Thundermist!
HEALTH CENTER

Welcome to Thundermist! Thank you for choosing Thundermist Health Center as your medical home. Before your appointment, please complete all highlighted fields on the new patient packet and medical records release form. Any incomplete forms will have to be completed again. We look forward to meeting with you.

You may return documents by:

Mail: 25 John A. Cummings Way, Attn: Document Management, Woonsocket, RI 02895

Fax: 401-235-6896 Attn: Document Management

Email: MedicalRecords@ThundermistHealth.org

If you have any questions, please contact us by email,

MedicalRecords@ThundermistHealth.org

We will be happy to help you.

THUNDERMIST HEALTH CENTER
Patient Consent Form

Please fill out the information below and read, write your initials and sign this form as indicated. Please BRING IT WITH YOU to your first appointment at Thundermist. If you have any questions, please ask them of our staff when you come for your visit.

PATIENT LAST NAME _____ **FIRST** _____ **MI** ____
DOB _____ **MR#**_____
Month Day Year (For Office Use Only)

Consent to Treatment / Release of Information:
I consent to treatment by Thundermist staff according to their policies and my rights as a patient (refer to the patient handbook) I give Thundermist permission to release my (or my dependent's) personal health information to third parties in order to process requests for payment and to release my personal health information to other providers, in accordance with HIPAA policies in order to coordinate my health care.

I have received a copy of Thundermist's Notice of Privacy Practices in accordance with HIPAA law. The policy explains how Thundermist will use my personal health information and how it will maintain the confidentiality of my personal health information.

Patient Rights and Responsibilities:
I know as a patient I have rights and responsibilities. These Patient Rights and Responsibilities are posted in every Thundermist Health Center and can be read on line at www.thundermisthealth.org. I understand that I may ask staff for assistance if I have any questions about these policies.

Advance Directives ("Living Will"):
I have the option of speaking with my health care provider at Thundermist about my wishes about end of life care (sometimes called a living will) in the event of serious illness or injury. Thundermist staff can provide me with more information about creating an Advanced Directive Document.

I would like MORE information about these Directives at this time: Yes No
(If I do not want information now, I realize I can ask for this information at any time in the future).

Financial Responsibility / Assignment of Benefits:
I assign directly to Thundermist Health Center all benefits payable to me under my insurance policies and health benefit plans. I acknowledge financial responsibility for all services rendered to me or my dependent. I authorize the use of my signature (below) on all insurance submissions. I understand that I am responsible for all fees and charges including those not covered by insurance.

I have read the above information, or it was read (and/or translated to me) and I understand and consent to the policies stated above.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____ **I am the:**
PRINT YOUR NAME
Patient **Patient's Legal Guardian/Representative**
(select one)

Adolescent Confidential Services
Teenagers may avoid getting needed care for certain problems unless they know that they can be treated confidentially and parents most often would prefer that their children have a place to turn when they need medical care. Adolescents, while encouraged to communicate with their parents, can receive confidential services for Sexually Transmitted Disease Testing and Treatment, Pregnancy Testing, Family Planning Counseling and Referral and Substance Abuse Counseling and Referral. I understand that information regarding the above conditions will be shared if the adolescent agrees or when there is a serious health risk that requires reporting by State or Federal law.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative **Date**

Thundermist HEALTH CENTER

Patient Registration Form

Name: Last: _____ First: _____ Middle: _____ Preferred Name: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Mailing Address (if different) Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____	**Date of Birth:** **Month/Day/Year**	**Pronouns: she/her, he/him, they/them, ze/zer, other**_____	**Social Security #:** _____

Do you have medical/dental insurance? ☐ **Yes** ☐ **No**

If someone other than the patient is responsible for the bill, please complete the following information:

Name: Last: _____ First: _____ Middle Initial: _____ **Date of Birth:** _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Employer Name: _____ **Address:** _____ **Phone** _____

Marital Status: ☐ Married ☐ Widowed ☐ Partnered ☐ Divorced ☐ Single ☐ Separated	**Employment Status:** (Check all that apply) ☐ Employed full time ☐ Employed part time ☐ Retired ☐ Unemployed ☐ Student full time ☐ Student part time ☐ Other _____

Patient's Employer: _____ **Address:** _____ **Phone:** _____

Emergency Contact: Name: _____ Address: _____

Phone Number(s): _____ Relationship to Patient: _____

What is your household income? $_____ ☐ Annual ☐ Weekly ☐ B-Weekly ☐ Monthly ☐ No Income

How many people (including you) does this income support? _____

Email Address: _____

How would you describe your race (check all that apply)? ☐ African American (Black) ☐ Caucasian ☐ Alaskan Native/Native American Indian ☐ Native Hawaiian ☐ Other/Pacific Islander ☐ Asian	**Ethnicity:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino
Primary Language: ☐ English ☐ Spanish ☐ Laotian ☐ Vietnamese ☐ Cambodian ☐ Sign Language ☐ Other _____	**Do you need an interpreter?** ☐ Yes ☐ No

Which pharmacy do you use? (Name, Address, Phone):

How did you hear about us? ☐ Friend/Relative ☐ HealthHut ☐ Television ☐ Provider/Community Agency ☐ Radio ☐ Outdoor Ad/Billboard ☐ Website/Intranet ☐ Newspaper ☐ Other _____

The following information will be used for demographic purposes only. How, and if, you answer the questions will not affect your care.

