Welcome to Rowe Health Center

We are honored to be a part of your health care journey. We are committed to a partnership that promotes health and well-being. We look forward to a relationship that enables us to support you in your mission of being the healthiest you.

To gather information necessary to ensure our providers and staff can provide quality care, please fill out the enclosed forms completely prior to your appointment. If you have any questions or problems filling out the forms, do not hesitate to call for assistance at 1.603.747.2900.

To help keep our providers on schedule, please report 15 minutes prior to your scheduled time to complete the check-in process. Our goal is to provide quality care in a timely manner. Occasionally, emergencies or the unexpected may cause delays. We appreciate your consideration.

We understand that there are times when a patient must miss an appointment due to emergencies or obligations with work or family. However, when a patient does not call in a timely manner to reschedule or cancel an appointment, this may prevent another patient from receiving needed care. Therefore, please be aware of our No-Show Policy:

- → Two (2) no-shows, you will be sent a warning letter.
- → Three (3) no-show, you will be sent a letter stating you may be discharged from the practice.

Once again, welcome to our practice. We look forward to providing you with quality care.

Cordially,

Rowe Health Center Staff

Rev 11.4.2019

Authorization for Disclosure of Medical Records

This will authorize **Cottage Hospital and/or Rowe Health Center** to use or disclose my protected health information for the following purpose: ____to:

- ☐ Self or Representative [Name of Representative]:____
- ☐ Other Provider or Facility / Name and Address of Provider or Facility: ____________________
  ____

Copies provided directly to the **<u>patient or representative</u>** will be confined to the following:

- ☐ Complete copy of medical record, excluding psychotherapy notes.
- ☐ Other (describe): ____

Copies provided to other **<u>provider or facility</u>** may relate to: [Check all that apply]:

☐ Complete copy of medical record

☐ Excluding Psychotherapy Notes ☐ Including Psychotherapy Notes
(If neither box is checked, they will be excluded)

☐ Mental Illness ☐ HIV/AIDS Related Illness

☐ Drug or Alcohol Treatment (further re-disclosure prohibited or governed by 42 CFR Part 2).

I understand that I may inspect or copy the protected health information, with the exception of psychotherapy notes, described by this authorization. I understand that this authorization may be revoked in writing and delivered to the Privacy Officer of Cottage Hospital at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has to be taken in reliance on an authorization I have signed. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I understand that Cottage Hospital shall not condition treatment, payment, or enrollment in a health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION FORM. I understand that Cottage Hospital shall have the opportunity to obtain direct or indirect remuneration in the form of [describe]:____________ from [third party]:_________________ ____as a result of this authorization.

____________ ____ ____________________________

Date Signature of Individual/Legal Representative Printed Name

____ ____________________________

Authority of Relationship of Representative Witness

* * * *

EXPIRATION DATE: This authorization will expire on __________________ (If no date is stated, expiration is six months from the date of signature).
COPY PROVIDED: Cottage Hospital shall provide a copy of this authorization, when signed, to the patient.
MEDICAL RECORD: Cottage Hospital will file a copy of this signed authorization in the patient's medical record.

Patient Intake Form

Name________________________________Date____________________________________

Address____

Date of Birth______________ Phone (Home)_______________Phone (Work)______________

Current Medications

Name	Dose	Frequency	# of refills remaining

Hospitalizations, procedures or surgeries

Date	Reason	Location

Illnesses or Injuries in last 6 months

Date	Reason	Location

Medical History (Past or Present)

- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bowel Irregular
- ☐ Bronchitis
- ☐ Chest Pain
- ☐ Chronic Pain
- ☐ Chronic Renal Failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Dizziness/fainting
- ☐ Gallbladder Disease
- ☐ GI Disorder
- ☐ Gout
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Murmur
- ☐ Heart Palpitations
- ☐ Hypertension
- ☐ Incontinence
- ☐ Nervousness/Anxiety
- ☐ Obstructive Sleep Apnea
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Overactive bladder
- ☐ Pneumonia
- ☐ Prostate Problems
- ☐ Sexual Menstrual Dysfunction
- ☐ Seizure Disorder
- ☐ Shortness of breath
- ☐ STD
- ☐ Ulcer
- ☐ Vascular Disease

Patient Intake Form Continued

List any urgent needs or concerns:____

____

____

____

____

____

Is there anything else you would like us to know?:

____

____

____

____

____

____

____

____

________________________________ ______________________________

Signature Date

Patient Demographic and Billing Information Form

First Name: ________________________ MI: ____ Last Name: _________________________________

Preferred Name: ____________________ DOB:___________ Sex:_____ SSN:_______________________

Are you of Hispanic / Latino descent: Y / N

Mailing Address: _____________________________ City: ___________________________________

State: ________________ Zip:___________

For access to our patient portal, please provide your Email Address: ______________________________

Billing Information

Primary Insurance Company: ____

Primary Care Provider on file with Insurance Company: ___________________________________

Policy # (include dashes):______________________________Group #:______________________

Policy holder: ______________________________ Relationship:___________________________

Policy Holder DOB: ______________________________ SSN:___________________________

