Welcome to Thundermist!

Thank you for choosing Thundermist Health Center as your Patient-Centered Medical Home. Before your appointment, please complete the new patient packet and medical records release form. We look forward to meeting with you.

You may return documents by:

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

Drop Off: At any Thundermist Health Center location

Fax: 401-235-6896 - Attn: Document Management

Email: Medicalrecords@thundermisthealth.org

We'd like to take a moment to provide a few important reminders:

- **Do you need help with insurance?** If you do not currently have health insurance or are exploring your options, please speak with our staff. We're happy to assist you with the enrollment process.
- **Keep us informed of insurance changes.** If your insurance coverage changes, please notify our office as soon as possible. This helps us ensure your visits and care are processed correctly and helps avoid unexpected charges.
- **Co-pays are due at the time of service.** We kindly remind you that any co-payments required by your insurance plan are due when you check in for your appointment. We accept cash, credit, and checks and appreciate your cooperation.

If you have any questions or need assistance, please contact our office at 401-767-4100. We will be happy to help you.

Thundermist Patient Registration Form

Thundermist HEALTH CENTER

Patient's Legal Name: Last:	First:	Middle Initial:	Name to Use:
Street Address:	City:	State:	ZIP:
Mailing Street Address (*if different*):	City:	State:	ZIP:

Date of Birth (*Month/Day/Year*):	Pronouns: □ she/her □ he/him □ ze/zir □ they/them □ another pronoun/ please specify: _____	Social Security #:

Home Phone: _____ Voicemail OK? □ Yes □ No	Cell Phone: _____ Voicemail OK? □ Yes □ No	Work Phone: _____ Voicemail OK? □ Yes □ No

Email Address:	**Communication Methods** □ Cell Phone (Voice) □ Cell Phone (Text) □ Home Phone □ Work Phone □ Email (Patient Portal)
Which pharmacy do you use? Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____	

Do you have medical insurance? □ Yes □ No	Do you have dental insurance? □ Yes □ No

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

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

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Employer Name: _____ Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ ZIP: _____

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

Patient's Employer: _____ Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

How did you hear about Thundermist?

□ Friend/Relative □ Health Hut □ Radio □ Television □ Provider/Community Agency

□ Website/Internet □ Outdoor Ad/Billboard □ Newspaper □ Other _____

Do you have an Advance Directive(s)? □ Living Will □ Durable Power of Attorney

If yes, please provide us with a copy to add to your health record.

Thundermist Patient Registration Form

This information is for demographic purposes only and will not affect your care.

What is your household income?
$_____
□ Annual
□ Monthly
□ Bi-Weekly
□ Weekly
□ No income
□ Decline

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

Employment Status: (***Check all that apply***)
□ Employed full time
□ Employed part time
□ Student full time
□ Student part time
□ Retired
□ Unemployed
□ Other _____

Marital Status:
□ Married
□ Widowed
□ Partnered
□ Divorced
□ Single
□ Separated

Veteran Status:
□ Veteran
□ Not a Veteran

We collect information on race and ethnicity so we can measure where there may be gaps in services for some groups. Our goal is to create programs and policies that support access to quality healthcare for everyone.

***How would you describe your race? (*Check all that apply*)**
□ American Indian/Alaska Native
□ Asian
□ Asian Indian
□ Black/African American
□ Chinese
□ Filipino
□ Guamanian or Chamorro
□ Japanese
□ Korean
□ Native Hawaiian
□ Other Asian
□ Other Pacific Islander
□ Samoan
□ Vietnamese
□ White
□ Other Race
□ More than one race

***Ethnicity:**
□ Chicano/a/x
□ Cuban
□ Hispanic or Latino/a/x
□ Mexican
□ Mexican American
□ Not Hispanic or Latino/a/x
□ Puerto Rican

Do you need an interpreter?
□ Yes
□ No

Primary Language: (*Check one*)
□ English
□ Cambodian
□ Laotian
□ Portuguese
□ Sign Languages
□ Spanish
□ Vietnamese
□ Other _____

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
- □ Unknown

Do you consider your work:
□ Migratory agricultural work
□ Seasonal agricultural work
□ Neither of these

What was your sex assigned at birth?
□ Female
□ Male
□ Other _____

Sexual Orientation:
Do you think of yourself as:
□ Straight (Heterosexual)
□ Gay (Homosexual)
□ Lesbian
□ Bisexual
□ Queer
□ Other/Please describe:
_____
□ Unsure

What is your current gender identity?
□ Man
□ Woman
□ Transgender man (female to male)
□ Transgender woman (male to female)
□ Genderqueer
□ Neither male nor female
□ Other/Please specify:
_____

Thundermist HEALTH CENTER

Patient Consent Form

Please carefully read this form and initial and sign where indicated.

