

## **B Street Health Center**

Community Clinical Services

57 Birch Street Lewiston, ME 04240 • Tel: (207) 513-3850 • Fax: (207) 786-0489

Welcome to B-Street Health Center,

I would like to take this opportunity to welcome you to Community Clinical Services. We are pleased that you have given us the opportunity to provide you with your health care services. We are committed to providing you with high quality medical care in a warm, respectful and compassionate environment. Our Mission is to help you make an informed choice about your health. We are pleased you have decided to join our patient centered medical practice.

Our office hours are 8:00 am to 5:00 pm, Monday through Friday. Extended hours are available by appointment. Our telephone will be answered during this time by one of the staff of your medical home. If you call after hours, you will be directed to our answering service who will contact the appropriate on-call physician to provide the non-emergency response you require. If you have an emergency, we encourage you to call 911.

In order to make your visits with us as efficient as possible, we ask that you arrive 15 minutes prior to your scheduled appointment. We are then able to assure up to date information about you by reviewing your personal and insurance information prior to your appointment with your provider. We also ask that you bring in your current list of medications as well as your insurance card.

We realize schedule conflicts arise and that from time to time, this may make it difficult for you to keep your scheduled appointment. We ask that you provide us with 24-hour notice of any need to reschedule your appointment. If you consistently are unable to keep your scheduled appointments, please ask us for help. We want to assist you with making your appointments. For the sake of all the members of our medical practice, keeping appointments and arriving on time are important in providing high quality medical care.

If you need a prescription refill called into your pharmacy, please plan ahead, especially if a weekend is near, and notify us 24-48 hours in advance so it can be completed.

If your insurance plan requires a co-payment, this is expected at the time of your appointment. Patients who do not have medical insurance or have an inability to pay may inquire about the FreeCare and Self Pay Discount Programs at the office or by contacting the Patient Representative Business office at 207-777-8208.

We look forward to meeting your health care needs, answering your questions and building a long-term relationship that helps to insure your good health.

Sincerely,

B-Street Health Center Providers and Staff  
Your Patient Centered Medical Home

**Did you know that our office now offers a secure way for you to view your test results plus request appointments, prescription refills and medical records? Please speak to the office staff about Your Healthlink at your next appointment.**

**PATIENT REGISTRATION FORM**  
**B Street Health Center, 57 Birch Street, Lewiston, Maine 04240**  
**(207) 513-3850**

*International Clinic Referral* (Referred by: \_\_\_\_\_)

**PATIENT INFORMATION:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Gender: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Telephone Numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Veteran Yes No Homeless Yes No Employer: \_\_\_\_\_

Name of Parent/Legal Guardian: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_

**ETHNIC BACKGROUND (please circle):**

White American Indian or Alaska Native Asian Black or African American Hispanic or Latino Oromo Sudanese  
Native Hawaiian or other Pacific Islander Somali or Somali Bantu Congolese Togolese Ethiopian Unknown or Other

Primary Language Spoken: \_\_\_\_\_ Interpreter Needed: Yes or No

Interpreter's Name: \_\_\_\_\_ Interpreter's Telephone Number: \_\_\_\_\_

**INSURANCE INFORMATION:**

**Primary Insurance:**

Insurance Company Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Secondary Insurance:**

Insurance Company Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

1. I understand that in providing or arranging these healthcare services, Community Clinical Services will learn personal information about me, but that information shall remain confidential.
2. I agree on behalf of myself, or my minor child, that Community Clinical Services may share medical information with the health plan(s) and that the health plan(s) may share all relevant medical information with other involved parties, as appropriate. However, my agreement is limited to the extent that the sharing of medical information is reasonably necessary for the administration of the health plan including all procedures for quality and cost efficiency.
3. I authorize my insurance carrier to pay benefits directly to my physician.

X \_\_\_\_\_  
Signature (Parent/Guardian if Minor) \_\_\_\_\_ Date \_\_\_\_\_

**As a Federally Qualified Health Center, we can offer a sliding fee scale based on income eligibility.**  
**Please see receptionist for further information.**

## *Medical Questionnaire*

- Have you or any blood relatives had any of the following (please circle appropriate answer)

Heart condition	yes	no	Lung Disease	yes	no
Diabetes	yes	no	Kidney Disease	yes	no
Cancer	yes	no	High Blood Pressure	yes	no
Stroke	yes	no	High Cholesterol	yes	no
Depression	yes	no	Substance Abuse	yes	no

If you have answered yes to any of above, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- Please list any allergies you may have: \_\_\_\_\_  
 \_\_\_\_\_
- Do you smoke or use tobacco products? yes no If so, how much? \_\_\_\_\_ Are you interested in quitting? yes no
- What type of exercise do you do? \_\_\_\_\_  
 How many times do you exercise weekly? \_\_\_\_\_

