Compass Family Health LLC

835 Central Ave. Suite 200 Dover, NH 03820 Phone: 603-749-0001

Dear New Patient,

Thank you for choosing us to help you with your medical and wellness needs. We strive to provide our patients with exceptional care; so we ask that you to thoroughly fill out the following forms and return them to our office. You are welcome to return the forms by dropping them off or mailing them into the address listed above. We also accept records faxed to **(603) 749-1006** or emailed to **info@compassfamilyhealth.com**

Below is a checklist of the information we need in order to set up your initial appointment. Once we review everything and your provider has determined how long they would like set aside for *your* initial appointment, we will call you to find a time that works with your schedule.

- ☐ A Copy of Your Insurance Card front and back (We confirm eligibility prior to your appointment)

  Or ☐ Check here if you are self-pay / have insurance we do not participate with
- ☐ Registration Information (ok to leave insurance #s off, but MUST include guarantor's info if not the patient)
- ☐ General Information (2 pages)
- ☐ Financial Policies (please note new patients are agreeing to pay $100 if you do not show for your appointment of cancel last minute)
- ☐ Liability Waiver
- ☐ HIPPA Agreement
- ☐ Permission to Share Information Form (If you do not want anyone listed please check none and sign)
- ☐ Health History (2 pages)
- ☐ PCP referral if indicated (For HMO insurance policies, if we are NOT your pcp)

☐ Please **circle** the reason(s) you wish to establish care at the office, and return **this form** with the ones listed above.

-To Establish Primary Care ("meet and greet" & set up your medical record) *-required for new primary care patients*

-Specialty Health Problem (discuss concerns / issues, but not primary care)

-Primary Care Physical Exam (typically no pelvic exam) -Sport / School Physical

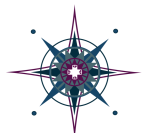
-Establish Gynecology Care (eventually schedule gyn-exam) - Women's Health Problem Visit

-Nutrition / GI Consultation -Therapeutic Cannabis -Medication Management

- Hormone Management - Pellet HRT - Cosmetic Consult / Treatment Plan

-Other:____

We are excited to meet you and help you achieve your wellness goals. ~ *Dr. Laura and Team*



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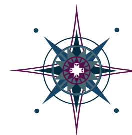
PATIENT REGISTRATION



**Please complete each section below.*

CURRENT PATIENT INFORMATION -- PLEASE PRINT	Guarantor Information (to whom statements are sent)
Last Name:	Name:
First Name:	Address:
Middle Name:	
Address:	Relationship to patient: ________________________
City: State:	Date of Birth:
Zip:	Social Security No.:
Home Phone:	Phone: ( ) _______ - ______________
Work Phone:	**Emergency Contact Information**
Mobile Phone:	Name:
Sex: **F**	Relationship:
Date of Birth:	Phone:
Social Security No.:	Mobile Phone:( ) _______ - ______________
Patient email:	
Required by government mandate [although you may refuse]:	**Employer information**
Language:	Employer:
Race:	Address:
Ethnicity:	Phone:
Marital Status:	

Other	Pharmacy Information:
Patient Referred by:	Name:
Primary Care Provider:	Crossroads:
Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email	Phone:

Primary Insurance Information	Secondary Insurance Information
Insurance Plan Name:	Insurance Plan Name:
Last Name:	Last Name:
First Name:	First Name.:
Middle Name:	Middle Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**	Date of Birth: Sex (please circle): **M** or **F**
Employer Name:	Employer Name:
Patient's relationship to policy holder:	Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed____ **Date:**______________________

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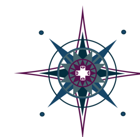

GENERAL INFORMATION

**Please initial each paragraph and sign below*

____ PRIVACY & BILLING HIPAA is a Federal Act which protects your Private Health Information. We ask you to sign a HIPPA release form because it is required by law. We must inform you of our strict adherence to these guidelines. We are happy to forward records, as long as you sign a Release of Records with specific delineation of what can and cannot be released, with the exception of referrals being sent as your PCP for continuity of care. We are prohibited from discussing your care, testing or billing matters with anyone, including parents and spouses, without your expressed written consent. Per HIPAA, a health care provider or a business associate of a health care provider or a patient or patient's legal representative may transmit the patient's protected health information through the health information organization. This will occur within this practice for the purpose of billing insurance with the expectation that remittance will be rendered to the practice.

