Bucksport Regional **Health Center**

110 Broadway – Bucksport, ME 04416
37 Commerce Park – Ellsworth, ME 04605
(207) 469-7371 www.bucksportrhc.org

Welcome to Bucksport Regional Health Center!

We are pleased that you have chosen Bucksport Regional Health Center for your healthcare services. Our staff is committed to providing you with an exceptional experience in service and quality care. At BRHC, we provide patient-centered and team-based care. You will have a team of people who collaborate closely with your provider to meet your healthcare needs. We want you to feel comfortable asking questions and participating in your care to help you have the best experience possible.

To help our providers understand your needs and provide exceptional care to you, please complete the following enclosed or attached documents prior to your first appointment and return them to Bucksport Regional Health Center ~ 110 Broadway, Bucksport, Maine 04416. Please Note: If you are requesting both medical and dental services, both Release of Information forms mut be completed and signed.

- Patient Registration & Information Form
- Health History Form
- Authorization to Obtain Health Information – Medical
- Authorization to Obtain Health Information - Dental
- Patient Informed Consent for Telehealth Services

As a Federally Qualified Health Center, Bucksport Regional Health Center offers a Sliding Fee Discount Program for those who qualify. Please call (207) 469-7371 Ext. 253 for further information.

Thank you again for choosing Bucksport Regional Health Center as your health care provider. We hope to have a long and healthy relationship with you.

Sincerely,

Carol Carew, CEO

Enclosures 11-7-2023TLH

Bucksport Regional Health Center

PATIENT REGISTRATION FORM

INTERESTED SERVICES:	☐ MEDICAL-BUCKSPORT ☐ MEDICAL-ELLSWORTH ☐ DENTAL ☐ BEHAVIORAL HEALTH

PATIENT INFORMATION				
PATIENT NAME	FIRST	LAST	MI	SUFFIX
DATE OF BIRTH		SS #		
PHONE #	HOME	CELL		
ADDRESS (MAILING)				
ADDRESS (PHYSICAL)				
ADDRESS (EMAIL)				
EMPLOYER/SCHOOL		PHONE #		
PRIMARY LANGUAGE	☐ ENGLISH	☐ FRENCH	☐ SPANISH	☐ OTHER
MARITAL STATUS	☐ SINGLE	☐ MARRIED	☐ DIVORCED	☐ WIDOWED
RACE	☐ WHITE/CAUCASIAN	☐ ASIAN	☐ NATIVE HAWIIAN	
	☐ AFRICAN AMERICAN	☐ OTHER:		
ETHNICITY	☐ HISPANIC OR LATINO	☐ NOT HISPANIC OR LATINO	☐ CHOOSE NOT TO DISCLOSE	
	☐ OTHER			
GENDER AT BIRTH	☐ MALE	☐ FEMALE		
SEXUAL ORIENTATION	☐ STRAIGHT OR HETROSEXUAL	☐ BISEXUAL	☐ SOMETHING ELSE	
	☐ LESBIAN, GAY OR HOMOSEXUAL	☐ DON'T KNOW	☐ CHOOSE NOT TO DISCLOSE	
GENDER IDENTITY	☐ MALE	☐ FEMALE	☐ TRANSGENDER MALE/FEMALE TO MALE	
	☐ GENDER QUEER/QUESTIONING		☐ TRANSGENDER FEMALE/MALE TO FEMALE	

THE BUCKSPORT REGIONAL HEALTH CENTER PATIENT PORTAL ALLOWS YOU TO HAVE ACCESS TO YOUR ELECTRONIC HEALTHCARE INFORMATION. WOULD YOU LIKE PORTAL ACCESS PROVIDED TO YOU? IF YES, YOUR EMAIL ADDRESS PROVIDED WITHIN THIS APPLICATION WILL BE USED TO REGISTER YOU.	☐ YES ☐ NO

