SERVICE	✖	DATE
BH		
PCP		
DENTAL		
MAT		
RESPITE		

HARBOR CARE HEALTH & WELLNESS CENTER

Patient Intake Form

Please print clearly. Please ask for assistance in completing this form if needed.

Today date: _____

Patient Full Name: _____ Date Of Birth: _____

Street: _____ City: _____ Zip Code: _____

Primary Phone: (____) _____ Cell Home Work Other Phone #: (____) _____

Ok to leave a message? Yes No SSN: _____-_____-_____ Email Address: _____

Gender: ◯ Female ◯ Male ◯ Transgender Marital Status: ◯ Single ◯ Married ◯ Other: _____

If the patient is under 18 years old please complete this section:

Parent/Guardian Name: _____ Date of Birth: _____
Relationship to Patient: _____
Address if different: _____ City: _____ Zip Code: _____

Employment Status: ◯ Full Time ◯ Part Time ◯ Unemployed ◯ Disabled ◯ Retired ◯ Child/Student

Employer Name: _____Address:_____ Occupation: _____

Do you have Health Insurance? ◯ Yes ◯ NO

Please present your Insurance Card(s) at EVERY visit

<u>Primary Insurance Carrier</u>: _____

Name of Policy Holder: _____ DOB: _____

Insurance ID #_____

Relationship to patient if other: _____

Who does your insurance company list as your Primary Care Provider? _____

<u>Secondary Insurance Carrier</u>: _____

Name of Policy Holder: _____ DOB: _____

Insurance ID #_____

Relationship to patient if other: _____

If you DO NOT HAVE HEALTH INSURANCE:

Please request a Sliding Fee Discount application

and meet with our Certified Navigators to assist with insurance enrollment.

Please Circle All That Apply:

- **Is your Primary Language English?** Yes No **Do you need an interpreter?** Yes No
  If NO what Language? _____
- **Are you Deaf or hard of hearing**? Yes No **Do you need sign language interpreter**? Yes No
- **What is your highest level of education?**
  Grade School Some High School High School Graduate GED Some College / Degree
- **Have you ever served in the military?** Yes No
- **What is your discharge Status?** Honorable General Dishonorable

Do you have a permanent address? Yes No **Do you receive Section 8?** Yes No

If no permanent address where did you spend your night?

Shelter	Unsheltered	Transitional Housing	Doubling Up	Agency/Facilities
Ash Street	Street	Veterans First	Couch Surfing	Hospital
Kinsley Street	Park	Keystone/Cynthia Day	Family	Jail Prison
Maple Street	Tent	Mary's House	Friends	Other_____
Rescue Mission		Safe Haven/YMCA	Parents Home	

Some of our grants ask us to report on the race and ethnicity of the people we serve.
*Your information **will not be shared** with your name.*
*It will only be shared as a **summary** of all the people we serve. Responses to these questions are optional.*

Race:

- White
- Black/African American
- Asian
- Native Hawaiian
- Multi-Racial
- Other Pacific Islander
- American Indian/Alaskan Native
- I do not want to respond

Ethnicity:

- Hispanic/Latino
- Non-Hispanic/Latino
- I do not want to respond

Sexual orientation:

- *Heterosexual*
- *Bisexual*

How did you hear about us?

- Employee
- Hospital
- Friend
- Family
- Walk-in
- Keystone
- Hospital
- School
- Insurance Carrier
- Other Provider
- Website
- Other_____

• *Homosexual* •*Other*_____ • *Choose not to disclose*	
Family Household Size: _____	Estimated Monthly/Annual Household Income: _____

Emergency Contact:

Name: _____Relation_____
Address: _____Phone Number: _____

Name:_____DOB:_____

Medical History Form

Family and Health History: *Please enter Y / N or U for unknown*

	Self	Mother	Father	Grandparents	Brother/Sister	Aunts/Uncles
Alcohol/Drug Abuse						
Anemia						
Asthma or Bronchitis						
Behavioral Health Emotional/Nervous/Mental						
Bladder/Kidney Disease or Problems						
Broken Bones/Fracture						
Cancer or Tumors						
Diabetes						
Epilepsy or Seizures/Blackouts						
Eye or Vision Problems						
Gyn Problems or Miscarriages						
Head Injury						
High Blood Pressure						
Heart Disease (stroke, heart attack)						
HIV/AIDS						
Liver Disease/Hepatitis						
Pneumonia						
Skin Problems						
Stomach/bowels Problem						
Thyroid Problems						

Teeth Problems						
Tuberculosis (TB) or TB exposure						

Are you allergic to any food or medications? Yes or No

Please List All Allergies:

_____

Please list any medications that you are prescribed by a doctor or taking over the counter:

Name of medication	Dose	How Often	Who Prescribed it?

Medical Questionnaire

Have you ever been hospitalized? Yes or No

If yes please explain_____

Where did you last receive Health related services?

_____

When is the last time you had went to the dentist? _____

Do you have pain today? Yes No If yes on a scale 0 to 10 (10 being horrible) how bad is your pain today?

_____

When was your last Tetanus shot? _____ Other Vaccines: _____

Are you sexually active? Yes No With: Men Women Both Number of partners in last year _____

Do you use condoms to protect against STD's? Yes No

Have you been tested for HIV? Yes No *Results*: Negative Positive

Have you ever been tested for Hepatitis? Yes No *Results*: Negative Positive

Have you ever had an STD? Yes No When? _____ What? _____

Are you currently concerned about your safety at home or with others? Yes No

Have you experienced abuse in the past? Yes or No *Type of abuse:* Emotional Physical Sexual From who?

_____

Do you use Tobacco Products? Yes No

If yes how much per day? _____ Would you like help to quit? Yes No

Do you use Drugs or Alcohol? If yes drug type _____ How often_____

When did you last use? _____ Have you ever gone through withdrawals? Yes or No When? _____

Have you ever been arrested or in prison? Yes No If yes when? _____

Have you ever detoxed? Yes No How long have you been substance free? _____

Have you had any other medical condition that has not been listed?

_____

If you are over 65 years, have you fallen in the past 12 months? Yes or No

In our efforts to coordinate care do you receive services from other agencies? If so please provide name of person(s) you work with._____

_____

If you are a female:

Are you on birth control? Yes No

Date of last menstrual period? _____ Date of last PAP? _____Was it abnormal? Yes NO

Have you ever had a mammogram? Yes No If yes when and result? _____

Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Patient/Client Name: _____ DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Harbor Homes Inc.'s Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at 45 High Street Nashua, NH 03060.

Signature of Patient/Client **Date**

Signature or Parent, Guardian or Personal Representative **Date**

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, Healthcare surrogate, etc.)

☐ **Patient/Client Refuses to Acknowledge Receipt:**

Signature of Staff Member **Date**

Appropriate Clinic Conduct Policy

Harbor Care Health and Wellness Center must maintain a safe and comfortable atmosphere for all staff and patients. Anyone who conducts themselves in a manner considered to be inappropriate (outlined below) will be informed of our concern and asked to sign a

patient agreement. Patients who refuse, or who break the agreement, may be discharged from our services. A report of a staff acting inappropriately will be investigated and may result in employment termination.

Inappropriate Conduct:

Threatening verbal or written statements
Threats of bodily harm
Violence toward any staff or patient
Throwing objects or hitting, slamming walls, doors etc.
The presence of any weapon in the building

Readmission:

Patient who have been discharged for these reasons can only be re-admitted through the Medical Director's permission in consultation of the VP, of Operations. The medical Director will be to consider all viewpoints in his/her deliberation.
I have read the above policy:

_____ _____

Signature of patient/Guardian **Date**

_____ _____

Signature of Staff/Witness **Date**

Medical Consent Form and
Liability Release Agreement

Name of Patient: _____ DOB: _____

Name of Parent/Guardian: (printed) _____

Home address: _____

Telephone No.: _____

I hereby voluntarily authorize and consent to the provision of health services to myself of such medical care, attention and treatment that any provider of the Harbor Care Health and Wellness Center may deem necessary or advisable, including any x-ray examination medical service or procedure.