PATIENT LAST NAME: _____ FIRST_____ MI____

DOB _____/_____/_____

Month Day Year

Consent to Treatment:

I consent to treatment for myself or my minor child by Thundermist. This includes routine treatments or services that are considered necessary for my care or recommended by my provider. I understand my rights as a patient and that I have the right to refuse any treatment, care, medications, or interventions as permitted by law. I also understand that I will be informed of any risks associated with the care provided to myself or my minor child before agreeing to proceed. In addition, I acknowledge that trainees and students may participate in our care under the supervision of Thundermist staff.

Patient Rights and Responsibilities:

As a patient, I understand I have specific rights and responsibilities. In accordance with HIPAA, Thundermist is committed to keeping me informed about its privacy practices, which explain how my personal health information is used and the measures taken to protect my confidentiality. If I have any questions about these policies, I can ask to speak with a staff member or can access copies of the Patient Rights and Responsibilities and Notice of Privacy Practices documents online at https://www.thundermisthealth.org/patient-resources/patient-forms/. Additionally, information about my rights and responsibilities as a patient is available at all Thundermist Health Center locations.

Consent to Telehealth Treatment:

I consent to receiving secure telehealth services from my Thundermist provider or care team. I understand that telehealth has potential risks and certain limitations, including the inability to meet with my provider in person, which may affect the evaluation and treatment process. I understand that my personal health information will be protected in accordance with applicable privacy laws during telehealth sessions. I also acknowledge that I have the right to withdraw my consent for telehealth services at any time without affecting my right to future care or treatment. I acknowledge that telehealth services are available only to patients physically located in Rhode Island at the time of service. If I encounter technical difficulties or have concerns about telehealth, I will promptly contact the care team for assistance.

Financial Responsibility I Assignment of Benefits:

I authorize Thundermist to submit billing information to my insurance company on my behalf and acknowledge that I am financially responsible for all services provided to me or my dependent. I understand I am responsible for paying all fees and charges due for services provided by Thundermist that are not covered by my insurance. This includes any applicable copayments, co-insurance, or deductibles. If I fail to provide necessary information to my insurance company, I may be billed for services at the full rate. I understand that I have access to a sliding fee scale discount program based on my income and agree to notify Thundermist immediately of any changes to my financial status that may affect my eligibility.

Thundermist HEALTH CENTER

Patient Consent Form

Health Information Exchange:

Thundermist participates in an electronic health exchange system (HIE), which allows us to securely access and share medical information with other healthcare providers, including hospitals, nursing homes, specialists, and other facilities involved in my or my minor child's care. Please note that certain health information, such as substance use treatment records are protected and require a specific consent to be shared. However, mental health treatment information is included in the HIE and is subject to the same opt-out option as other health data. If you have concerns about sharing your mental health or medical information, opting out of the HIE will prevent this data from being disclosed through the exchange. By consenting to this authorization, you are allowing us to access and share your health information. If you prefer not to participate in the electronic health exchange, please inform a Patient Service Representative (PSR) or care team member who can assist you.

Adolescent Confidential Services:

Adolescents (age 12-17) are encouraged to communicate openly with their parents/guardians. However, they have the right to receive confidential services for the following: sexually transmitted infection testing and treatment, pregnancy testing, family planning counseling and referrals, substance use counseling and referrals. I understand that information related to these services will only be shared with me if the adolescent provides their consent. However, in certain situations involving serious health risks, state or federal law may require the disclosure of this information to appropriate authorities.

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.

I am the:

☐ Patient ☐ Patient's Legal guardian/Representative

_____

Print Name

_____ _____

Patient or Parent/Guardian Signature Date

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. Forms are available on the Thundermist website, available to be emailed, sent by text message, or mailed.

Important information when filling out the form:

Complete All Sections:

- **Purpose of release –** Check the option that best fits the reason for the request of records.
- **Where should Thundermist send your records to** – 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 Thundermist should contact regarding the records. (You must include the correct contact information for faster processing.)
- Choose the correct option for picking up or emailing records when requesting copies for yourself.
- Please check off specific sensitive information you **DO NOT** want released if it exists in the record.
- We recommend only releasing the last two years of records (Abstract option). 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 one 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. Our hours of operation are Monday through Friday, 8 a.m.-4:30 p.m.

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 Thundermist 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 add documents as clear attachments. If the form is not readable, ***we will not be able to process your request.****)*

Requests for records may take up to 30 days for processing

Thundermist HEALTH CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

By completing and signing this form, Thundermist Health Center and its affiliates (e.g., subsidiaries, agents, employees) are authorized to disclose my protected health information (PHI) to the individuals or entities listed below.

Please complete all sections of this form.

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

City: _____ State: _____ ZIP code: _____

Purpose of Release:

Please check the appropriate box or specify another purpose.