EMERGENCY CONTACT			
NAME		RELATIONSHIP:	
PHONE	HOME:	CELL:	
ADDRESS			
YOU MAY DISCUSS MY MEDICAL HISTORY WITH MY EMERGENCY CONTACT?			☐ YES ☐ NO

YOU MAY DISCUSS MY MEDICAL HISTORY WITH THE FOLLOWING PERSONS			
I AUTHORIZE BUCKSPORT REGIONAL HEALTH CENTER TO DISCUSS/DISCLOSE ANY OF MY MEDICAL INFORMATION WITH THE FOLLOWING INDIVIDUALS. I UNDERSTAND THAT THIS CONSENT IS UPDATED YEARLY WITH ALL PREVIOUS FORMS BEING NULL-VOID. I UNDERSTAND THAT I CAN REVOKE THIS AUTHORIZATION AT ANY TIME.			☐ YES ☐ NO
NAME		RELATIONSHIP	
PHONE	(HOME)	(CELL)	
NAME		RELATIONSHIP	
PHONE	(HOME)	(CELL)	
NAME		RELATIONSHIP	
PHONE	(HOME)	(CELL)	

RESPONSIBLE PARTY INFORMATION FOR BILLING	☐ SELF	☐ PARENT	☐ GUARDIAN
NAME	DOB		SS #
PHONE	(HOME)	(CELL)	
ADDRESS			

HOUSEHOLD INCOME RANGE			
☐ $0 - $10,000	☐ $30,001 - $35,000	☐ $55,001 - $60,000	☐ $80,001 - $85,000
☐ $10,001 - $15,000	☐ $35,001 - $40,000	☐ $60,001 - $65,000	☐ $85,001 - $90,000
☐ $15,001 - $20,000	☐ $40,001 - $45,000	☐ $65,001 - $70,000	☐ $90,001 and Above
☐ $20,001 - $25,000	☐ $45,001 - $50,000	☐ $70,001 - $75,000	☐ CHOOSE NOT TO DISCLOSE
☐ $25,001 - $30,000	☐ $50,001 - $55,000	☐ $75,001 - $80,000	
# OF PEOPLE LIVING IN HOUSEHOLD:		# OF ADULTS:	# OF CHILDREN:

PREFERRED PHARMACY	
PHARMACY NAME	
PHARMACY ADDRESS	
PHARMACY PHONE #	

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)			
PRIMARY INSURANCE	(COMPANY)		
POLICY #		GROUP ID #	CO-PAY
SECONDARY INSURANCE	(COMPANY)		
POLICY #		GROUP ID #	CO-PAY
POLICY HOLDER	(NAME)		
	DOB	SS #	
PHONE	(HOME)	(CELL)	
ADDRESS			

PATIENT INFORMATION-SOCIAL HISTORY			
BRHC WOULD LIKE TO PROVIDE YOU WITH THE BEST CARE AND SERVICES POSSIBLE TO MEET YOUR MEDICAL, DENTAL AND BEHAVIORAL HEALTH NEEDS. TO BETTER UNDERSTAND YOUR NEEDS, WE WOULD LIKE TO KNOW A LITTLE MORE ABOUT YOU. THIS INFORMATION WILL BE KEPT SECURE AS WELL AS ALL OF YOUR HEALTH INFORMATION PER OUR NOTICE OF PRIVACY GUIDELINES.			
ARE YOU A MILITARY VETERAN?			☐ YES ☐ NO
ARE YOU AN AGRICULTURAL WORKER:	☐ MIGRAINT	☐ SEASONAL	☐ YES ☐ NO
HOUSING STATUS:	☐ NOT HOMELESS	☐ TRANSITIONAL	☐ DOUBLE UP
	☐ PUBLIC HOUSING	☐ SHELTER	☐ STREET
	☐ HOMELESS (IF HOMELESS, WHERE DO YOU LIVE:)		
	☐ OTHER		
COMMUNICATION NEEDS	☐ NONE	☐ LIMITED ENGLISH PROFICIENCY	☐ NEED INTERPRETER
PRIMARY LANGUAGE	☐ ENGLISH	☐ FRENCH	☐ SPANISH ☐ OTHER
ARE YOU VISUALLY IMPAIRED?			☐ YES ☐ NO
ARE YOU HEARING IMPAIRED?			☐ YES ☐ NO
IMMUNIZATION DATA PROTECTION ALLOWS YOUR IMMUNIZATION RECORDS TO BE SHOWN ON THE STATE OF MAINE REGISTRY. I AUTHORIZE MY IMMUNIZATION RECORD DATA TO BE SUBMITTED TO THE STATE OF MAINE REGISTRY?			☐ YES ☐ NO

