GREATER PORTLAND HEALTH
CARING FOR THE WHOLE COMMUNITY

PATIENT REGISTRATION

180 Park Avenue Portland, Maine 04102
Phone # 207-874-2141 Fax# 207-874-2164

PATIENT INFORMATION

______________________ ______________________ ______________

LAST NAME FIRST NAME MIDDLE NAME

DATE OF BIRTH: _____/_____/_______ GENDER: M F T U

Month Day Year

SOCIAL SECURITY OR ALIEN REGISTRATION NUMBER: _______-_______-_______

Social Security ☐ Alien Registration Number (I-94 Number form US Gov't) ☐ None ☐

____
Mailing Address (Street Address)

____
City

__________ __________
State **Zip Code**

____
Email Address Okay to send appt. reminder? Yes No

Phone Numbers: OK to leave message? (please circle yes or no for each phone number provided)

______________________ Yes No
Home Phone

______________________ Yes No
Work Phone

______________________ Yes No
Cell Phone

Text Message Okay to send appt. reminder? Yes No

The following information is for demographic purposes only and will not affect your care.

RACE / ETHNICITY

RACE: (Please check one of the races below that apply to you):

- ☐ **White**
  Portugal, Germany, Poland, Bosnia, Middle Eastern Countries
- ☐ **Black, African, African American**
  Haiti, Jamaica, Kenya, Congo, etc.
- ☐ **Other, Pacific Islander**
  Samoa, Guam, Micronesia, Tahiti, Palua, etc.
- ☐ **Asian**
  China, Philippines, Bangladesh, Nepal, Pakistan, Vietnam, Indonesia
- ☐ **South/Central/North American Indian, Alaska Native**
  Native American, Eskimo, Mayan, Incan, Puerto Rican, Miskito, Chatino, etc.
- ☐ **Native Hawaiian**
  Native of any Hawaiian Island
- ☐ **Multiracial**
  More than one race/ethnicity

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

PATIENT DEMOGRAPHICS

Have you ever served in any branch of the US Military? ☐ YES ☐ NO

Mark any living situation you have experienced in the last 12 months

- ☐ Own a Home
- ☐ Rent
- ☐ Shelter *(Oxford Street, Florence House, Family Shelter, Milestone, etc.)*
- ☐ Street *(Living in car, abandoned building, etc.)*
- ☐ Transitional Housing *(Logan Place, Pharos House, SARC, etc.)*
- ☐ Doubling Up *("Couch surfing", temporary housing arrangements due to economic reasons)*
- ☐ Living with Relatives

Employment Status

- ☐ Full-Time
- ☐ Part-Time
- ☐ Unemployed
- ☐ Self-Employed
- ☐ Disabled
- ☐ Student

Total Household Income

(Choose one)

Weekly ______________

Monthly ______________

Annual ______________

Public Housing

Housing subsidized by public funding

- ☐ Yes
- ☐ No

Benefits

(SSI/SSDI, Unemployment, Etc)

Weekly ______________

Monthly ______________

Annual ______________

Financial Assistance Program (Please pick all that apply):

☐ MaineHealth FreeCare Program Exp. Date:____________ ☐ EMHS (Mercy) FreeCare Exp. Date:____________

☐ CarePartners ☐ General Assistance

Total# of family members living in household: ______________

Total# of adults living in the household: ______________

Total# of children living in the household: ______________

Do you have an Advanced Directive? ☐ YES ☐ NO *If so, could you please bring it with you to your next appt.

What is your country of origin? ____

How did you hear about Greater Portland Health? ____

Do you require an interpreter? ☐ YES ☐ NO

Preferred Language (Choose One):

☐ English ☐ Spanish ☐ French ☐ Arabic ☐ Portuguese ☐ Somali ☐ Cantonese

☐ Mandarin ☐ ASL (Hearing Impaired) ☐ Kinyarwanda ☐ Kirundi

☐ Other: ______________________________

INSURANCE COVERAGE

☐ **I do not have health insurance and I wish to apply for the Financial Assistance Program at Greater Portland Health.**

Medicaid/Medicare

☐ MaineCare: ______________________ ______________________
(Medicaid) MaineCare ID # Name of Insured

