Patient Information Form

Please Print Clearly

If needed, please ask for assistance in completing this form.

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

List any different name(s) you've used, such as a maiden name: _____

Street: _____ P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ (check one) → Cell ☐ Home ☐ Work ☐

Secondary Phone: _____ (check one) → Cell ☐ Home ☐ Work ☐

Email Address: _____

I authorize Lamprey Health Care to communicate with me using email: ☐ Yes ☐ No

Gender assigned at birth: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner

Employment Status: ☐ Full Time ☐ Part Time ☐ Disabled ☐ Unemployed ☐ Retired (date): _____ Employers Name: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Relationship: _____

If the patient is a child, please complete this section.

Parent/Guardian #1 Name: _____

Date of Birth: _____ (Month / Day / Year) Relation to patient: _____

Address (if different from patient): _____

Parent/Guardian #2 Name: _____

Date of Birth: _____ (Month / Day / Year) Relation to patient: _____

Address (if different from patient): _____

I have health insurance.

Great, please provide your card(s) so we can make a copy.

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

Relationship to patient: _____ Insurance Company: _____

Who does your insurance company list as your Primary Care Provider?: _____

I don't have health insurance.

No problem! Ask a team member about our Financial Assistance Programs.

Patient's Printed Name: _____

Patient's Date of Birth: _____
Month / Day / Year

GENERAL CONSENT FOR OUTPATIENT DIAGNOSIS, CARE AND TREATMENT

On an ongoing basis, I request, consent, and authorize Lamprey Health Care, Inc. to perform diagnostic and therapeutic tests and procedures and provide general care and treatment as determined necessary and/or ordered by those health care professionals involved in my care. This includes, but is not limited to, the performance of physical examinations and x-rays or other diagnostic or radiological procedures, as well as the taking of blood, tissues, fluids, or other bodily samples. I also consent and authorize Lamprey Health Care to examine, use for the purposes for which they were provided, store, and dispose of any blood, tissue, fluids, or bodily samples in accordance with legal requirements and customary procedures. I understand I may ask my health care providers about my care, treatment and procedures at any time and I am encouraged to do so.

BEHAVIORAL HEALTH SERVICES

Lamprey Health Care provides an integrated team approach for the coordination of primary and behavioral health care. As an integrated team all staff members work together, improving communication among providers by sharing information in one medical record and decision making, as well as shared responsibility for a patient's care plan. Behavioral Health Services are available to all individuals. I consent to the sharing of my Private Health Information in order to formulate a plan of care. I understand health care professionals in training may be involved in my care and I consent to their involvement in it under appropriate supervision.

FINANCIAL RESPONSIBILITY AGREEMENT AND ASSIGNMENT OF BENEFITS

I understand I am financially responsible for all of the charges and bills associated with my care and treatment, except to the extent that all or part of these charges or bills are paid or covered by health insurance, a government health care program (such as Medicare or Medicaid), a financial assistance program, or another party responsible for their payment (all of which are referred to as "Third Party Payers"). I authorize Lamprey Health Care to submit bills or claims and related information concerning my health status, care, treatment, and payments made for my care and treatment to any applicable Third Party Payer and its business associates. I also authorize such Third Party Payers to make direct payments to Lamprey Health Care in response to these bills or claims.

CONSENT AND AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Lamprey Health Care maintains records in electronic and other forms. These records describe, among other things, my past and current health status, including the diagnosis of any illness and conditions, the nature and results of examinations and tests, treatment provided, and any plans for care or treatment. In addition, these records include billing, social, and other identifying information and may include sensitive information such as genetic testing results, HIV/AIDS status, and drug and alcohol use (all of which is referred to as my "Health Information"). I consent and authorize Lamprey Health Care, when necessary for my treatment, payment of my bills, or Lamprey Health Care's business and healthcare operations, to release and exchange my Health Information with other health care professionals and organizations involved in my care and with business associates that Lamprey Health Care has contracted for the same reasons. I understand that any disclosures of this Health Information may be used or redisclosed by the recipient of the records and will, thus, no longer be protected by federal privacy laws such as 42 CFR Part 2. I understand that my refusal to consent to my records being disclosed for payment purposes may result in Lamprey Health Care refusing to treat me.