- Please list any admissions, procedures or surgeries you have had during the past 10 years (*please include dates*):

<i>Hospitalizations</i>	<i>Procedure or Surgery</i>

- Please list any current medications, including over-the counter medications, you are currently taking:

<i>Medication Name</i>	<i>Dosage</i>	<i>How often do you take medication</i>

- If you have seen any other medical and/or behavioral providers during the past 5 years, please complete the following:

<i>Provider Name</i>	<i>Address</i>	<i>Telephone Number</i>

**\*\*please complete the “release of records” so we may obtain your records prior to your appointment\*\***  
 Thank you for your assistance. Should you have any questions, please contact us at (207) 513-3850

## B Street Health Center

**Community Clinical Services, 57 Birch Street, Lewiston, ME 04240 (207) 513-3850 Fax: (207) 786-0489**  
**Release of Records**

Previous Provider's Name: \_\_\_\_\_

Previous Provider's Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

I hereby authorize the above named Provider and those physicians and other clinicians or those associated with or employed by their office in connection with my medical care to disclose my HealthCare information to:

**B Street Health Center**  
**Community Clinical Services**  
**57 Birch Street, Lewiston, ME 04240**

Dates of Service: From \_\_\_\_\_ to \_\_\_\_\_ Disclose only the following information (patient must indicate each item to be released/obtained):

<input type="checkbox"/> Radiology Films <input type="checkbox"/> Radiology Report <input type="checkbox"/> Pathology Report <input type="checkbox"/> Laboratory Report <input type="checkbox"/> Laboratory and all other tests <b>except</b> HIV/AIDS mental health and/or drug substance abuse results <input type="checkbox"/> Recertification <input type="checkbox"/> Care Plans	<input type="checkbox"/> HIV/AIDS test/counseling records <input type="checkbox"/> Physician orders <input type="checkbox"/> Provider progress notes <input type="checkbox"/> Nursing notes <input type="checkbox"/> Facial Photo <input type="checkbox"/> All Therapy Notes or select below: <input type="checkbox"/> Physical <input type="checkbox"/> Occupational <input type="checkbox"/> Speech <input type="checkbox"/> Cardiac	<input type="checkbox"/> Operative Notes <input type="checkbox"/> Rehabilitation Notes <input type="checkbox"/> Discharge Summary <input type="checkbox"/> History & Physical <input type="checkbox"/> Medical History <input type="checkbox"/> Plan of Treatment <input type="checkbox"/> Emergency Room Visit <input type="checkbox"/> Dietary Records <input type="checkbox"/> Nursing Assessments	<input type="checkbox"/> Mental Health History/Treatment <input type="checkbox"/> Mental Health Discharge <input type="checkbox"/> Psychiatric Medication <input type="checkbox"/> Information relating to commitments, orders, applications and reports <input type="checkbox"/> Alcohol/Drug Abuse Records limited to 6 months from Date of Consent <input type="checkbox"/> Sexually transmitted disease records <input type="checkbox"/> Sexual/Alleged Sexual Abuse records
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Other (describe): \_\_\_\_\_

Note – No substance abuse treatment or care information may be redisclosed; each disclosure requires the consent of the patient. All other information that I have authorized to be disclosed may be redisclosed to others consistent with the purposes above:

\_\_\_\_\_ Yes                      \_\_\_\_\_ No

**The form in which the information is to be released:**

Written/photocopied/faxed     Verbally     E-Mail Address: \_\_\_\_\_     Other (describe) \_\_\_\_\_

I understand that I can revoke (cancel) this authorization to disclose the above-referenced information at any time, except to the extent that disclosure has been made in reliance upon my authorization before revocation. In order to revoke my authorization, I must send a written notice to: B Street Health Center, Community Clinical Services, 57 Birch Street, Lewiston, ME 04240.

This consent will expire **Thirty (30) months** from the date hereof, unless I have previously revoked this consent, or unless I have specified a shorter period for expiration of this Consent, as follows: \_\_\_\_\_. I understand that I may refuse authorization to disclose all or some health information, but that refusal may result in improper diagnosis or treatment, denial of coverage of a claim for health benefits or other insurance or other adverse consequences. I also understand that if I revoke an authorization to disclose healthcare information, which may be the basis for denial of health benefits or other insurance coverage or benefits. I know that I can review/print the Sisters of Charity System full notice of privacy practices from the [WWW.STMARYSMAINE.COM](http://WWW.STMARYSMAINE.COM) website for more information about my right to revoke this authorization. I understand that I may receive a copy of this Full Notice of Privacy Practices as well as this authorization.

\_\_\_\_\_  
 Witness                                      Signature of Patient or Authorized Representative                                      Print Name                                      Date