_____ MINORS by law, are considered adults when they become 18 years old, or have legally emancipated from their parents in prior to the age of 18. Minors between 14 and 18 years old are able to seek care for reproductive, pregnancy or sexually related concerns and testing, either alone or with a parent in attendance are considered adults and their medical information will not be shared with their parents without written permission. Minors 12 and older are able to seek care for themselves without parental permission for drug or alcohol treatment. Minors are also protected under the same HIPAA standards, meaning that the office staff is not allowed to discuss any aspect of their care, including diagnosis, treatment, lab results, or billing information without permission of the patient (for the above concerns) or their parent for general medical care.

_____ EMAIL, FAX and PORTAL. Email is not considered secure, but can be used at your discretion to contact us regarding personal matters. We will assume that if you contact us via email regarding medical or billing matters, there is implied consent that we reply to you via unsecure email. Our fax line is secure and can be used for transmission of medical related material. Use of the secure portal is preferred and we are required by law to use our portal when sending you any records, results, or communications over the internet. Questions sent via the portal will integrate and store in your medical record so we are able to consult them in the future as needed.

_____ COMMUNICATION Email and E-Newsletter are our way of keeping everyone updated for important insurance news, changes in business hours, progress in the practice, additional providers in the Journey to Wellness building, etc. We will try to limit our communication so not to overwhelm your inbox but ask that you read emails when possible. TEXT messages may be sent from time to time for urgent or out of office notifications so they are not overlooked in emails. TEXT may also be used for reminder notifications if you choose. You will receive statements via mail and from time to time other correspondence we urge you to open.

_____ APPOINTMENTS are made for 30, 45 or 60 minutes depending on the type of visit and a specific patient's needs. We all do our utmost to ensure that we run on time, because we value your time. The time that we give you for your appointment is your expected appointment time and we ask you arrive 15 minutes prior to that to complete the check in process. This check-in time is used to update medical, contact and insurance information etc. When a patient misses an appointment with less than a full business day notice, he or she will be personally billed (not their insurance) for a no-show or short notice fee, unless there are emergent or extenuating circumstances. Please be courteous and value the time that the providers have to care for all patients and understand that some appointments might unexpectedly run late depending on the severity of a case. We will be respectful of your time, and inform you if we are running more than 15 minutes behind schedule and offer you choices of getting coffee/tea, shopping at the shops in the building, waiting or rescheduling.

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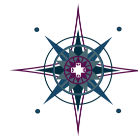
GENERAL INFORMATION 2



____ DISMISSAL from the practice is the providers legal right if they for any reason become uncomfortable continuing to treat you. That being said, patients also have rights and shall not be abandoned. Although dismissal does not occur often appropriate reasons for dismissal would be recurrent no-shows, large unpaid balance, poor treatment of staff, inability to agree upon a mutually acceptable treatment plan, drug seeking or threatening behaviors, exhausting office resources or unacceptable / unnecessary communication attempts. If the event were to arise that one would be released from the practice a certified letter will be sent to the last address on file and the patient will be permitted care for an additional 30 days until they are able to find a new provider.

____ TEST RESULTS will be sent to you directly via the secure portal unless you are legitimately unable to operate the portal, or we deem it necessary to contact you via phone or mail. Each test that we order will be reported to you within a week or so. If you do not hear from us *after a week*, we ask that you call the office to check in regarding results as we may not have received them from the testing facility (except the facility that performs your Mammogram will send you their report directly and we will become involved only if there is an issue). Calling to check if your results are in prior to a week after testing can actually slow down the review process, so we ask you be patient unless there are extenuating circumstances requiring fast knowledge of your results (ie pending meds or surgery). If you would like more information regarding your testing than what is supplied via the portal an appointment can be made to review them and your questions at length.