ANY QUESTIONS I HAD ABOUT THIS CONSENT HAVE BEEN ANSWERED. I UNDERSTAND THE INFORMATION IN THIS FORM AND AGREE TO THE CONDITIONS SET FORTH ABOVE. THIS CONSENT SHALL REMAIN EFFECTIVE UNTIL I REVOKE IT IN WRITING, WHICH I MAY DO AT ANY TIME EXCEPT TO THE EXTENT THAT LAMPREY HEALTH CARE OR ANY OTHER RECIPIENT OF INFORMATION DISCLOSED HEREUNDER HAS ALREADY ACTED IN RELIANCE ON IT

Signed: _____ Date: _____
Month/Day/Year

Relationship of Authorized Representative _____
(For example: Parent, Guardian, or Health Care Agent)

MEDICARE ONLY

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or by Lamprey Health Care. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

If you have Medicare please sign to confirm you have read and understand this section.

Signed: _____ Date: _____
(Patient or Authorized Representative) Month / Day / Year

Patient Information Form

Please Print Clearly

If needed, please ask for assistance in completing this form.

Lamprey Health Care receives state and federal funding to support our services. Occasionally we are asked to report on the general financial status and the race/ethnicity of our patients. Your assistance in completing this information will help us apply for future grant funding. ***All information is confidential.***

Thank you for your cooperation.

Ethnicity ☐ Not Hispanic ☐ Mexican ☐ Puerto Rican
☐ Cuban ☐ Another Hispanic, Latino, Spanish origin
☐ Another Hispanic, Latino, Spanish origin combined
☐ Unreported/choose not to disclose

Are You ... (check all that apply)
☐ Full Time Student ☐ Part Time Student
☐ Veteran ☐ Migrant Worker
☐ Seasonal Worker

Race: (Check up to two boxes that best apply.)

☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Guamanian or Chamorro
☐ Samoan
☐ Black / African American
☐ American Indian/Alaska Native
☐ White
☐ More than one race
☐ Unreported/choose not to disclose

Sexual Orientation
What is your sexual orientation?
☐ Straight or Heterosexual
☐ Lesbian, Gay, or Homosexual
☐ Bisexual
☐ Something else
☐ Don't Know
☐ Choose not to disclose

Gender Identity
What is your gender identity?
☐ Male
☐ Female
☐ Transgender Male / Trans Male/ Female to Male (FTM)
☐ Transgender Female / Trans Female / Male to Female (MTF)
☐ Genderqueer (neither exclusively male or female)
☐ Additional gender category or Other
☐ Choose not to disclose

Communicating With You	**Yes**	**No**
Is your primary language English?	☐	☐
If no, what is your primary language?	_____	
Do you need an interpreter?	☐	☐
Are you hearing impaired?	☐	☐
Do you need a sign language interpreter?	☐	☐

Living Arrangements
☐ Rent ☐ Live with relative or friend
☐ Own Home ☐ Transitional housing
☐ Shelter ☐ Street
☐ Other _____

How Did You Hear About Us?
☐ Relative/Friend
☐ Hospital/Other Provider
☐ Internet/Social Media
☐ Community Event
☐ Social Service/Insurance Directory
☐ Other: _____

AUTHORIZATION TO RELEASE OR OBTAIN PROTECTED HEALTH MEDICAL RECORD INFORMATION

CONTACT FOR LAMPREY HEALTH CARE: ALL SITES

Fax (833) 953-3701 * Phone (603) 895-3351 option 7 * Mail: 128 State Route 27, Raymond, NH 03077

PATIENT REQUEST:

Patient Name: (Please Print) _____ DOB: _____ Phone: _____

I AUTHORIZE LAMPREY HEALTHCARE TO: Check one: **RELEASE TO** ☐ **OR** **OBTAIN FROM** ☐

To/From: Name of Person or Organization _____ Phone: _____ Fax: _____

Full Address: _____

Check one: ☐ **SEND** ☐ **VERBAL** ☐ **FAX** ☐ **ELECTRONIC** **PICK UP IN**: ☐ **Nashua** ☐ **Newmarket** ☐ **Raymond**