DO YOU HAVE A RELIGIOUS AFFILIATION? IF SO, WHAT AFFILIATION:	☐ YES ☐ NO
EDUCATION: ☐ SOME HIGH SCHOOL ☐ GED-HIGH SCHOOL GRADUATE ☐ SOME COLLEGE ☐ COLLEGE GRADUATE	☐ TRADE TECHNICAL/VOCATIONAL
DO YOU UNDERSTAND YOUR HEALTHCARE NEEDS?	☐ YES ☐ NO
DO YOU HAVE ANY TROUBLE EATING?	☐ YES ☐ NO
HAVE YOU USED DRUGS OTHER THAN THOSE FOR MEDICAL REASONS IN THE PAST 12 MONTHS?	☐ YES ☐ NO
WITHIN THE PAST 12 MONTHS, WE WORRIED WHETHER OUR FOOD WOULD RUN OUT BEFORE WE GOT MONEY TO BUY MORE.	☐ YES ☐ NO
WITHIN THE PAST 12 MONTHS, THE FOOD WE BOUGHT JUST DIDN'T LAST AND WE DIDN'T HAVE MONEY TO GET MORE.	☐ YES ☐ NO
WOULD YOU LIKE TO MEET WITH OUR HEALTH EDUCATOR TO DISCUSS LIFESTYLE CHANGES OR TO ACCESS OTHER HEALTH RESOURCES? **NOTE: THERE IS NO CHARGE TO YOU FOR THIS SERVICE.**	☐ YES ☐ NO

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE	DATE
PARENT/GUARDIAN SIGNATURE (IF APPLICABLE)	DATE

11-7-2023TLH

Bucksport Regional **Health Center**

HEALTH HISTORY FORM

FULL LEGAL NAME		Date of Birth	
Most Recent Primary Care Provider		Last Visit	
Most Recent Dental Provider		Last Visit	Last X-Ray
Have you ever been seen at BRHC before?	☐ Yes ☐ No	How did you hear about BRHC?	
Provider Preference	☐ Male ☐ Female		

HEALTH HISTORY

Place a mark on "yes" or "no" to indicate if you have had any of the following:

☐ Yes ☐ No AIDS/HIV	☐ Yes ☐ No Epilepsy	☐ Yes ☐ No Radiation Treatment
☐ Yes ☐ No Anemia	☐ Yes ☐ No Fainting or Dizziness	☐ Yes ☐ No Respiratory Disease
☐ Yes ☐ No Arthritis/Rheumatism	☐ Yes ☐ No Glaucoma	☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Artificial Heart Valves	☐ Yes ☐ No Headaches	☐ Yes ☐ No Scarlet Fever
☐ Yes ☐ No Artificial Joints	☐ Yes ☐ No Heart Murmur	☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Asthma	☐ Yes ☐ No Heart Problems	☐ Yes ☐ No Sinus Trouble
☐ Yes ☐ No Back Problems	☐ Yes ☐ No Hepatitis - Type:_____	☐ Yes ☐ No Skins Rash
☐ Yes ☐ No Bleeding Abnormally with Extractions or Surgery	☐ Yes ☐ No Herpes	☐ Yes ☐ No Special Diet
	☐ Yes ☐ No High Blood Pressure	☐ Yes ☐ No Stroke
☐ Yes ☐ No Blood Disease	☐ Yes ☐ No High Cholesterol	☐ Yes ☐ No Swollen Feet or Ankles
☐ Yes ☐ No Cancer	☐ Yes ☐ No Jaundice	☐ Yes ☐ No Swollen Neck Glands
☐ Yes ☐ No Chemical Dependency	☐ Yes ☐ No Jaw Pain	☐ Yes ☐ No Thyroid Problems
☐ Yes ☐ No Chemotherapy	☐ Yes ☐ No Kidney Disease	☐ Yes ☐ No Tonsillitis
☐ Yes ☐ No Circulatory Problems	☐ Yes ☐ No Liver Disease	☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Congenital Heart Lesions	☐ Yes ☐ No Low Blood Pressure	☐ Yes ☐ No Tumor-Growth on Nead/Neck
☐ Yes ☐ No Cortisone Treatments	☐ Yes ☐ No Mitral Valve Prolapse	☐ Yes ☐ No Ulcer
☐ Yes ☐ No Cough, Persistent or Bloody	☐ Yes ☐ No Nervous Problems	☐ Yes ☐ No Venereal Disease
☐ Yes ☐ No Diabetes	☐ Yes ☐ No Pacemaker	☐ Yes ☐ No Weight Loss, Unexplained
☐ Yes ☐ No Emphysema	☐ Yes ☐ No Psychiatric Care	

☐ Yes ☐ No	Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.
☐ Yes ☐ No	Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).
☐ Yes ☐ No	Do you wear contact lenses?
☐ Yes ☐ No	Do you smoke? If Yes, How Many Per Day?
☐ Yes ☐ No	Do you drink alcohol? If Yes, How Many Per Week?
☐ Yes ☐ No	Are you pregnant? If Yes, Due Date:
☐ Yes ☐ No	Are you nursing?
☐ Yes ☐ No	Are you taking birth control pills?

SURGERY - Please indicate any surgeries that you have had.

CURRENT MEDICATIONS

PHARMACY (Please indicate which pharmacy you use.)

Name:				Phone Number:	
Address		Town:		State:	

Bucksport Regional **Health Center**

HEALTH HISTORY FORM

FULL LEGAL NAME	

ALLERGIES

☐ Aspirin ☐ Barbiturates (Sleeping Pills) ☐ Codeine ☐ Other _____
☐ Iodine ☐ Latex ☐ Local Anesthetic _____
☐ Penicillin ☐ Sulfa _____

FAMILY ILLNESS HISTORY	
Please Identify Who	
Alcoholism	
Asthma	
Cancer - Breast	
Cancer - Colon	
Cancer - Prostate	
Cancer - Other	
Depression	
Diabetes	
Heart Attack	
Heart Problems	
High Blood Pressure	
Thyroid Problem	
Stroke	
Other	

FAMILY HEALTH HISTORY				
How is the health of your family?				
	Good	Poor	Died	Cause of Death
Father				
Mother				
Brother(s)				
Sister (s)				
Children				

DENTAL HISTORY

Place a mark on "yes" or "no" to indicate if you have had any of the following:

☐ Yes ☐ No Bad Breath	☐ Yes ☐ No Foreign Objects	☐ Yes ☐ No Periodontal Treatment
☐ Yes ☐ No Bleeding Gums	☐ Yes ☐ No Grinding Teeth	☐ Yes ☐ No Sensitivity to Cold
☐ Yes ☐ No Blisters on Lips/Mouth	☐ Yes ☐ No Gums Swollen or Tender	☐ Yes ☐ No Sensitivity to Heat
☐ Yes ☐ No Burning Sensation on Tongue	☐ Yes ☐ No Jaw Pain or Tiredness	☐ Yes ☐ No Sensitivity to Sweets
☐ Yes ☐ No Chew on One side of Mouth	☐ Yes ☐ No Lip or Cheek Biting	☐ Yes ☐ No Sensitivity When Biting
☐ Yes ☐ No Cigarette/Pipe/Cigar Smoking	☐ Yes ☐ No Loose Teeth or Broken Fillings	☐ Yes ☐ No Sores or Growths on Mouth
☐ Yes ☐ No Clicking or Popping Jaw	☐ Yes ☐ No Mouth Breathing	How Often do you floss?
☐ Yes ☐ No Dry Mouth	☐ Yes ☐ No Mouth Pain, Brushing	How often do you brush?
☐ Yes ☐ No Fingernail Biting	☐ Yes ☐ No Orthodontic Treatment	Have you had a dental cleaning in the past year? ☐ Yes ☐ No
☐ Yes ☐ No Food Collects Between Teeth	☐ Yes ☐ No Pain Around Ear	