____ PHONE COMMUNICATION We pride ourselves on educating our patients so they can be involved in their care. If you choose not to make an appointment to come in for a discussion, phone appointments are available with the nurse or provider. In some cases these may be billed to your insurance but coverage may be limited and you will likely be responsible for the bill. If you do not have tele-visit coverage, please be advised that we have low cost self-pay phone rates where a 5-10 min phone appointment charges are $25, 11-20 min $50 and 21-30min are $75. Longer phone calls (> 10 min) and those scheduled with the provider must be booked and payed in advanced to insure your spot will be held at this low rate. If you call for medical advice from our nurses and require extensive (>5min) discussion please be advised that you may be billed accordingly as outlined above.

____ MEDICATIONS will be provided by the prescriber at their comfort level. I understand that for some medications it is the law that my provider check my PDMP record, and if they are ever concerned about providing me with a prescription they have the right to refuse to write a prescription and offer me alternatives. The medical software used in this office will link with your pharmacy and will update your medication list when you check in for an appointment. This is done to keep your record accurate and more importantly to keep you safe as it allows us to better evaluate for drug interactions when prescribing. Please bring your most up to date medication list with you to verify with the nurse at check in.

Thank you for reading and understanding and agreeing to our general terms and policies.

Patient Name ____ DOB ______________________

Signature Patient / Guardian ________________________________ Date ______________________

Print name of signer if not Patient ____________________________ Relationship________________

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FINANCIAL POLICIES

**Please initial each paragraph and sign below*

_______The purpose of this policy is to encourage our patients to take their appointments and healthcare as seriously as we do. When we book you an appointment that time is reserved specifically for you and the time that you require. We plan longer appointments to provide you with great care, despite receiving the same insurance payments for shorter visits. Because of this we ask you to please remember that if you cancel with short notice or do not show for your visit we are unable to offer your spot to those waiting.

_______Appointments can be made if the event arises where you need paperwork filled out / signed by the provider. Examples include but are not limited to: disability forms, handicap plate requests, redoing forms already completed, insurance wellness incentives or physical validations for work/school, communication or letters to attorneys, landlords etc. If you choose to forgo the appointment to discuss this paperwork it can be mailed in or dropped off to be completed for an administrated / paperwork fee of $30, as you may find this more convenient and cheaper than your copay. Please notify us in advance regarding your plans and deadlines so we can determine if we have / schedule the time needed to complete the forms in a timely manner.

_______The fee for missing an appointment **or** cancelling an appointment with less than one full working day notice. The fees are $150.00 for new patient appointments (as they are scheduled for longer blocks of time since they are more involved) and $100.00 for established patient appointments.

_______Returned payment / insufficient funds will result in a $30 fee in addition to the balance originally due. If you need accommodations for a payment plan to pay for an appointment or resolve a balance, please call to make arrangements. If you know you will not be able to pay for your portion of a visit, payment plan options should be discussed with the financial coordinator in advance so biweekly or monthly payments can be scheduled to keep your account in good standing.

_______We encourage a credit card be stored on file so in the event you have an appointment balance that goes unpaid for 3 monthly billing cycles and your claim hits collections status, a payment plan can be initiated for you. Our in-office payment plan will split your balance due in half and your card on file will be charged 1/2 of the balance plus a $5 fee for the next 2 months required to settle the balance. To avoid these fees and the automatic payment policy please pay attention to your statements and call with questions. You can mail, call in or go to the portal to make payments, or call the office to set up a more convenient payment plan if needed. We offer this option to avoid having claims sent to an external collections agency where an additional $50 fee will be added to the balance due and delinquency may be reported to credit agencies.

_______Excessive disregard of these policies may jeopardize future appointments with our practice. We understand that unforeseen crises may arise and a fee may not apply. Please call us to explain the circumstances as we remain available to discuss this policy for individual cases. We will consider each circumstance and your history to determine if a fee will be reduced or waived. Please note that any cancelations for “convenience” or last-minute “schedule conflicts” will be assessed this fee. Also, as we are a medical practice so most often we are comfortable with you coming in when sick, especially since we may be able to help you with your concerns.