- Consent for the release of information is not required as a condition of treatment.
- This authorization may be revoked at any time in writing except that information that has been disclosed prior to the date of revocation. Please contact the Privacy Officer at the address listed above.
- Only information necessary to fulfill the purpose(s) stated below may be released.
- I understand that if I authorize disclosure of protected health information, the recipient may further disclose this information, and Federal law will no longer protect it.
- I understand that I have the right to inspect or copy the information I am consenting to release. A copying fee may apply.
- I am entitled to receive a copy of this signed authorization. I have received a copy Initial here: _____
- I understand that information may be released by any acceptable means, including by fax.

****

INFORMATION TO BE RELEASED / OBTAINED: (*Please check all that apply below)*

☐ Abstract of last 3 years or most recent to include: Facesheet, Encounters, Vaccines, Imagings, Labs, Hospital reports, Consult notes, Pathology and GYN records. ***more than 3 years old:** Colonoscopy, Cardiac reports, PSA, Pap and Mammogram will be released.

☐ Physical and immunizations (health form) ☐ Other (*Please specify*) _____

For the Following Reason: ☐ Transfer of Care ☐ Attorney ☐ Insurance ☐ Personal Other: _____

If Transferring please give reason: _____

****

I understand that the information I have agreed to release may include the following SENSITIVE information: Please initial the sensitive information we are permitted to release in the spaces provided:

☐ **Substance Use Disorder Treatment records**	☐ **Genetic Testing**
☐ **Behavioral Health Treatment records**	☐ **Sexually Transmitted**
☐ **Sexual Assault/Child Abuse**	☐ **HIV/AIDS Test Results**

I authorize Lamprey Healthcare to release my information for Treatment, Payment, or Healthcare Operations:

☐ By checking this box I understand this release shall never expire.

☐ By checking this box I would like this release to expire on _____

If neither box is checked above, this release will expire one year from the date signed below.

****

This information has been disclosed to you from your records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who it pertains or otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Date: _____ _____ _____

Signature of Patient or Authorized Representative Relationship if not patient

INTERPRETER'S STATEMENT: I have translated the information on this form orally to the individual in _____ (language) and explained its contents to her/him. To the best of my knowledge and belief, she/he understood this explanation.

Interpreter's Signature: _____ DATE: _____

Patient Information Form

Please Print Clearly

Mark the income range that applies to your family size.

Step 1: Look down the first column and find the row that matches the number of people in your household, including children. If there are more than 8 in your household, use row 8.

Step 2: Put a checkmark next to your family size. Then go across the top until you find the income level that best matches your household and check the box above that column.
CHECK ONLY ONE BOX for family size and ONLY ONE BOX for income.

		☐	☐	☐	☐	☐	☐	☐
Family Size		**From To**	**From**	**To**	**From**	**To**	**From**	**To**	**Above**
☐	**1**	$0- $15,650	$15,650.01	$21,127.50	$21,127.51	$28,952.50	$28,952.51	$31,300	$31,300
☐	**2**	$0- $21,150	$21,150.01	$28,552.50	$28,552.51	$39,127.50	$39,127.51	$42,300	$42,300
☐	**3**	$0- $26,650	$26,650.01	$35,977.50	$35,977.51	$49,302.50	$49,302.51	$53,300	$53,300
☐	**4**	$0- $32,150	$32,150.01	$43,402.50	$43,402.51	$59,477.50	$59,477.51	$64,300	$64,300
☐	**5**	$0- $37,650	$37,650.01	$50,827.50	$50,827.51	$69,652.50	$69,652.51	$75,300	$75,300
☐	**6**	$0- $43,150	$43,150.01	$58,252.50	$58,252.51	$79,827.50	$79,827.51	$86,300	$86,300
☐	**7**	$0- $48,650	$48,650.01	$65,677.50	$65,677.51	$90,002.50	$90,002.51	$97,300	$97,300
☐	**8+**	$0- $54,150	$54,150.01	$73,102.50	$73,102.51	$100,177.50	$100,177.51	$108,300	$108,300

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Thank you for your cooperation.

