GREATER PORTLAND HEALTH
CARING FOR THE WHOLE COMMUNITY

PATIENT REGISTRATION

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

For Office Use Only:
Provider: **Insurance:**
Appointment Date/Time:
ID: ☐ **Scanned** ☐ **Copied**

PATIENT INFORMATION

LAST NAME _____ **FIRST NAME** _____ **MIDDLE NAME** _____

SOCIAL SECURITY OR ALIEN REGISTRATION NUMBER: _____ – _____ – _____
☐ Social Security ☐ Alien Registration Number (I-94 Number from US Gov't) ☐ None

DATE OF BIRTH: _____ / _____ / _____ (Month / Day / Year)

Preferred Name: _____

Mailing/Billing Address (Street): _____

City _____

State _____ **Zip Code** _____

Email Address _____

Are you interested in our Patient Portal? ☐ Yes ☐ No

Phone Numbers :

OK to leave a Message? (please circle yes or no next to each number provided)

Home Phone _____ **Yes** **No**

Work Phone _____ **Yes** **No**

Cell Phone _____ **Yes** **No**

Preferred Contact: ☐ **Home** ☐ **Work** ☐ **Cell**

Birth Sex
☐ Male
☐ Female

Current Gender
☐ Male
☐ Female
☐ Undifferentiated

Gender Identity
☐ Male
☐ Female
☐ Male to Female (Transgender)
☐ Female to Male (Transgender)
☐ Genderqueer, neither exclusively male nor female
☐ Other _____
☐ Choose not to disclose

Sexual Orientation
☐ Straight
☐ Gay or Lesbian
☐ Bisexual
☐ Something Else
☐ Don't Know
☐ Chose Not To Disclose

Pronoun
☐ He, Him, His
☐ She, Her, Hers
☐ They, Them, Theirs
☐ Ze, Hir
☐ Other
☐ Decline to Answer
☐ Asked but unknown

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

RACE / ETHNICITY

☐ **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,

☐ **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

☐ **Declined to Specify**

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

PATIENT DEMOGRAPHICS

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

Public Housing

Housing subsidized by public funding (Section 8)

- ☐ Yes
- ☐ No

Are you a Migrant or Seasonal Farm Worker?

- ☐ Seasonal
- ☐ Migrant
- ☐ Not a Farm Worker

Total Household Income

(Choose one)

Weekly $ _____

Monthly $ _____

Annual $_____

Benefits

(SSI/SSDI, Unemployment, Etc)

Weekly $_____

Monthly $_____

Annual $_____

Financial Assistance Program (Please pick all that apply):

☐ Maine Health Free-Care Program—Expiration Date:_____

☐ EMHS (Mercy) Free-Care—Expiration Date:_____

☐ Care Partners ☐ General Assistance

Total# of adults living in the household: _____
Total# of children living in the household: _____
Total# of family members living in household: _____

Do you have an Advanced Directive or Living Will ? ☐ YES ☐ NO

If so, please bring it with you to your next appt.

How did you hear about Greater Portland Health? _____

What is your country of origin? _____

Preferred Language (Choose One):

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

☐ ASL (Hearing Impaired) ☐ Kinyarwanda ☐ Kirundi ☐ Swahili ☐ Other:_____

Do you require an interpreter? ☐ YES ☐ NO

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

Patient Name: _____ Date of Birth: _____

INSURANCE COVERAGE

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

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

EMERGENCY CONTACT/ SUPPORT ROLE INFORMATION

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

_____ _____
Address Telephone #

*Patient of Greater Portland Health ?
☐ Yes ☐ No

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

_____ _____
Address Telephone #

*Patient of Greater Portland Health?
☐ Yes ☐ No

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

X_____ _____

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

Patient Name: _____ Date of Birth: _____

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 needed to make more informed treatment decisions. This is an opt-out program, meaning 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. **Grievance rights**: I am aware of my grievance rights as a patient as outlined in Greater Portland Health's Admin 210 Grievance Handling Policy.

9. **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** _____

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

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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.

Patient Last Name: _____

Patient First Name: _____

Patient Date of Birth: _____

_____
Patient Signature (or Parent/Legal Guardian)

Date: _____

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 a 24-hour 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 in 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 Patient's Rights and Responsibilities for Greater Portland Health.

_____ _____

Printed Patient Name Date of Birth

_____ _____

Patient Signature (or Parent/Legal Guardian) Date

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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.

_____ _____

Patient Name **Date of Birth**

X_____ _____

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