_____ Form Completed By (Name)

_____ Date

Bucksport Regional **Health Center**

AUTHORIZATION TO OBTAIN HEALTH INFORMATION

MEDICAL

INDIVIDUAL WHOSE INFORMATION MAY BE DISCLOSED:

Patient First Name	Patient Last Name	Patient Maiden Name (If Applicable)	Middle Initial

Patient Telephone Number	Date of Birth

Patient Address	City	State	Zip Code

AUTHORIZE	TO DISCLOSE TO
Provider:	☐ Bucksport Regional Health Center MEDICAL RECORDS - BUCKSPORT 110 Broadway - Bucksport, Maine 04416 Phone #: (207) 469-7371 Fax #: (207) 469-7306
Practice Name:	☐ Bucksport Regional Health Center MEDICAL RECORDS - ELLSWORTH 37 Commerce Park - Ellsworth, Maine 04605 Phone #: (207) 469-7371 Fax #: (207) 469-7306
Address:	☐ Bucksport Regional Health Center DENTAL RECORDS - BUCKSPORT 110 Broadway - Bucksport, Maine 04416 Phone #: (207) 902-1100 Fax #: (207) 902-1104 Email: dentalteam@brhcme.org
Phone #:	
Fax #:	
Purpose of Release: ☐ Transfer of Care (Physician Practice Only) ☐ Continuity of Care ☐ Shared Medical ☐ Other _____	

INFORMATION TO BE RELEASED

☐ Office Treatment Notes	☐ Emergency Department	☐ Psychiatric/Psychological Evaluation
☐ History & Physical	☐ Consultation	☐ Psychosocial Evaluation
☐ Discharge Summary	☐ Operative Report	☐ Assessment/Care/Plan Notes
☐ Laboratory	☐ Radiology Report	☐ Cardiology
☐ Pathology	☐ Homecare & Hospice Reports	☐ Vaccinations/Immunizations

Additional Information to Be Released

☐ Dental

☐ Mental Health Treatment Records

☐ **Alcohol/Drug Dependency Records** - Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)

☐ **Specific Diagnosis: HIV/AIDS Antibody Test Results & Diagnosis/Treatment**

THE INFORMATION AUTHORIZED TO BE DISCLOSED IS FROM THE FOLLOWING PERIOD(S):

From (mm/dd/yyyy)	To (mm/dd/yyyy)

This Authorization is For: ☐ **A One Time Disclosure** ☐ **Multiple Disclosures**

Note: Authorization for disclosure of certain mental health records cannot be continuing authorizations.

I understand I have the right to revoke this authorization at any time. Authorization will be considered null and void when Bucksport Regional Health Center receives a request in writing revoking authorization. This authorization for disclosure is effective for one year from the date signed.

