LAMPREY HEALTH CARE
Where Excellence and Caring go Hand in Hand

Patient Information Form

Please Print Clearly

If needed, please ask for assistance in completing this form.

Patient Name: _____ Date of Birth: _____ (Month / Day / Year)

List any different name(s) you've used, such as a maiden name: _____

Street: _____ P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ (check one) → Cell ☐ Home ☐ Work ☐

Secondary Phone: _____ (check one) → Cell ☐ Home ☐ Work ☐

Email Address: _____

I authorize Lamprey Health Care to communicate with me using email: ☐ Yes ☐ No

Gender assigned at birth: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Other

Employment Status: ☐ Full Time ☐ Part Time ☐ Disabled ☐ Unemployed ☐ Retired (date): _____ (Month / Day / Year)

Employers Name: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Relationship: _____

If the patient is a child, please complete this section.

Parent/Guardian #1 Name: _____

Date of Birth: _____ (Month / Day / Year) Relation to patient: _____

Address (if different from patient): _____

Parent/Guardian #2 Name: _____

Date of Birth: _____ (Month / Day / Year) Relation to patient: _____

Address (if different from patient): _____

I have health insurance.
Great, please provide your card(s) so we can make a copy.

Name of policy holder: _____ Date of Birth: _____ (Month / Day / Year)

Relationship to patient: _____

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

I don't have health insurance.
No problem! Ask a team member about our Financial Assistance Programs.

Complete All Pages and Return to the Front Desk

LAMPREY HEALTH CARE
Where Excellence and Caring go Hand in Hand

Patient's Printed Name: _____

Patient's Date of Birth: _____
Month / Day / Year

GENERAL CONSENT FOR OUTPATIENT DIAGNOSIS, CARE AND TREATMENT

On an ongoing basis, I request, consent, and authorize Lamprey Health Care, Inc. to perform diagnostic and therapeutic tests and procedures and provide general care and treatment as determined necessary and/or ordered by those health care professionals involved in my care. This includes, but is not limited to, the performance of physical examinations and x-rays or other diagnostic or radiological procedures, as well as the taking of blood, tissues, fluids, or other bodily samples. I also consent and authorize Lamprey Health Care to examine, use for the purposes for which they were provided, store, and dispose of any blood, tissue, fluids, or bodily samples in accordance with legal requirements and customary procedures. I understand I may ask my health care providers about my care, treatment and procedures at any time and I am encouraged to do so.

BEHAVIORAL HEALTH SERVICES

Lamprey Health Care provides an integrated team approach for the coordination of primary and behavioral health care. As an integrated team all staff members work together, improving communication among providers by sharing information in one medical record and decision making, as well as shared responsibility for a patient's care plan. Behavioral Health Services are available to all individuals. I consent to the sharing of my Private Health Information in order to formulate a plan of care. I understand health care professionals in training may be involved in my care and I consent to their involvement in it under appropriate supervision.

FINANCIAL RESPONSIBILITY AGREEMENT AND ASSIGNMENT OF BENEFITS

I understand I am financially responsible for all of 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 Lamprey Health Care 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 Lamprey Health Care in response to these bills or claims.

CONSENT AND AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Lamprey Health Care maintains records in electronic and other forms. These records describe, among other things, my past and current health status, including the diagnosis of any illness and conditions, the nature and results of examinations and tests, treatment provided, and any plans for care or treatment. In addition, these records include billing, social, and other identifying information and may include sensitive information such as genetic testing results, HIV/AIDS status, and drug and alcohol use (all of which is referred to as my "Health Information"). I consent and authorize Lamprey Health Care, when necessary for my treatment, payment of my bills, or Lamprey Health Care's business operations, to release and exchange my Health Information with other health care professionals and organizations involved in my care and with business associates that Lamprey Health Care has contracted for the same reasons.

ANY QUESTIONS I HAD ABOUT THIS CONSENT HAVE BEEN ANSWERED. I UNDERSTAND THE INFORMATION IN THIS FORM AND AGREE TO THE CONDITIONS SET FORTH ABOVE. THIS CONSENT SHALL REMAIN EFFECTIVE UNTIL I REVOKE IT IN WRITING, WHICH I MAY DO AT ANY TIME.

Signed: _____ Date: _____
(Patient or Authorized Representative) Month / Day / Year

Relationship of Authorized Representative: _____
(For example: Parent, Guardian, or Health Care Agent)

MEDICARE ONLY

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or by Lamprey Health Care. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

If you have Medicare please sign to confirm you have read and understand this section.

Signed: _____ Date: _____
(Patient or Authorized Representative) Month / Day / Year

Complete All Pages and Return to the Front Desk

LAMPREY HEALTH CARE
Where Excellence and Caring go Hand in Hand

Patient Information Form

Please Print Clearly

If needed, please ask for assistance in completing this form.

Lamprey Health Care receives state and federal funding to support our services. Occasionally we are asked to report on the general financial status and the race/ethnicity of our patients. Your assistance in completing this information will help us apply for future grant funding. ***All information is confidential.***

Thank you for your cooperation.

Ethnicity

Are you: ☐ Hispanic ☐ Not Hispanic

Race: (Check up to two boxes that best apply.)

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black / African American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ White

Sexual Orientation

What is your sexual orientation?

- ☐ Straight or Heterosexual
- ☐ Lesbian, Gay, or Homosexual
- ☐ Bisexual
- ☐ Something else
- ☐ Don't Know
- ☐ Chose not to disclose

Gender Identity

What is your gender identity?