Secondary Insurance Primary Insurance Company:_______________________________________

Policy # (include dashes):______________________________Group #:______________________

Policy holder: ______________________________ Relationship:___________________________

Policy Holder DOB: ______________________________ SSN:___________________________

Additional Information

Preferred Pharmacy:_______________________________ Location:_______________________

Emergency Contact:_________________________________ Phone #:_______________________

How did you hear about us?____

SUMMARY OF BILLING & PAYMENT POLICIES

GENERAL

1) Please be sure to bring your Insurance card(s) with you to each visit.
2) Attention all new Primary Care Patients: So that we do not have to bill you directly, please reach out to your insurance company to update your insurance card to your new Primary Care Provider. If you fail to do so, you will be responsible to pay your bill directly and work with insurance company for reimbursement.
3) Rowe Health Center will request payment of all co-payments and charges not covered by a third party (insurance) at the time of your visit. Outstanding balances are due within 30 days of statement.
4) All patients are eligible for a Prompt Pay Discount of 10% for payments made within 30 days of statement.
5) Self-pay patients who have no insurance coverage are eligible for a Community Health Discount of 44%.
6) If self-pay patients cannot make payment in full at the time of service, a $50 minimum payment towards the visit will be required at registration on day of appointment.

UNPAID BALANCES

1) For balances not paid at the time of visit, you will receive a monthly billing statement until your balance is paid in full.
2) We reserve the right to charge interest and collection fees.
3) Payment plans are available for those unable to make payment in full. Email our Patient Financial Counselor at customerservice@cottagehospital.org, or call us at 603-747-9220.
4) We understand that many patients face financial pressures that prevent them from being able to pay their balance in full. We are willing to accommodate individual situations, so long as you:

    a. Are honest about your situation
    b. Remain in contact with us about your account and comply with payment plan
    c. Stay current with payment plan

5) In the event that your account balance remains outstanding for more than 120 days and you have not met these criteria, Rowe Health Center may choose to place your account with a collection agency.

6) If your account is placed with a collection agency, you may no longer be able to access care at Rowe Health Center. All further payment arrangements will need to be made with the collection agency directly. If Rowe Health Center suspends your eligibility for services due to unpaid bills, once your balance is paid, you may re-access care through the next available patient appointment.

____
Signature of Patient /Legal Representative

____
Date

Legal Guardian: Patient is unable to sign (circle one):

Minor / temporarily incapacitated / permanently incapacitated

HIPAA Directive Consent for Release of Protected Health Information

Communication Release: ___Cottage Hospital ___Rowe Health Center

To assist us in providing the best possible uninterrupted service to you/the Patient, may we contact you by: Home Phone (if yes number):________________ Work Phone (if yes number):______________

Cell Phone (if yes number):__________________ Other (please specify):___________________

If we need to contact you by mail, what is best address?:________________________________
____

May we leave a message if you are not home (information will be limited only to date and time if call is for appointment reminder, and the name of the individual calling for the practice name)? __Yes __No

Prescription Release

Name of individual(s) you give permission to pick up medication prescriptions if needed:

NAME	RELATIONSHIP
1. __________________________________	___________________________________
2. __________________________________	___________________________________

Health Information Release

I,_______________________________ allow the healthcare provider and their representatives, with whom I share confidential relationship to disclose information to the following individuals:

NAME	RELATIONSHIP
1. _______________________________________	___________________________________
2. _______________________________________	___________________________________
3. _______________________________________	___________________________________
4. _______________________________________	___________________________________

____

Such information as they possess with respect to me can be disclosed freely and without limitation including individual identifiable protected health information. Such individuals shall be considered my personal representatives as defined in 45 CFR Section 164.502 of the regulation adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This will expire in one year from the date of signature, at which point you will be required to update this information. Failure to do so will prevent us from honoring your requests.

_______________________________________ ____________

Signature of Patient or Legal Representative Date and Time

_______________________________________ ____________

Signature of Patient or Legal Representative Date and Time Rev 9-25-19

GENERAL CONSENT FOR TREATMENT AT COTTAGE HOSPITAL AND THE ROWE HEALTH CENTER

1. Consent to Hospital Care
I request, consent and authorize Cottage Hospital and Rowe Health Center, its medical staff, nursing staff and other personnel, including employees and independent contractors, to provide care and treatment and to administer such diagnostic , radiologic, and/or therapeutic procedures and treatments as the medical staff determines is necessary or advisable. These include all diagnostic tests and procedures, including without limitation x-rays, laboratory tests (including test for infectious disease such as HIV), vaccinations, pharmaceuticals, and drawing of blood. I understand that no guarantee or assurance can be made as to the effect/result/outcome of an examination/treatment/surgery related to my condition. It is understood that some doctors and allied health professionals providing services are not employees or agents of the hospital.

2. Specific Consent
Except for emergencies, extraordinary circumstances, or routine treatments/procedures, I understand that I will be asked to sign additional, specific consent forms for certain procedures or treatment or to authorize the disclosure of or access to information regarding federally funded substance use or mental health services, if any, I may have received from Cottage Hospital or other health care providers. I understand that I have the right to consent to or refuse any medical treatment/procedure. I also understand that I have the right to evoke my general or specific consent for treatment provided it is in a timely manner before the treatment.