_______All Fees and prior balances should be paid in full prior to any subsequent appointment being scheduled. These are personal fees and cannot be billed to insurance, and are not subject to self-pay or cash discount.

Thank you for your understanding and agreeing to our policy, as indicated by your signature and initials.

Patient Name ____ DOB ______________________

Signature Patient / Guardian __________________________________ Date ______________________

*Initial if _______ agreeing **or** ______ declining to keep a card on file to be billed automatically for unpaid balances more than 3mo old as outlined above, to avoid being sent to an outside collections agency.

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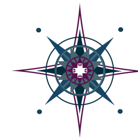

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LIABILITY WAIVER

**Please fill out the following, initial the appropriate lines and sign the bottom of this form.*

Primary Care Provider's information is required for proper billing of all insurance claims

Check if your insurance lists your PCP as:

☐ Laura Hudson NPI # 1659723286

☐ Rebecca Turner NPI # 1730842790

☐ Brittany Beaumier NPI # 1801503800

OR

Non-Compass PCP's Name: ______________________ **Practice:**__________________________________

PCP's City/State: ________________________________ **Office Phone**: _____________________________

GENERAL INFORMATION & INSURANCE WAIVER OF LIABILITY

_______Most medical insurance companies have high deductibles and highly variable and changing rules and restrictions about specific visits, labs, radiology studies, medications and procedures. It is impossible for us to verify if we are in your network, what your particular plan covers or when you have met your deductible or even if a visit will or will not apply to your deductible. It is *YOUR* responsibility to learn / know what tests are covered, what lab, medical or radiology groups are in your network, and if your insurance covers only routine or only problem care and. It is *YOUR* responsibility to discuss this information with your provider while testing is being ordered, and accept any costs that are billed to you by our office or the labs / facilities that process your testing. It is expected that you will be able to pay *YOUR* copay, co-insurance or previous balance upon arrival to an appointment. It is *YOUR* responsibility to pay your bill in full; and as a courtesy you we bill your insurance on your behalf if we are participating with that company. By signing this Waiver of Liability, you agree to be personally responsible to pay any balances acquired from services at this office in a timely manner, whether fees for services received have not been covered by your insurance company due to: Deductible not being met; Non-covered Benefit on your policy; or Not in Network or any other reason not due to fault of ours.

HMO WAIVER OF LIABILITY

_______I understand that if my insurance is or becomes an HMO Insurance policy, it is **required for me to obtain a referral** from my Primary Care Provider (PCP) and present it **prior to** or **at the time** services are rendered at this office, for **any type of visit**, including routine yearly check-up or problem visits. If I do not have a referral on file at the time services are provided, I agree to be personally responsible to pay the full amount of charges for all routine and problem care, devices, studies, tests and procedures. If this practice is your PCP office this does not apply. If you require an insurance referral from us we request that you provide us with 1 week notice prior to any appointment or procedure requiring a referral and that when you contact us for the referral you provide us with the location, name and NPI of the provider you will be seeing, and for what reason.

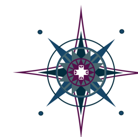
MEDICARE WAIVER OF LIABILITY

_______Notice: Medicare will only pay for services that is determined to be "reasonable and medically necessary" under Section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare Program standards, Medicare will deny payment for that service. Be advised that Medicare is ***likely to deny payment for*** preventive exams, some lab tests, pap smears, some radiology studies, medications, equipment, and some procedures. By signing this form I agree that if I have Medicare insurance and they deny payment, I agree to personally be fully responsible for the full amount for such services.

Patient Name ____ DOB ______________________

Signature Patient / Guardian __________________________________ Date ______________________

Print Name of signer if not patient ______________________________ Relationship_________________



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HIPAA

Privacy and Release of Information Authorization

**Please initial each paragraph and sign below*

_____I authorize the above practice and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve insurance claims and health benefit coverage issues.

_____I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice of intent to revoke this authorization. I also understand that I have a right to have a copy of this authorization.

