



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



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: <input type="checkbox"/> she/her <input type="checkbox"/> he/him <input type="checkbox"/> ze/zir <input type="checkbox"/> they/them <input type="checkbox"/> another pronoun/ please specify: _____		Social Security #: _____	
Home Phone: _____	Cell Phone: _____	Work Phone: _____		
Voicemail OK? <input type="checkbox"/> Yes <input type="checkbox"/> No	Voicemail OK? <input type="checkbox"/> Yes <input type="checkbox"/> No	Voicemail OK? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Email Address: _____			Communication Methods <input type="checkbox"/> Cell Phone (Voice) <input type="checkbox"/> Cell Phone (Text) <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Email (Patient Portal)	
Which pharmacy do you use? Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____				
Do you have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you have dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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?				
<input type="checkbox"/> Friend/Relative <input type="checkbox"/> Health Hut <input type="checkbox"/> Radio <input type="checkbox"/> Television <input type="checkbox"/> Provider/Community Agency <input type="checkbox"/> Website/Internet <input type="checkbox"/> Outdoor Ad/Billboard <input type="checkbox"/> Newspaper <input type="checkbox"/> Other _____				
Do you have an Advance Directive(s)? <input type="checkbox"/> Living Will <input type="checkbox"/> 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.

<p>What is your household income? \$ _____</p> <p><input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Weekly <input type="checkbox"/> No income <input type="checkbox"/> Decline</p>	<p>Employment Status: (Check all that apply)</p> <p><input type="checkbox"/> Employed full time <input type="checkbox"/> Employed part time <input type="checkbox"/> Student full time <input type="checkbox"/> Student part time <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Other _____</p>	<p>*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.</p>		
	<p>Marital Status:</p> <p><input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated</p>	<p>*How would you describe your race? (Check all that apply)</p> <p><input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black/African American <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> White <input type="checkbox"/> Other Race <input type="checkbox"/> More than one race</p>	<p>*Ethnicity:</p> <p><input type="checkbox"/> Chicano/a/x <input type="checkbox"/> Cuban <input type="checkbox"/> Hispanic or Latino/a/x <input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Not Hispanic or Latino/a/x <input type="checkbox"/> Puerto Rican</p>	
	<p>Veteran Status:</p> <p><input type="checkbox"/> Veteran <input type="checkbox"/> Not a Veteran</p>			
<p>How many people (including you) does your income support? _____</p>				
<p>Do you need an interpreter?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Primary Language: (Check one)</p> <p><input type="checkbox"/> English <input type="checkbox"/> Cambodian <input type="checkbox"/> Laotian <input type="checkbox"/> Portuguese <input type="checkbox"/> Sign Languages <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____</p>	<p>In the past 12 months, have you been living in stable housing that you own, rent, or stay in as part of a household?</p> <p><input type="checkbox"/> Yes, living in stable housing <input type="checkbox"/> No, not living in stable housing:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Street (outside, RV, car, tent, vacant building, etc.) <input type="checkbox"/> Doubling up (sharing a room, etc.) <input type="checkbox"/> Transitional housing (group home, etc.) <input type="checkbox"/> Homeless shelter <input type="checkbox"/> Other <input type="checkbox"/> Unknown 		
<p>Do you consider your work:</p> <p><input type="checkbox"/> Migratory agricultural work <input type="checkbox"/> Seasonal agricultural work <input type="checkbox"/> Neither of these</p>	<p>Sexual Orientation:</p> <p>Do you think of yourself as:</p> <p><input type="checkbox"/> Straight (Heterosexual) <input type="checkbox"/> Gay (Homosexual) <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Queer <input type="checkbox"/> Other/Please describe: _____ <input type="checkbox"/> Unsure</p>	<p>What is your current gender identity?</p> <p><input type="checkbox"/> Man <input type="checkbox"/> Woman <input type="checkbox"/> Transgender man (female to male) <input type="checkbox"/> Transgender woman (male to female) <input type="checkbox"/> Genderqueer <input type="checkbox"/> Neither male nor female <input type="checkbox"/> Other/Please specify: _____</p>		
<p>What was your sex assigned at birth?</p> <p><input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other _____</p>				

Thundermist!
HEALTH CENTER
Patient Consent Form

PATIENT LAST NAME: _____ **FIRST** _____ **MI** _____

DOB: _____

Consent to Treatment:

I consent to treatment for myself or my minor child by Thundermist Health Center. This includes routine care and any services considered necessary for care or recommended by my provider. I understand my rights as a patient and that I may refuse any treatment, care, medications, or interventions as permitted by law. I will be informed of any risks associated with care before agreeing to proceed. Trainees and students may participate in care under the supervision of Thundermist staff.