- ☐ Male
- ☐ Female
- ☐ Transgender Male / Trans Male/ Female to Male (FTM)
- ☐ Transgender Female / Trans Female / Male to Female (MTF)
- ☐ Genderqueer (neither exclusively male or female)
- ☐ Additional gender category or Other
- ☐ Chose not to disclose

Communicating With You	**Yes**	**No**
Is your primary language English?	☐	☐
If no, what is your primary language?	_____	
Do you need an interpreter?	☐	☐
Are you hearing impaired?	☐	☐
Do you need a sign language interpreter?	☐	☐

Living Arrangements

- ☐ Rent
- ☐ Own Home
- ☐ Shelter
- ☐ Other _____
- ☐ Live with relative or friend
- ☐ Transitional housing
- ☐ Street

Are You ... (check all that apply)

- ☐ Full Time Student
- ☐ Part Time Student
- ☐ Veteran
- ☐ Migrant Worker
- ☐ Seasonal Worker

How Did You Hear About Us?

- ☐ Relative
- ☐ Friend
- ☐ Hospital
- ☐ Other Provider
- ☐ School
- ☐ Employer
- ☐ Insurance Directory
- ☐ News/Media Story
- ☐ Lamprey's Website
- ☐ Internet / Social Media
- ☐ Advertisement
- ☐ Walk In
- ☐ Social Service Agency
- ☐ TV/Radio
- ☐ Community Event
- ☐ Other: ff

Complete All Pages and Return to the Front Desk

LAMPREY HEALTH CARE
Where Excellence and Caring go Hand in Hand

Patient Information Form

Please Print Clearly

Circle the income range that applies to your family size.

Step 1: Look down the first column and find the row that matches the number of people in your household, including children. If there are more than 8 in your household, use row 8.

Step 2: Put a checkmark next to your family size. Then go across the top until you find the income level that best matches your household and check the box above that column.

Family Size	From	To	From	To	From	To	From	To	Above
☐ 1	$0-	$12,760	$12,760.01	$17,226.00	$17,226.01	$23,606.00	$23,606.01	$25,520.00	$25,520.01
☐ 2	$0-	$17,240	$17,240.01	$23,274.00	$23,274.01	$31,894.00	$31,894.01	$34,480.00	$ 34,480.01
☐ 3	$0-	$21,720	$21,720.01	$29,322.00	$29,322.01	$40,182.00	$40,182.01	$43,440.00	$ 43,440.01
☐ 4	$0-	$26,200	$26,200.01	$35,370.00	$35,370.01	$48,470.00	$48,470.01	$52,400.00	$ 52,400.01
☐ 5	$0-	$30,680	$30,680.01	$41,418.00	$41,418.01	$56,758.00	$56,758.01	$61,360.00	$ 61,360.01
☐ 6	$0-	$35,160	$35,160.01	$47,466.00	$47,466.01	$65,046.00	$65,046.01	$70,320.00	$ 70,320.01
☐ 7	$0-	$39,640	$39,640.01	$53,514.00	$53,514.01	$73,334.00	$73,334.01	$79,280.00	$ 79,280.01
8 or more	$0-	$44,120	$44,120.01	$59,562.00	$59,562.01	$81,622.00	$81,622.01	$88,240.00	$ 88,240.01

If needed, please ask for assistance in completing this form.

Lamprey Health Care receives state and federal funding to support our services. Occasionally we are asked to report on the general financial status and the race/ethnicity of our patients. Your assistance in completing this information will help us apply for future grant funding. ***All information is confidential.***

Thank you for your cooperation.

Please consider following us!

Complete All Pages and Return to the Front Desk

LAMPREY HEALTH CARE
Where Excellence and Caring go Hand in Hand

Authorization to Disclose Protected Medical Record Health Information

Patient Information:

Patient Full Name *(please print)* _____ **Previous Name if applicable** _____

Street Address _____ **Date of Birth** _____

City _____ **State** _____ **Zip Code** _____ **Daytime Phone #** _____

Receive Medical Records from:

Doctor/Organization _____ Phone # _____ Fax # _____

Street Address _____ City _____ State _____ Zip Code _____

Information to be released:

☐ Abstract of **last 3 years of treatment on file** or most recent to include: Chart Summary, Advanced Directives, Immunizations, Progress Notes, Imaging, Labs, Hospital Reports, Consultation Notes, Pathology, GYN Records, PSA, Urology, and Dermatology. Colonoscopy, Cardiac Reports, Pap and Mammogram if more than 3 years old.

☐ Only some portion of the record (*please specify what to release*) _____

Records to be sent to the office below: ***Please Check One:***

☐ **LHC-Nashua Center**
Attn: Medical Records
22 Prospect Street
Nashua, NH 03060
P: (603) 883-1626
F: (603) 881-9914

☐ **LHC-Newmarket Center**
Attn: Medical Records
207 So. Main Street
Newmarket, NH 03857
P: (603) 659-3106
F: (603) 659-8003

☐ **LHC-Raymond Center**
Attn: Medical Records
128 State Route 27
Raymond, NH 03077
P: (603) 895-3351
F: (603) 895-0773

Reason for release of records:

☐ Permanent Transfer Other (*please specify*) _____

This authorization is valid for one year from date of signature and may be revoked by writing to the Organization listed above. My record may contain sensitive information (Alcohol and or drug use, STD, HIV/ AIDS, Genetic Testing, Mental and Behavioral Health) and I agree to this release. I have the right to receive a copy of this authorization. Records released pursuant to this authorization may be re-released and no longer protected by Federal Privacy Laws. Consent for release of information is not required as a condition of treatment.

This information is protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who it pertains or otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____
Please print name of Patient or Authorized Representative Relationship if not Patient

_____ _____
Signature of Patient/Authorized Representative Date