Veteran Status: ☐ Veteran ☐ Not a Veteran		**Do you consider your work:** ☐ Migratory agricultural work ☐ Season agricultural work ☐ Neither of these	**In the past 12 months, have you been living in stable housing that you own, rent, or stay in as part of a household?** ☐ Yes, living in stable housing ☐ No, not living in stable housing ☐ Street (outside, RV, car, tent, vacant building, etc.) ☐ Doubling Up (sharing a room, etc.) ☐ Transitional Housing (group home, etc.) ☐ Homeless Shelter ☐ Other _____
Required for ages 18+. **Optional for ages 12-17.**	**What was your sex assigned at birth?** ☐ Female ☐ Male ☐ Other_____	**Sexual Orientation** **Do you think of yourself as:** ☐ Straight (Heterosexual) ☐ Lesbian or Gay ☐ Bisexual ☐ Queer ☐ Something else _____ ☐ Don't Know	**What is your current gender identity?** ☐ Man ☐ Woman ☐ Transgender Man (female to male) ☐ Transgender Woman (male to female) ☐ Gender Queer/Non-Binary ☐ Something else _____

Thundermist Health Center
Informed Consent for TeleVisits

I will have a TeleVisit to assess and treat my health condition. The treatment could be limited because I am not in the same room as my provider.

During my TeleVisit, I understand:

A. The TeleVisit is done through a secure two-way video link-up. The Thundermist Health Center provider will see me on the screen and hear my voice.
B. A physical examination may take place.
C. Other members of my care team may be present during my visit.
D. Photos may be taken of me during the TeleVisit.

1. I can ask questions about the TeleVisit technology.
2. I can ask that the TeleVisit be stopped at any time.
3. I know there are potential risks with the use of this technology. These include but are not limited to:
    - Interruption of the audio/video link
    - Disconnection of the audio/video link
    - An audio and/or video that is not clear enough to meet the needs of the visit

If any of these risks occur, the visit might need to be stopped.

By signing this consent, I understand and agree to comply with its contents. I volunteer to participate in the TeleVisit. I authorize Thundermist Health Center and the providers, clinical and non-clinical team members involved to assess and treat my current health condition. I also affirm that I am the individual I am representing myself to be.

_____ _____

Patient Name Patient Date of Birth

_____ _____

Patient Signature Date

Office Use Only: [check box] is this for a phase II dental service? Y N

If yes – staff required to collect income verification.

Thundermist HEALTH CENTER

Sliding Fee Discount Program Form

We will care for you even if you cannot pay. You may be eligible for discounts based on income and family size. Discounts are available, even if you have insurance.

Patient Name: _____ Patient Date of Birth: _____

1. Including yourself, what is the size of your family? (Use definition below)

   _____

2. What is the total annual income of those included in your family In Question #1?

   $ _____ ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually

3. Please select 1 (one) option below:

☐ I certify the information entered above is correct to the best of my knowledge. I agree to inform Thundermist if my family size or income changes. I understand changes to my family size or income may change if I am eligible for the Thundermist Sliding Fee Discount Program.

☐ I do not want to participate in the Thundermist Sliding Fee Discount Program.

Print Responsible Party Name (If other than Patient) Date

Responsible Party Signature Date

*Family Size: Include yourself and other people related by birth, marriage, or adoption who live together. Family also includes unrelated people who live in the same household and are supported by or supporting a member of the family. Foster children are not included in Family Size.

Thundermist HEALTH CENTER

Medical Release of Information

How can I get a copy of my medical records?

- Please fill out the medical release of information form. You must complete the entire form.
- Important information when filling out the form:
  - **Obtain Records** - You are requesting another provider to send records to Thundermist)
  - **Release Records**- You are requesting Thundermist send records to an outside facility, provider, or hospital. You should also select this option if you would like a copy of Thundermist records for yourself.)
- Enter the information of the person/facility that Thundermist should contact regarding the records. (You must include the correct contact information to allow faster processing)
- Choose the correct option for picking up or emailing the records.
- Please initial which specific sensitive information you would like to release if it exists in the record.
- We recommend only release the last two years of records. If more information is needed, your provider will ask to request additional records.
- ***IF THE FORM IS NOT SIGNED OR DATED, IT IS INVALID AND WILL NOT BE PROCESSED.***
- ***You must complete a form for each facility/provider.***

Do you have questions on how to fill out this form?