Patients age **16–18 may consent to their own care**, and certain services may also be consented to by adolescents age **12–17**, as permitted by state or federal law.

Patient Rights and Responsibilities:

I understand I have specific rights and responsibilities as a patient. Thundermist is committed to protecting my privacy and keeping me informed about how my health information is used, in accordance with HIPAA. Copies of the Patient Rights and Responsibilities and Notice of Privacy Practices are available at all Thundermist locations and online at [Thundermist Patient Forms](#).

Consent to Telehealth Treatment:

I consent to receive secure telehealth services from Thundermist providers. I understand that telehealth may have risks and limitations, including the inability to meet in person, which may affect evaluation and treatment. My personal health information will be protected according to privacy laws. I may withdraw consent for telehealth at any time without affecting my right to care. Telehealth services are available only to patients physically located in Rhode Island at the time of service.

Financial Responsibility / Assignment of Benefits:

I authorize Thundermist to submit billing to my insurance on my behalf and acknowledge financial responsibility for services not covered by insurance, including copays, coinsurance, or deductibles. I understand I may be billed at full rate if insurance information is incomplete. I also understand that I may qualify for a sliding fee scale based on income and will notify Thundermist of any changes affecting eligibility.

Health Information Exchange (HIE):

Thundermist participates in a secure electronic health exchange, allowing access to and the sharing of medical information with other providers involved in care. Certain information, such as substance use treatment, requires specific consent to share, while mental health treatment information is included with an opt-out option. If I prefer not to participate, I may inform a Patient Service Representative or care team member.

Acknowledgment:

I have read this form, or someone has read or explained it to me, and I understand it. I agree to the policies described above.

Print Name: _____ **I am the:** Patient Patient's Parent / Legal Guardian

Signature: _____ Date: _____



Hello,

Thundermist provides care to all patients regardless of their ability to pay. We are writing to remind you about Thundermist's Sliding Fee Discount Program, which is available to all eligible patients, with or without insurance. The program ensures all patients who are insured, uninsured, or underinsured can receive care without a financial barrier.

To find out if you qualify for the program, please fill out the Eligibility Form attached to this message, sign it electronically, and email it back to us/submit it. If electing to email, please send to medicalrecords@thundermisthealth.org.

While we are required to let you know about the Program, you do not have to enroll if you do not want to. If you do not want to, simply click that box on the form that says you do not want to enroll, sign it electronically and email it back to us/submit it. Please note: Even if you have insurance, you may qualify for discounts to certain co-pays and other fees.

If you need additional help in applying for Sliding Fee Discount Program or have more questions, please call us at 401-767-4100. We'll be happy to help you. You may also find additional information on our website.

Best Regards,

Thundermist Health Center

WOONSOCKET

Medical

450 Clinton St.
Woonsocket, RI 02895

Phone: 401-767-4100

Fax: 401-235-6896

Dental & WIC

25 John A. Cummings Way
Woonsocket, RI 02895

Dental Phone: 401-767-4161

Dental Fax: 401-767-5441

WIC Phone: 401-767-4109

WIC Fax: 401-235-6883

WEST WARWICK

Medical

186 Providence St.
West Warwick, RI 02893

Phone: 401-615-2800

Fax: 401-615-2805

Dental

5 Washington St.
West Warwick, RI 02893

Phone: 401-615-2804

Fax: 401-352-6248

SOUTH COUNTY

Medical & Dental

1 River St.
Wakefield, RI 02879

Phone: 401-783-0523

Fax: 401-783-9448

Dental Phone: 401-783-5646

Dental Fax: 401-284-2081

Pediatrics

360 Kingstown Rd.
Narragansett, RI 02882

Phone: 401-789-6492

Fax: 401-783-9448

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

If yes – staff required to collect income verification.



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.



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?

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.



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.

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



Permission to Discuss Form

Patient Name: _____ **DOB:** ____/____/____

Permission to Discuss

I, the undersigned, give Thundermist Health Center permission to discuss my health information with:

Choose selection (select all applicable) Medical Dental Behavioral Health

Name #1: _____ **Relationship:** _____

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

Name #2: _____ **Relationship:** _____

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

Choose selection (select all applicable) Medical Dental Behavioral Health

I understand I can revoke this authorization at any time through a written or verbal statement to Thundermist. I understand if revoked, it will apply to all individuals on this form.

Patient/Legal Guardian Signature: _____

Patient/Legal Guardian Print Name: _____

Date: ____ / ____ / ____