior to the date of your appointment. By signing the authorization to 'release medical records' we will do our best to obtain these records for you. Should we experience any difficulties, you will be contacted to assist in their retrieval. Please return your information 48 hours after receiving it so that we may be well prepared for your first visit. We look forward to meeting you. If you have questions, please feel free to call us.

Below we have highlighted a few items from your handbook for immediate reference:

PROVIDER SCHEDULE: In order to provide better care and continuity, our providers like to see their own patients as much as possible. So if your provider is not in the office, unless it is urgent, we will schedule you when your provider is working.

APPOINTMENTS: It is important for your health to keep your scheduled appointments. If you are unable to keep an appointment, please notify us within 24-hours and we will be happy to reschedule you for another appointment. We do not charge a fee for missed appointments, however; if you miss two or more appointments without calling the office 24 hours in advance, you will be placed on an on-call list and you will have to call on the day you want to be seen. (Please see complete policy in your handbook) In other words, you will not be able to schedule an appointment in advance.

PRESCRIPTIONS: Please notify our office within 72 hours prior to needing your medication refilled.

Thank you again for choosing Avis Goodwin Community Health Center as your medical, mental and oral health provider. We look forward to working with you to stay healthy.

Sincerely,
The Staff of Avis Goodwin Community Health Center

**Avis Goodwin Community Health Center
Registration Form**

Patient Information

Name:	Patient ID#	Sex: ()M ()F
Address:	Primary Care Provider:	
	Marital Status: ()Married ()Single ()Divorced	
City, State, Zip:	Race:	
Phone: () ()Home()Work()Other	Ethnicity:	
Phone: () ()Home()Work()Other	Language:	
Date of Birth:	Estimated Household Gross Income: \$	
Social Security #:	# of People Supported by this Income:	

Patient Employment

()Employed ()Retired ()Unemployed ()Other
Employer:

Emergency Contact

Name:
Relationship:
Phone: ()
() yes, it is ok to speak with this person regarding my appointments
() yes, it is ok to speak with this person regarding my medical care

Parent/Guardian Information (fill in if patient is under 18 years old)

()N/A ()Parent ()Guardian ()Other	Phone: () ()Home()Work()Other
Name:	Phone: () ()Home()Work()Other
Address:	Date of Birth:
	Social Security #:
City, State, Zip:	Employer:

Primary Insurance

Insurance Name:	Subscriber's Name:
Policy #:	Subscriber's SSN#
Group #:	Subscriber's DOB:
Effective Date:	Subscriber's Relation to Patient:

Secondary Insurance

Insurance Name:	Subscriber's Name:
Policy #:	Subscriber's SSN#
Group #:	Subscriber's DOB:
Effective Date:	Subscriber's Relation to Patient:

Other Information

Is there a particular provider who you would like to establish care with?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, who?:	
Are you receiving assistance from the State of New Hampshire?	<input type="checkbox"/> YES <input type="checkbox"/> NO
How would you like our office to contact you?	<input type="checkbox"/> PHONE <input type="checkbox"/> MAIL <input type="checkbox"/> EMAIL <input type="checkbox"/> OTHER
If Email, address?:	If Other:
How did you hear about Avis Goodwin Community Health Center?:	
Are you transferring your care from another medical office?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, please fill out a records release.	

Patient/Guardian Signature: _____ Date: _____

Sliding Fee Scale Determination

Since Avis Goodwin Community Health Center receives both state and federal funds, you and your family may be eligible for a discount on the fees charged for services and supplies you receive. This discount is based on family size and household income. If you wish to apply for a discount, you will need to answer the questions below and supply proof of income. If you are applying for our sliding fee, once proof of income is received, you will be eligible for that discount for one year.

The following are appropriate examples of types of income:

- i Social Security
- i Retirement
- i Business
- i Welfare Payments
- i Child Support
- i Alimony
- i Disability
- i Others

The following are appropriate examples of proof of income:

- i 4 weeks of current and consecutive pay stubs
- i Current tax return
- i 4 weeks of Unemployment check stubs
- i Schedule C (Profit and Loss from Business)

In the table below, please tell us about the person(s) living with you.

Name (First, MI, Last)	Sex	Relationship to you	Date of Birth	Income and Frequency	Income Type
		SELF		\$	
				\$	
				\$	
				\$	
				\$	
Family Size:			Household Income:	\$	

The above information supplied is current and accurate to the best of my knowledge,

Patient/Guardian Signature _____ Date: _____

If you have any questions on this form please ask the Patient Advocate or the Front Office Staff

OFFICE USE ONLY:
 Staff Signature: _____ Date: _____

Sliding Fee Category: _____ Discount Received: _____

Confidential Client:
 Yes If Yes, Emergency Information _____
 No

Reviewed by:
 Staff Signature _____ Date: _____



ALL PATIENTS

New Hampshire law provides what is said and done in private between you and our professional staff remains confidential, and we cannot and will not disclose such medical records to anyone else unless you authorize us in writing to do so, or unless a judge orders it.

There are some limitations to this confidential relationship, and the limitations are spelled out in the New Hampshire Statutes and Federal Law.

If you would like further information about the law of Physician/Patient privilege or its limitations, please speak to someone on your treatment team.

MINORS

You need to know New Hampshire law requires we report any physical or sexual abuse, past or present, because of your age to DCYF.

Because the results of being abused can affect us for the rest of our lives, it is very important to get help as early as possible. If you don't wish to tell us, please consider talking with another trusted adult.