_____I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

_____I have been advised of this practice's privacy practices, release of billing information policy, assignment of benefits policy, and grant the practice medication history authority, including access to my current medication record.

By signing below, I acknowledge that all my questions have been answered and I am signing this document willingly.

Patient Name ____ DOB ____________________

Patient Signature ____ Date ____________________

Or

**Legal Representatives: By signing this form, I represent that I am the legal representative of the patient / insurance member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.*

Signature Representative ____________________________________ Date __________________________

Print Name of Representative _________________________________ Relationship______________________

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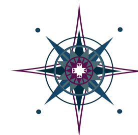

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

There are times where the providers and employees at Compass Family Health may need to discuss certain aspects of your care. Communication with your other providers, pharmacists, testing facilities and insurance company is allowed in order to coordinate care and treatments. Only the necessary information about your health will be communicated for instances of continuity of care.

Adding names to this form allows the Compass Family Health providers and their staff to verbally discuss your health care with additional individuals that you can name below. By listing someone, you acknowledge that these individuals play some role in your care, either by assisting you directly or by offering support to me and other family members.

This document is not a Health Care Power of Attorney. The sole purpose of this form is to protect your privacy by ensuring that your health care can only be discussed with individuals you have chosen. It is important that you understand that you may retract permission to share your information with anyone on this list, and that when you fill out a new form, it will supersede all previous ones.

Please note that this form does NOT give the individuals named below any authority to make health care decisions for me. It also does NOT allow them access to my medical record or documents.

By signing this form, you acknowledge you have read the above information and that you understand that you may list as many individuals as you want, and that you are not required to designate anyone, if that is what you choose

_______ I choose to authorize NO ONE at this time. (Only Initial if Applicable)

1.____ ____________________________
Name of Individual Authorized to Receive Information — Relationship

2.____ ____________________________
Name of Individual Authorized to Receive Information — Relationship

3.____ ____________________________
Name of Individual Authorized to Receive Information — Relationship

4.____ ____________________________
Name of Individual Authorized to Receive Information — Relationship

Patient Name ____ DOB ____________________

Signature Patient / Guardian ________________________________ Date ____________________

Print Name of signer if not patient ____________________________ Relationship________________

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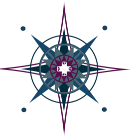

MEDICAL HISTORY

Date ______________

Legal Name ________________________________ Preferred Name _______________ DOB ______________

Gender assigned at birth: M / F **Current Gender Identity (if different):**_________________________________

MEDICAL HISTORY: **Indicate **past** (**P**) or **current** (**C**) next to each applicable condition below or blank if N/A*

__ Heart Disease	__ Hepatitis	__ Headache	__ Anxiety	__ Mono
__ Lung Disease	__ Hernia	__ Sinus Problem	__ Panic Attacks	__ Lyme Disease
__ Liver Disease	__ Asthma	__ Eye Problem	__ Depression	__ Fibromyalgia
__ Kidney Disease	__ Emphysema	__ Ear Problem	__ Suicide Attempt	__ Chronic Fatigue
__ Thyroid Disease	__ Ulcers / GERD	__ Mouth Problem	__ Trouble Sleeping	__ Arthritis OA/RA
__ Diabetes	__ High Cholesterol	__ TMJ Problem	__ Restless Leg	__ Carpal Tunnel
__ Seizures	__ Blood Disease	__ Neck Problem	__ Trauma	__ MRSA
__ Stroke	__ Cancer	__ Bone Disease	__ Skin Lesions	__ Eczema/ Psoriasis

__ Urinary Issues: __ leaking __ frequency __ urgency __ blood __can't empty __weak stream

Other: ____

Elaborate on above: ____

____

ALLERGIES: Penicillin Sulfa E-mycin Cephalosporins Morphine Aspirin Codeine NSAIDs

Other meds:____

Latex Y / N Tape/Adhesive Y / N Iodine Y / N Shellfish Y / N Bees Y / N Nuts Y / N

Environmental ____

Food / Intolerances ____

SCREENING TESTS: *(when was the last time you had one done?)*

PCP Physical________________ GYN Exam_________________ Pap Smear ________ HPV__________