3. Consent to Photography & Observation
I consent to photography for the purpose of medical documentation, patient safety, identification, and educational and research purposes. For the purpose of advancing medical education, I also consent to the presence of observers such as students and medical sales representative.

4. Patient's Rights
Hospital patients have specific rights under state and federal law; I have received a copy of the Patient's Bill of Rights, Patient Responsibility, Information on Concerns and Complaints, the Notice of Privacy Practice, and Cottage Hospital Advance Directives. If I presented with New Hampshire Medicaid insurance, I received information on what New Hampshire does not routinely cover and information on what Medicare does not routinely cover.

5. Assignment of Insurance Benefits

For purposes of this Assignment, without limitation intended, third party payors include: Medicare, Medicaid, Tricare, other government sponsored health benefits programs, commercial insurers, health maintenance organizations, self-insured employers, and any combination variations thereof. I hereby authorize payment directly to Cottage Hospital for hospital benefits otherwise payable to me but not to exceed the hospital's regular charge for this period of service. I understand that I (the patient or authorized person) am financially responsible to the hospital for charges not paid under this assignment; or if I have no insurance or coverage is denied, I understand that I am financially responsible to the hospital for the payment of my account in full. This financial obligation may include, without limitation, applicable deductibles, co-insurance, co-payments or payment for services not covered by a third party payor even if, at the time services are rendered, it was assumed that the service would be covered, but was later denied by third party payors. I further understand that the hospital cannot accept responsibility for collecting my third party benefits or for negotiating a settlement of a dispute claim, and I am responsible for the timely payment of my account. Should my account be referred to collection, I shall be liable for the cost of collection, including a reasonable attorney's fee and/or collection expense.

6. For Medicare Inpatients Only

I have received a copy of the "Important Message from Medicare".

7. Champus/Tricare Inpatients Only

I have received a copy of the "Important Message of Champus"

8. Visitors/Telephone Calls

I understand that, unless I request otherwise, Cottage Hospital will provide my room location or telephone number to visitors and callers.

9. Personal Belongings

I understand that Cottage Hospital is not responsible for my personal belongings. If I wish to keep any personal items including valuables with me in the hospital, I will accept full responsibility for them. I understand that I may request my personal belongings be placed in the hospital safe during my inpatient stay.

10. Declaration of Understanding Emergency Department Policy

I understand that I have presented to the Emergency Department, I will be registered as an Emergency Department patient. I will receive a medical screening exam and any treatments needed for stabilization. As part of the provision, coordination and management of your health care, the Cottage Hospital Emergency Department will store information regarding your visit to the Emergency Department in a special electronic data base known as an Emergency Department Information Exchange (“EDIE”). To facilitate the delivery of consistent quality care, EDIE will automatically alert other emergency departments which subscribe to the EDIE system within (and potentially beyond) the State of New Hampshire, of the fact of your emergency department visit to Cottage Hospital, and certain additional basic information. Cottage Hospital will also receive alerts regarding any visits you may have made to other emergency departments. The Emergency Departments may, upon request through the EDIE system, access information regarding the services you received.

11. Release of Medical Records

I authorize Cottage Hospital, at its discretion, to disclose information from or provide copies of my medical records, which may include drug, alcohol, psychiatric or human immunodeficiency virus) HIV) diagnoses or treatment, to any person, corporation or agency who may be liable for all or part of the hospital charges or who may be responsible for determining the necessity, appropriateness, amount of other matter related to the hospital's treatment of charges. This may include, but is not limited to, insurance companies, health maintenance organizations, preferred provider organizations, worker's compensation carriers, welfare funds, the social Security Administration and its intermediaries or carriers. I further authorize the same disclosure to the hospital's insurance carrier when so requested.

I also authorize Cottage Hospital to provide medical information to my primary care physician, referring physician, referring clinician, and other health care providers, such as rehabilitation facilities, nursing homes, visiting nurse and home health agencies, as necessary to continue my medical care during and after my hospital stay.

I have read and understood the information above and I have had the opportunity to ask questions and have them answered to my satisfaction. I agree to all of the conditions for admission for inpatient and/or outpatient treatment at Cottage Hospital and the Rowe Health Center as described as above. If I am not the patient, I certify that I am authorized by law to agree to these Conditions of Admission on the patient's behalf.

Patient Signature____________________________________Date:________________________

Translator Used: _____ No _____ Yes _____ Refused Translator

Translator ID# ________________________and/or Signature: ____________________________

If the patient is unable to consent on his/her own behalf and telephone/fax consent was obtained, complete the following:

Legally Authorized Representative, Full Name:____

Relationship to Patient:______________________ Telephone Number:___________________

Street Address:____

City: ___________________________________ State: ____________ Zip code:____________

Reason cannot be present at hospital for consent:____________________________________

Patient unable to sign because:____

Signature of Legal Representative:____

Date:_________________________

Signature Witness #1:____

Signature Witness #2:____

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