Patient Printed Name: _____ Date: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Patient/Guarantor Initials

- I have voluntarily come to Avis Goodwin Community Health Center (“AGCHC”) seeking medical, dental and/or behavioral health services including examinations, diagnostic tests and treatment. _____

- I understand and recognize that with the provision of any medical treatment, there are potential risks and benefits associated with that treatment. I understand that I should discuss any concerns I have regarding the potential risks and benefits of such treatment with my or my child's health care providers at AGCHC. _____

- I understand that I am financially responsible for all charges incurred that are not covered by my or my child's insurance company. _____

- I have received a copy of the Patients Bill of Rights and Financial Policy. _____

- AGCHC is required by law to maintain the privacy of your health information and to provide you with the Notice of Privacy Practices. I have received a copy of AGCHC’s Notice of Privacy Practices. _____

- All information I have supplied to AGCHC is true and complete, including income information. _____

- I understand that this consent will remain in effect unless it is revoked by me in writing. _____

- I hereby authorize Avis Goodwin Community Health Center and its agents to disclose and release personal health information about me or my child, whomever is the patient, including but not limited to information about diagnostic, therapeutic, and/or operative procedures, to my or my child's referring/mutual provider of care and any persons necessary to process insurance claims. This information may include diagnostic information relating to behavioral health services provided to me or my child, excluding psychotherapy notes. I understand that demographic and income data about me or my child that is not individually identifiable may be disclosed by AGCHC in order to receive State, Federal and Private Grants. _____

Patient/Legal Guardian Signature

Date:

FOR OFFICE USE ONLY:

Staff Signature:

AUTHORIZATION FORM FOR RELEASE OF PERSONAL HEALTH INFORMATION

Avis Goodwin Community Health Center

Patient Name: _____ **DOB:** _____

I authorize **Avis Goodwin Community Health Center** (“AGCHC”) to the use or disclosure of the above-named individual’s personal health information as described below.

Release my Protected Health Information from:	Office receiving my Protected Health Information:
Name: _____	Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Phone #: _____	Phone #: _____
Fax #: _____	Fax #: _____

Is the purpose of this release to transfer your care? **Yes** **No**

If yes, please check below the care you are transferring to another provider:

Medical Dental Behavioral Health All

If no, purpose of release: _____

Please initial the type and amount of information to be used or disclosed is as follows:

- _____ Medical diagnostic, testing, and treatment information
- _____ Dental diagnostic, testing and treatment information
- _____ Dental x-rays; date x-rays taken: _____
- _____ Immunization record
- _____ Current prenatal records, copies of all lab tests (including HIV results) and/or scans
- _____ Summary of labor and delivery notes; date of delivery: _____
- _____ Pregnancy Test Results
- _____ Sexually Transmitted Diseases
- _____ HIV/AIDS
- _____ Psychiatric/psychological evaluation(s), reports, assessments, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records and behavioral observations.

* **Provider Acknowledgement:** _____ **Date:** _____

Other: _____

Methods of Disclosure Authorized: Faxed, written, phone conversation, in-person and/or secure e-mail

- i I understand that I have the right to revoke this authorization in writing, at any time by presenting written notification to AGCHC. Revocation will be effective as of the date received.
- i I understand that a revocation will not be effective to the extent that AGCHC has taken action in reliance on the authorization prior to the revocation date, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- i I understand that my clinician generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.
- i I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by federal privacy regulations.
- i I understand that I have the right to: 1. Inspect or copy the protected health information to be used or disclosed as permitted under Federal law; 2. Refuse to sign this authorization.
- i Unless otherwise revoked, I understand this authorization expires on the earlier of one year of date signed or _____.(If left blank, the authorization will expire one year from the date signed).
- i Unless otherwise noted only the past two years of electronic records within will be sent

Signature of Patient and/or Legal Representative: _____ **Date:** _____

For office use only: Witness: _____ Date: _____ Sent by: _____ Date: _____
--



Goodwin Community Health

Sliding Fee Scale

Effective 8.25..11

WEEKLY

Category		1		2		3		4		5
Client Pays		20%		40%		60%		80%		100%
Title X Client Pays		0%		40%		60%		80%		100%
Dental Visits - Client Pays		50%		50%		75%		75%		100%
% of Federal Poverty Level		0%	100%	101%	150%	151%	185%	186%	200%	201 +
Family Size	1	0	\$209	210	\$314	315	387	388	419	420
	2	0	\$283	284	\$424	425	523	524	566	567
	3	0	\$356	357	\$535	536	659	660	713	714
	4	0	\$430	431	\$645	646	795	796	860	861
	5	0	\$503	504	\$755	756	931	932	1,007	1,008
	6	0	\$577	578	\$865	866	1,067	1,068	1,153	1,154
	7	0	\$650	651	\$975	976	1,203	1,204	1,300	1,301
	8	0	\$724	725	\$1,085	1,086	1,339	1,340	1,447	1,448
Each add'l member		+	73	+	110	+	147		184	
All procedures and lab cost will be discounted according to sliding fee scale										

Under Family Planning (Title X) income and eligibility determination must follow Federal guidelines and State regulations

- 1) If a client's income cannot be determined for the initial visit the client is considered unable to pay and placed in category 1
- 2) In return visits the fee category may be changed but the patient's inability to pay cannot be a barrier to service
- 3) Charges to individuals between 101 and 200 percent of poverty shall be based on sliding fee
- 4) Clients whose documented income is at or below 100% of poverty must not be charged but AGCHC must bill all third parties for the fee
- 5) Charges to confidential minors shall be based on the minor's own income