☐ Medicare: ______________________ ______________________
Medicare ID # Name of Insured

Commercial/Private Insurance

______________________	___/___/___	______________________	
Name of Subscriber	Date of Birth	Relationship to Patient	
Name of Insurance Company	ID #	Group#	Effective Date
Address	City	State	Zip

EMERGENCY CONTACT/ SUPPORT ROLE INFORMATION

1.) ______________ ______________ ______________ ______________
Last Name First Name Relationship Date of Birth

______________ ______________ *Patient of Greater Portland Health? ☐ YES ☐ NO
Address Telephone #

2.) ______________ ______________ ______________ ______________
Last Name First Name Relationship Date of Birth

______________ ______________ *Patient of Greater Portland Health? ☐ YES ☐ NO
Address Telephone #

<u>If patient is under 18 years of age, please be sure to complete the box above**</u>**

X ______________________ ______________________

Signature Patient / Parent or Legal Guardian **Date**

GREATER PORTLAND HEALTH

CARING FOR THE WHOLE COMMUNITY

PATIENT REGISTRATION

180 Park Avenue Portland Maine 04102

PRIVACY HEALTH INFORMATION

I hereby authorize release of PHI (Private Health Information) necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the physician or group indicated on the claim. A copy of the signature below is as valid as the original.

By signing below you are stating that the information you have provided is true, and you are authorizing GREATER PORTLAND HEALTH to verify that information, and release it to referring/mutual providers of care. You are also agreeing to allow GREATER PORTLAND HEALTH to share demographic and income data with State, Federal and Private grantors as necessary. You also acknowledge that you are financially responsible for the full balance of your charges if you are self-pay; for the balance of your charges after any discount has been applied; and for any deductibles, co-pays or any services that your insurance does not cover. Any information provided that is discovered to be false now, or in the future, could be considered fraud for which you could be held liable. You have also been provided a copy of your Patient Bill of Rights, a Patient Contract for Care, and HIPAA: Notice of Privacy Practices. Your signature will also acknowledge receipt and understanding of these documents, and to verify that the information contained on this form was provided by you.

I, the undersigned certify that I have insurance coverage and assign all insurance benefits payable to Greater Portland Health, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the named health care entity to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

X____ ____________________

Signature of Insured / Responsible Party / Patient / Parent or Legal Guardian **Date**

____ ____________________

Print Name **Date of Birth**

Greater Portland Health
Acknowledgement of Receipt of Notice of Health Information Practices

---

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have received the Notice of Health Information Practices from the Greater Portland Health.

PLEASE PRINT

Last Name: ______________________________

First Name: ______________________________

Date of Birth: ______________

Signature of Patient
Parent or Legal
Guardian: ______________________________

Date: ______________

MHD HIPAA Signature Form CL/5/03

GREATER PORTLAND HEALTH
CARING FOR THE WHOLE COMMUNITY

GENERAL CONSENT TO TREATMENT

180 Park Avenue Portland Maine 04102
P. (207) 874-2141 F. (207) 874-2164

Patient Name ______________________ **Date of Birth**____________________

Greater Portland Health ("GPH") is a community health center that provides integrated medical care for physical and behavioral health, including HIV/AIDS and dental services, to patients regardless of age, sex, sexual orientation, gender identity, color, race, ethnicity, creed, national origin, religion, physical or mental disability, or veteran status. GPH uses an electronic health record that includes all of your medical information in one place. In order to give you the best care possible, your GPH providers may view any portion of your medical record relevant to your treatment, which may include your physical, mental health, substance use and/or dental records.

1. **General Consent to Treatment:** By signing below, I authorize health care providers at GPH 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 health care provider(s) to explain to me the nature of proposed care, treatment, services, prescribed medications, suggested interventions, or procedures. Before I undergo any procedures or tests, my provider(s) will explain the potential benefits, risks, or side effects, including potential problems that might occur during recovery, the likelihood of success, other options including relevant risks or side effects to those alternatives, as well as information about possible results of not choosing to undergo 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 decisions about my own healthcare and the consequences of those decisions.

