CCS Family Health Care
Community Clinical Services
100 Campus Avenue Suite 201 Lewiston, ME 04240
Tel: (207) 755-3445 • Fax: (207) 755-3475

Welcome to CCS Family Health Care,

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 7:00 am to 7:00 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,

CCS Family Health Care 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

CCS Family Health Care, 100 Campus Avenue Suite 201, Lewiston, Maine 04240
(207) 755-3445

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)***:

Hospitalizations	*Procedure or Surgery*

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

Medication Name	*Dosage*	*How often do you take medication*

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

Provider Name	*Address*	*Telephone Number*

****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) 755-3445.

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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:

CCS Family Health Care
Community Clinical Services
100 Campus Avenue Suite 201, Lewiston, ME 04240

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

___Radiology Films ___Radiology Report ___Pathology Report ___Laboratory Report ___Laboratory and all other tests **except** HIV/AIDS mental health and/or drug substance abuse results ___Recertification ___Care Plans	___HIV/AIDS test/counseling records ___Physician orders ___Provider progress notes ___Nursing notes ___Facial Photo ___All Therapy Notes or select below: ___Physical ___Occupational ___Speech ___Cardiac	___Operative Notes ___Rehabilitation Notes ___Discharge Summary ___History & Physical ___Medical History ___Plan of Treatment ___Emergency Room Visit ___Dietary Records ___Nursing Assessments	___Mental Health History/Treatment ___Mental Health Discharge ___Psychiatric Medication ___Information relating to commitments, orders, applications and reports ___Alcohol/Drug Abuse Records limited to 6 months from Date of Consent ___Sexually transmitted disease records ___Sexual/Alleged Sexual Abuse records

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:

_XX_ 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: CCS Family Health Care, Community Clinical Services, 100 Campus Ave Suite 201, 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** 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