I agree to pay the reasonable cost of such medical care, attention or treatment and to indemnify and hold free and harmless of and from any and all liability of such services.

_____

Signature Date

FINANCIAL RESPONSIBILITY AGREEMENT AND ASSIGNMENT OF BENEFITS

I understand I am financially responsible for all the charges and bills associated with my care and treatment, except to the extent that all or part of these charges or bills are paid or covered by health insurance, a government health care program (such as Medicare or Medicaid), a financial assistance program, or another party responsible for their payment (all of which are referred to as "Third Party Payers"). I authorize Harbor Care Health and Wellness Center to submit bills or claims and related information concerning my health

status, care, treatment, and payments made for my care and treatment to any applicable Third Party Payer and its business associates. I also authorize such Third Party Payers to make direct payments to Harbor Care Health and Wellness Center in response to these bills or claims.

X_____ Date_____

Signature

Received:

- Patient Bill Of Rights Signature: _____ Date:_____
- Consent to treatment Signature: _____ Date: _____
- Appointment Policy Signature: _____ Date_____

Employee Signature of witness _____ Date _____

Patient Bill Of Rights

1. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151 :3-b

2. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments the signing must be by the person legally responsible for the patient.

3. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.

4. The patient shall be fully informed by a health care provider of his or her medical condition , health care needs, and diagnostic tests results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable an so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, an to be involved in experimental research upon the patient's written consent only. For the purposes of the paragraph "health care provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist , and any officer, employee or agent of such provider acting in the course and scope of employment of agency related to or supportive of health care services.

5. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the social security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for Medicaid as a source of payment.

6. The patient shall be encouraged and assisted throughout the patients stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination or reprisal.

7. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient bill of rights under this subdivision and in conformance with state law and rules.

8. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.

9. The patient shall be free from chemical and physical restraints except when they are authorized in writing by the physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff in order to protect the patient or others from injury. The staff member must promptly report such actions to the physician and document same in the medical record.

10. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the coping of a patient's medical record shall not exceed $15 for the first 30 pages or $0.50 per page, which ever is greater; provided, the copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

11. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such may be included in a plan of care and treatment.

he patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident group, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to unmonitored use of a telephone.

12. The patient shall be free to participate in activates of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients

13. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.

14. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences; including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.

15. The patient shall not be denied appropriate care on the basis of race, color, religion, national origin, sex, age, disability, marital status, or source of payment, nor shall any such care be denied on account of the patient's sexual orientation.

16. The patient shall be entitled to be treated by the physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.

17. The patient shall be entitled to the patient's parents, if a minor, or spouse, or next of kin, or a personal representative, if an adult, visit the facility, with out restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.

18. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151 :28

19. The patient shall not be denied admission to the facility based on Medicaid as a source of payment when there is a available space in the facility.

No Show of Appointments, Late and Cancelations

Policy: If a patient no shows their appointment (as a new patient) or has three appointment no shows in any consecutive 3 months, then that patient must be placed on a same day status for three consecutive appointments. In regards to late arrival for appointments, patients will be given an arrival time for their appointment 15 minutes in advance of the actual appointment time. If a patient then arrives after the actual scheduled appointment time, there is no guarantee we will be able to see them. The provider will make the decision at the time if the patient can be accommodated. Specifically, there is no guarantee the patient can be seen if they are more than:

1. 5 minutes late for a short appointment
2. 10 minutes late for a long appointment
3. Late (at all) for any procedure.

If a patient cancels excessively, the provider may, at their discretion, choose to put the patient on a same day status to improve their compliance with care, or to deny them services if necessary.