Mammogram ________________ Bone Density ________________ Routine Blood Work _______________

Colonoscopy ____________= wnl / polyps / cancer = Planned next at: 3 yr / 5yr / 10 yr interval

Ultrasound __________ Stress Test ____________ EKG___________ Other ____________________________

IMMUNIZATION HISTORY:

Childhood Immunizations Complete? Y /N If No, What is missing:_________________________________

Did you have the Chicken Pox Y /N If No, did you receive the Vaccine Y / N Titer?___________________

Zostavax Vaccine (Shingles) Y / N Date:_________ Last Flu Shot Date:________ HPV Y / N Date:_________

Pneumovax Vaccine (pneumonia) Y / N Date:__________ Prevnar 13 Vaccine (pneumonia) Y / N Date:_________

MEDICATIONS:	DOSE	TIMES/ DAY	REASON

Multivitamin ______ Calcium mg/day ______ Vitamin D # IU/day ______ Iron_______ Probiotic_____ Magnesium________

OTC/ HERBAL/ HOMEOPATHIC: ____

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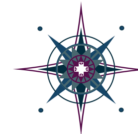

SEXUAL HEALTH:

Sexual Orientation:___________ Sexually Active: Y / N Condoms: Y / N Contraception?_____________

Hx Sexually Transmitted Infection: __HPV __Warts __Herpes __Chlamydia __Gonorrhea __Syphilis __HIV

Sexual Concerns? Y / N __no desire __no pleasure __ orgasm issue __ impotence __dryness __pain

GYNECOLOGY HISTORY: (if applicable)

Total Pregnancies _______ Live Births _______ Miscarriages/Terminations ________ #Living Kids ________
Age Periods Began__________ Age Periods Ended__________ Hyst? Y / N Ablation Y / N
Regular Periods? Y / N Happen how often ___________________ Last how long ___________________
Abnormally Heavy_____ Abnormally Painful ______ Bleed Between Periods______ Bleed After Sex _____
History Abnormal Paps: Y / N When _______ Diagnosis ______________ Treatment ________________
Vag Symptoms *(itch, pain, burn)* _____________________________________ Abn Discharge _______________
PMS: Y / N PMDD Y / N Hot Flashes / Night Sweats Y / N # Children: ____living ____deceased

FAMILY HISTORY: **Check applicable boxes*

Relative	age of death	Heart Disease	Diabetes	Stroke	Heart Attack	AFib	High BP	High Cholesterol	Thyroid	Cancers (type)
Mother										
Father										
Maternal G-Parents										
Paternal G-Parents										
Sisters										
Brothers										
Aunt/Uncle										
Children										

SURGICAL HISTORY:

Surgery ____________________________________ Year __________ Where __________________________
Surgery ____________________________________ Year __________ Where __________________________
Surgery ____________________________________ Year __________ Where __________________________
Surgery ____________________________________ Year __________ Where __________________________

OTHER PROVIDERS: **Ok to share info? Initial**

PCP (if not here) ___________________________________ Location _______________________ Y / N ______
Psychotherapist _________________________________ Location _______________________ Y / N ______
Gynecologist ___________________________________ Location _______________________ Y / N ______
Massage Therapist ________________ Chiropractor ___________________ Acupuncturist _________________
Other ____ Other ____

LIFE STYLE:

Have a living will Y / N *Medical DPA* Y / N -who if yes_________________________Ph#__________________
Who lives with you____ Pets __________________________
Occupation ____Like Work? _________________
Exercise ___________________ Frequency _______________ # meals/day ________ # veggie servings/day ______
Caffeine/day _________ Alcohol/day ___________ Street drugs? ____________________ any ever _______________
Tobacco: Y / N type___________how much / often _______________ for how long__________ want to quit ?_______
Prior Smoker _________ Quit when ___________ Sleep Well ____________ Need meds to sleep__________________
Safe at Home ______________ History of Physical, Emotional or Sexual Abuse ________________________________
What are your stressors? ____

Other Health Concerns:____

____