3. **Responsibility of Payment:** I understand that I must pay GPH for any charges resulting from my treatment. I request that payment of authorized covered benefits be made on my behalf to GPH for such services. I understand GPH may release health information about me including information related to HIV/AIDS, substance abuse (except information limited by law), and mental health treatment to my health insurance carrier(s) in order to verify those benefits.

4. **Release of Health Care Information:** I understand that, subject to certain conditions, I may ask to limit disclosures, receive confidential information by giving GPH an address, phone number or other means of receiving the information, see or obtain copies of my 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.

5. **Notice of Privacy Practices:** I understand that GPH must keep my health information confidential, but legally may use my health information for purposes of treating me, getting paid for services provided to me, coordinating care for me, or for GPH's necessary internal operations.

6. **HealthInfoNet:** HealthInfoNet is a secure, standardized electronic system where health care providers around the state of Maine can share important patient information, giving them the tools they need to make more informed treatment decisions. This is an opt-out program which means signing this consent form gives us permission to access your medical information on HIN. If you would like to learn more, or opt-out, please ask any one of our Patient Service Representatives at the front desk.

7. **Rules for Proper Behavior:** GPH must be a safe and respectful environment for everyone – clients, staff, visitors and volunteers. Any behavior which makes the clinic space unsafe, abusive, or threatening is unacceptable. Such behaviors will result in appropriate actions by GPH including collaborative care contract and possible termination from the practice.

8. **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** ____________

Patient Agreement for Care

Hours of Operation

1. The Greater Portland Health hours for operation are listed below per location:
   a. 180 Park Avenue

Monday, Wednesday, Thursday	8am- 7pm
Tuesday, Friday	8am-5pm
Saturday	8am-12pm

   b. 63 Preble (Health Care for the Homeless)

Monday-Friday	7:45am -3pm

   c. 211 Cumberland Ave (Franklin Towers)

Tuesday, Thursday, Friday	8am-12pm

   d. 59 Riverton Drive (Riverton Park)

Monday, Tuesday, Thursday, Friday	8am-5pm

   e. 100 Brick Hill Ave, South Portland (The Castle)

Monday-Friday	8am-5pm

Scheduling an Initial Appointment

1. In order to best serve you as a patient of Greater Portland Health, please complete the new patient paperwork during this first appointment. If you need assistance completing the paperwork, a staff member can assist you.
2. No patient will be refused care because of inability to pay. If you do not have insurance, we will make an initial intake appointment with a Financial Assistance Counselor to help ensure your care is affordable. We have a Sliding Fee Scale Discount Program (SFSD Program) based on income for patients who are not insured. If you are requesting consideration for our SFSD Program, you must provide proof of household income. This may include:
   - A copy of your most recently filed Tax Return, your self-employment ledger, your current household W-2's, or a copy of pay stubs. Please bring 4 pay stubs if you or your family members are paid weekly and 2 pay stubs if you are paid bi-weekly. We will need pay stubs for all working members of your family.
   - A copy of TANF checks, SSI/SSDI checks, retirement checks, VA Benefits statements, unemployment, workers compensation, social security, bank statements or direct deposits for any of the above.
   - Proof of alimony or child support that you pay or receive.
   - If anyone in your household receives assistance from City General Assistance (GA), please bring proof of assistance from GA.
   - If you receive assistance from a family member or friend, please bring a letter of support.
   - Documentation of rental income and interest-earning income.

Income information must be updated at least annually.

Full fees will be applied if documentation of income is not received.

3. Please complete the Release of Information Form, and provide us with the name, address, phone number, and fax number of your prior medical provider/s to ensure we have the necessary information to provide you with the best possible care. We would like all records related to your health, including immunization records.
4. You are required to arrive 10 minutes before all scheduled appointments.
5. It is required that you bring your insurance card with you to each appointment.
6. Co-pays are due at the time of visit.

Broken Appointment Policy

1. We understand that sometimes conflicts arise and appointments need to be rescheduled. We require 24 hours notice in advance, so that we may reschedule your appointment, and open the cancelled appointment for another patient.
2. An appointment is considered broken if:
    - The patient fails to keep the appointment.
    - The patient is more than 10 minutes late for an appointment.
    - The patient cancels or reschedules the appointment with less than the required notice.
3. After three broken appointments within a 12 month period, patients will be required to book same day appointments, and advance appointments will no longer be offered.