Please consider following us!

Updated 1/29/2025

LAMPREY HEALTH CARE

Where Excellence and Caring go Hand in Hand

Personal Representative Consent

I give permission to Lamprey Health Care to discuss my health information for the purposes of treatment, payment/financial matters, and Lamprey Health Care's operational purposes with:

Personal Representative's Name (print clearly): _____

Relationship to patient: _____ Phone: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Examples of how my information may be used include, but are not limited to, scheduling appointments, requesting refills and/or verbally receiving test results on my behalf. If applicable, the information disclosed may include substance use disorder treatment, behavioral health treatment, and other sensitive health information related to the aforementioned purposes.

This authorization will be valid until I provide Lamprey Health Care with a written notice of cancellation.

Patient's Name Printed Clearly: _____

Patient's Date of Birth: _____ Today's Date: _____

Patient's Signature: _____

Nashua Center, 22 Prospect Street, Nashua, NH 03060 (603) 883-1626
Newmarket Center, 207 South Main Street, Newmarket, NH 03857 (603) 659-3106
Raymond Center, 128 Route 27, Raymond, NH 03077 (603) 895-3351

LAMPREY HEALTH CARE

Patient Rights and Responsibilities

ACCESS

You have the right to equal access of primary medical care regardless of your race, color, sex, national origin, disability, religion, age, sexual orientation, gender identity, or ability to pay. You are assured access to 24-hour medical assistance and emergency care.

PRIVACY AND CONFIDENTIALITY

You have the right to personal privacy and confidentiality except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. You have the right to approve or refuse the release of your medical records to anyone except as required by law or third party contract. Your written consent must be obtained before any record will be released from our files.

INFORMATION

You will be fully informed of your medical condition and treatment plan. You have the right to see and examine your medical records, unless medically contraindicated. You are, in turn, responsible for providing complete and accurate pertinent information about your health, lifestyle and/or present illness.

CONSENT

Except in emergencies when the patient lacks decision-making capacity and the need for treatment is urgent, you are entitled to the opportunity to discuss and request information related to the specific procedures and/or treatments, the risks involved, the possible length of recuperation, and the medically reasonable alternatives and their accompanying risks and benefits.

SECURITY

You have the right to expect that Lamprey Health Care's practices and environment are safe. You are to maintain responsibility for your personal possessions during your visit.

RESPECT AND DIGNITY

You will be treated with consideration, respect and full recognition of your dignity, individuality, and cultural and/or spiritual needs, which will include privacy in treatment and in the care of your personal needs. No person will be discriminated against for reason of race, color, sex, national origin, disability, religion, age, sexual orientation, gender identity, or financial status. You, in turn, have the responsibility to show similar respect for our staff and be considerate in communications and in keeping scheduled appointments or notifying the center when unable to keep an appointment.

INVOLVEMENT IN CARE

You have the right to participate in developing your plan of care. You have the right to obtain complete and current information regarding your diagnosis, treatment, and prognosis to the degree known by the practitioners responsible for your care.

COMPLAINTS AND COMMENTS

You are encouraged to express any concerns, complaints or comments regarding any aspect of your experience with our center. This may be done in person, over the phone or in writing. You are assured that each concern, complaint or comment will be reviewed by the appropriate staff member with timely follow-up with you about the resolution of the issue.

BILLING INFORMATION

You have the right to request and receive a fee schedule and information concerning eligibility for third party reimbursement or our sliding fee scale.

ETHICAL ISSUES INVOLVING CARE

When conflicts arise in decisions about your care, you, your family and significant others have the right to receive an ethical consultation with appropriate parties, including caregivers, physicians, and others.

ADVANCE DIRECTIVES

You have the right to make, review, and modify Advance Directives (Living Will and Durable Power of Attorney) for health care at any time. You have the right to expect that Lamprey Health Care will honor the intent of your directives to the degree allowable by law and Lamprey Health Care policy.

RESEARCH

When research activities are approved by the Board of Directors, you have the right to consent or to decline to participate in any proposed study. If you choose to consider participation, the study will be fully explained to you prior to your signing a consent form.

Reviewed 1/29/2025