Our Medical Records team is here to help you with questions. You can call us at 401-767-4100, option 6. Our hours of operation are 8 a.m. to 4:30 p.m., Monday through Friday.

Did you know the patient portal can help you obtain your medical information faster?

If you do not have Patient Portal Account, you can make a request directly through **Medicalrecords@thundermisthealth.org** or call 401-767-4100, option 6

How do you send the form back to Thundermist?

Please use your preferred method of communication. You can return the form back via email to Medicalrecords@thundermisthealth.org, fax it to 401-235-6896 or mail it to Medical Records Department, 25 John A. Cummings Way, Woonsocket, RI 02895*

(If you are choosing to email the form back by using our email address listed above be sure to provide a clear ***photo or image****. If the form is not readable,* ***we will not be able to process your request****.)*

Thundermist HEALTH CENTER

Our Patient Portal allows for secure access to view, download and transmit your health information online. Please ask if you are interested.

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS & HEALTH CARE INFORMATION

1. PATIENT INFORMATION: Please provide us with your information or your child's information. One person per form.

Patient Name _____ Phone Number _____D.O.B. _____

Address: _____City:_____State:_____Zip: _____

I hereby authorize: Thundermist Health Center
25 John A. Cummings way, Woonsocket, RI 02895 ATTN: Medical Records Dept
Ph# 401-767-4100 Fax# 401-235-6896

2. *Check off OBTAIN, which means we are GETTING your records from another doctor OR check off RELEASE if you would like Thundermist to SEND your Thundermist records to an outside doctor/person. Once one is checked off fill out the information for the facility, we are obtaining from or releasing to.*

CHOOSE ONE:

- ☐ **To OBTAIN-Get records from an outside facility**
- ☐ **To RELEASE-Send records to outside person or self**

☐ Check HERE if you would like us to release your ENTIRE medical record.	**OR**	**Release ONLY these types of records (check all that apply):** ☐ Medical (includes primary care visits and Convenient Care visits) ☐ Dental ☐ Mental Health Treatment ☐ Alcohol/Drug Use and/or Treatment ☐ HIV/AIDS Testing, Diagnosis, and/or Treatment ☐ Sexually Transmitted Infections Testing, Diagnosis, and/or Treatment ☐ Transgender Information and/or Care	**Specify treatment dates for records to be released:** Provide dates of service you would like us to obtain or release. (Last 2 years is what most providers look for, if more information is needed, we can always ask for additional dates of service. ☐ Last Month ☐ Last Six Months ☐ Last Year ☐ Last Two years ☐ ALL ☐ Other (provide dates) _____

3. *Tell us who we should get your records from OR who you want us to send your records to:*

Name: _____ PH #: (_____) _____FAX #: (_____) _____
Address: _____City:_____ State:_____ Zip: _____

*****Only complete this section if you are requesting a copy of your medical records for yourself*****

I would like to: ***(select one option)*** ***Pick up a Paper Copy** ***Electronic Copy emailed to me**

Please allow up to 30 days to process. If you need your records sooner, or would prefer an alternative electronic format, please ask. By providing your email address, you consent for your record to be emailed to you and you understand that unencrypted email may not protect the privacy of your health information.

Email address:_____

***Fees for Records:** *You may be charged a nominal fee in accordance with state law for the processing of your medical record. This fee will not exceed $25.00.*

4. PURPOSE-Tell us what this records request is for: *(check one)*

☐ Personal use ☐ Legal matter ☐ Insurance ☐ Treatment by a Specialist
☐ Transferring my care due to: Moving Other or Dissatisfied with service provided (please explain):

_____

5. SIGN THE AUTHORIZATION STATEMENT BELOW:

I understand that I may revoke my authorization in writing any time by notifying Thundermist Health Center. I understand that any previously disclosed information would not be subject to this revocation request. I understand that my records are processed under the Federal Confidentiality Regulations of Alcohol and Drug Abuse Treatment (42 CFR, Part 2) and /or the General Laws of the State of Rhode Island and cannot be disclosed without my written authorization except as otherwise specifically provided by law. I understand that any disclosure of information carries with it the potential for redisclosure by the recipient and that the information may not then be protected by the Federal Privacy Rule. Therefore, I release Thundermist Health Center, its employees and my physicians from all liability arising from this disclosure of my health information. I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, health plan enrollment, or eligibility for benefits. I have read, and understand the above statement and voluntarily consent to the disclosure of information as indicated on this form.

Unless revoked by the patient in writing, this authorization will expire when the patient is no longer a patient.

_____ _____ _____
Signature of Patient/Legal Representative **Legal Representative's Relationship to Patient** **Date**

_____ _____ _____
Staff Member Receiving Form (Print Name) **Phone Ext.** **Date**

******FOR OFFICE USE ONLY******

☐ Obtain request sent on: _____ Initials _____

☐ Records released on: _____ Initials _____