Financial Policy

1. Payment is expected at the time you receive services. If you are insured or on our Sliding Fee Scale Discount Program, you will be asked for a co-payment.
2. If you are unable to pay your fee at time of service, you will be billed and you may request a payment plan. As long as you keep up with an established payment plan in good faith, we will continue to provide care. Refusal to pay or to arrange a payment plan may result in discharge from the health center, and forwarding of your account to an outside collection agency.
3. We accept cash, checks, Visa, Master Card, and Discover.
4. We accept most commercial insurance, MaineCare, Medicare, and Tri-Care.
5. There is a $20 fee for any checks returned for non-payment.
6. You are responsible for notifying Greater Portland Health that certain treatment is injury related (Worker's Compensation Case).
7. We work with NorDx for laboratory tests. If you have insurance, NorDx will bill your insurance for all lab tests completed. You will be billed by NorDx for any charges not covered by your insurance. If you are on our Sliding Fee Scale Discount Program, NorDx will honor our sliding fee based on your household income, and you will be billed for charges based on your discount. If you fail to pay NorDx for the cost of laboratory tests, NorDx may send your bill to a collection agency. If you have questions about the cost of labs, please ask our staff.

To See a Provider

1. If you need to schedule an appointment, we ask that you call during regular business hours and stay on the line to speak with a Patient Service Representative.
2. If you have a general medical question regarding a medication or your health, or an urgent medical need during our business hours, we ask that you call our office and choose option #3.
3. If you have an urgent medical need when the Health Center is not open, you can call our main line 207-874-2141 and be connected to our afterhours nurse.
4. If you have a medical emergency, dial 9-1-1.

Medication Refills

1. Please allow 48 hours for processing all medication refill requests. It is your responsibility to notify our office before you are out of medications.
2. If you do not have a scheduled appointment with your provider and need medications, you may request some medication refills by phone, we ask that you call during regular business hours and press **three (3)** to speak to a medical assistant.
3. Controlled substances will not be refilled by phone.

Referrals to Other Providers

1. If your provider refers you to another doctor or provider to assist with your care, our staff will take care of coordinating the referral. It is very important that you keep all appointments with other providers, and it is your responsibility to call and re-schedule if you cannot keep the appointment.

Policy on Controlled Substances

1. Providers at Greater Portland Health will not prescribe controlled substances for chronic pain. Providers limit use of narcotics or other controlled substances to rare situations due to the high potential for misuse.

GREATER PORTLAND HEALTH
CARING FOR THE WHOLE COMMUNITY

Patient Agreement for Care

Acknowledgement Form

Greater Portland Health's mission is to provide affordable, accessible, quality and culturally appropriate care for children and adults. When patients break appointments with too little notice or no prior notice it does not allow us to treat other patients in need of care.

We understand that sometimes conflicts arise and appointments need to be rescheduled. We require 24 hours notice in advance, so that we may reschedule your appointment, and open the cancelled appointment for another patient.

An appointment is considered broken if:

- The patient fails to keep the appointment.
- The patient is more than 10 minutes late for an appointment.
- The patient cancels or reschedules the appointment with less than the required notice.

After three broken appointments within a 12 month period, patients may be required to book same day appointments, and advance appointments will no longer be offered.

If you are having difficulty keeping appointments, please let us know. Our counselors can help address issues of transportation, payment plans, and other factors that may be preventing your ability to come to the health center, including motivation, depression, anxiety, or other life stressors.

Greater Portland Health is dedicated to our mission. Our goal is work in partnership toward your good health. Keeping appointments is part of keeping you healthy. Our broken appointment policy was developed to enable us to provide care to as many patients as possible. Thank you for your understanding and for being a part of the Greater Portland Health.

I have read and understand the Patient Agreement for Care, including the Broken Appointment Policy, as well as the Patients Rights and Responsibilities for Greater Portland Health.

______________________________ ________________
Print Name Date of Birth

______________________________ ________________
Patient Signature Date