☐ Treatment/ Continuing Care ☐ Transfer of Care ☐ Legal ☐ Personal use

☐ Disability Determination ☐ Employment ☐ Other (please specify): _____

Where should Thundermist send your records? (Please complete in full)

To: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Phone: _____ Fax: _____

Delivery Method: ☐ Pick up paper copy OR ☐ Secure email copy to _____

Specific Dates of Service(s) Requesting _____ To _____

☐ Progress/Consult Notes ☐ Laboratory Reports ☐ X- Ray Reports ☐ Dental Records

☐ Abstract Records (Last 2 years Medical Summary, Progress Notes/TeleVisits, Lab/X-Ray Reports, Special Studies)

☐ Complete Record (Last 10 years)

Thundermist Health Center does not provide records from other healthcare offices. Please request them directly from the original provider.

I understand my medical record may contain sensitive information. My checkmark(s) below indicates that I **do not** permit this information to be released.

Do Not Include:

☐ Treatment for HIV/AIDS

☐ Substance Use and/or Treatment

☐ Transgender Information and/or Care

☐ Behavioral Health Treatment

☐ STD/STI, Testing, Diagnosis, and/or Treatment

Unless I checked a box above, I understand that behavioral health information and medication lists will be released. I understand I may revoke this authorization in writing before any records are released. Thundermist Health Center will not condition treatment, payment, enrollment, or care eligibility on my decision to sign this authorization.

If the recipient is not a healthcare or health plan provider, my information may no longer be protected by federal privacy regulations. I also understand that I may be charged a fee for this request, as allowed by law.

My signature confirms consent for the use or disclosure of PHI above. This authorization expires one year from the date signed.

Signature of Patient:	Date:
Or Signature of Authorized Representative:	Date:
Printed name of Authorized Representative:	Phone Number of Authorized Representative:
Relationship to Patient or Representative's Legal Authority to act on Patient's Behalf:	

Our patient portal allows for secure access to view, download, and transmit your health information online.

25 John A. Cummings Way, Woonsocket, RI 02895 Attn: Medical Records Dept. Phone: 401-767-4100 Fax: 401-235-6896

How can I send a copy of my medical records?

Please fill out the medical release of information form. You must complete the entire form. Forms are available on the Thundermist website, available to be emailed, sent by text message, or mailed.

Important information when filling out the form:

- **Purpose of obtain –** Check the option that best fits the reason for the request of records.
- **Where should Thundermist get your records from -** You are requesting another provider to send records to Thundermist.
    - Enter the information of the person/facility Thundermist should contact regarding the records. (You must include the correct contact information for faster processing.)
    - Please check off specific sensitive information you DO NOT want obtained if it exists in the record.
    - We recommend only obtaining 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 one form for each facility/provider.**

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

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Thundermist HEALTH CENTER

AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

By completing and signing this form, Thundermist Health Center and its affiliates (e.g., subsidiaries, agents, employees) are authorized to disclose my protected health information (PHI) to the individuals or entities listed below.

Please complete all sections of this form.

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

City: _____ State: _____ ZIP code: _____

Purpose of Obtain:
Please check the appropriate box or specify another purpose.

☐ Treatment/ Continuing Care ☐ Transfer of Care ☐ Legal ☐ Personal use

☐ Disability Determination ☐ Employment ☐ Other (please specify): _____

From where should Thundermist get your records? (Please complete in full)

To: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Phone: _____ Fax: _____

Specific Dates of Service(s) Requesting _____ To _____

☐ Progress/Consult Notes ☐ Laboratory Reports ☐ X- Ray Reports ☐ Dental Records

☐ Abstract Records (Last 2 years Medical Summary, TeleVisits, Lab Reports, X-Ray Reports, Special Studies)

☐ Complete Record (Last 10 years)

Thundermist Health Center does not provide records from other healthcare offices. Please request them directly from the original provider.

I understand that my medical record may contain information that is considered sensitive under law. My checkmark(s) below indicate that I **do not** permit this information to be released or requested.

Do Not Include:

☐ Treatment for HIV/AIDS ☐ Behavioral Health Treatment

☐ Substance Use and/or Treatment ☐ STD/STI, Testing, Diagnosis, and/or Treatment

☐ Transgender Information and/or Care

Unless I checked a box above, I understand that behavioral health information and medication lists will be released. I understand I may revoke this authorization in writing before any records are released. Thundermist Health Center will not condition treatment, payment, enrollment, or care eligibility on my decision to sign this authorization.

If the recipient is not a healthcare or health plan provider, my information may no longer be protected by federal privacy regulations. I also understand that I may be charged a fee for this request, as allowed by law.

My signature confirms consent for the use or disclosure of PHI above. This authorization expires one year from the date signed.

Signature of Patient:	Date:
Or Signature of Authorized Representative:	Date:
Printed name of Authorized Representative:	Phone Number of Authorized Representative:
Relationship to Patient or Representative's Legal Authority to act on Patient's Behalf:	

Our patient portal allows for secure access to view, download, and transmit your health information online.

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