_____ **Signature**

_____ **Date**

_____ **Relationship to Patient**

Authority to Act -Legal Representative: ☐ Legal Guardian ☐ Executor of Estate ☐ Spouse of Deceased ☐ Health Care Power of Attorney

_____ **Legal Representative Signature**

_____ **Date**

_____ **Witness**

_____ **Date**

Bucksport Regional **Health Center**

AUTHORIZATION TO OBTAIN HEALTH INFORMATION

DENTAL

INDIVIDUAL WHOSE INFORMATION MAY BE DISCLOSED:

Patient First Name	Patient Last Name	Patient Maiden Name (If Applicable)	Middle Initial

Patient Telephone Number	Date of Birth

Patient Address	City	State	Zip Code

AUTHORIZE

Provider:

Practice Name:

Address:

Phone #:

Fax #:

Purpose of Release:

- ☐ Transfer of Care (Physician Practice Only)
- ☐ Continuity of Care ☐ Shared Medical
- ☐ Other _____

TO DISCLOSE TO

☐ Bucksport Regional Health Center
MEDICAL RECORDS - BUCKSPORT
110 Broadway - Bucksport, Maine 04416
Phone #: (207) 469-7371 Fax #: (207) 469-7306

☐ Bucksport Regional Health Center
MEDICAL RECORDS - ELLSWORTH
37 Commerce Park - Ellsworth, Maine 04605
Phone #: (207) 469-7371 Fax #: (207) 469-7306

☐ Bucksport Regional Health Center
DENTAL RECORDS - BUCKSPORT
110 Broadway - Bucksport, Maine 04416
Phone #: (207) 902-1100 Fax #: (207) 902-1104
Email: dentalteam@brhcme.org

INFORMATION TO BE RELEASED

- ☐ Office Treatment Notes
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Laboratory
- ☐ Pathology
- ☐ Emergency Department
- ☐ Consultation
- ☐ Operative Report
- ☐ Radiology Report
- ☐ Homecare & Hospice Reports
- ☐ Psychiatric/Psychological Evaluation
- ☐ Psychosocial Evaluation
- ☐ Assessment/Care/Plan Notes
- ☐ Cardiology
- ☐ Vaccinations/Immunizations

Additional Information to Be Released

- ☐ Dental
- ☐ Mental Health Treatment Records
- ☐ **Alcohol/Drug Dependency Records** - Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)
- ☐ **Specific Diagnosis: HIV/AIDS Antibody Test Results & Diagnosis/Treatment**

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I understand I have the right to revoke this authorization at any time. Authorization will be considered null and void when Bucksport Regional Health Center receives a request in writing revoking authorization. This authorization for disclosure is effective for one year from the date signed.

_____ Signature

_____ Date

_____ Relationship to Patient

Authority to Act -Legal Representative: ☐ Legal Guardian ☐ Executor of Estate ☐ Spouse of Deceased ☐ Health Care Power of Attorney

_____ Legal Representative Signature

_____ Date

_____ Witness

_____ Date

2-2-2021TLH

Bucksport Regional Health Center

CONSENT FORM

Consent to Treatment. I authorize Bucksport Regional Health Center (BRHC) and its medical, nursing and other professional staff members, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as, in the judgment of BRHC's medical personnel, is deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination.

Release of Information. I authorize BRHC to use and disclose my health information for the following purposes: (1) to provide for, arrange or coordinate my health care treatment; (2) to enable BRHC to obtain payment for the services it provides to me; and (3) to permit BRHC to carry out ordinary health care and business operations such as quality assurance, service planning and general administration.

Assignment of Benefits. I assign to BRHC all benefits to which I may be entitled from Medicare, MaineCare, other government agencies, insurance carriers and other third parties who are financially liable for the medical care and treatment provided by BRHC.

Financial Obligations. I agree that, except as may be limited by law or BRHC's agreements with third party payers, in the event of non-payment by a third party for which I have provided an assignment of benefits, I am obligated to pay all amounts due to services provided at BRHC facilities. I also agree that I am responsible for any applicable co-payments, coinsurance or deductibles.

Acknowledgment of Receipt of Notice of Privacy Practices. I acknowledge that I have been offered a copy of the BRHC Notice of Privacy Practices, which describes how health information provided by me may be used and disclosed by BRHC and how I may obtain access to and control the use and disclosure of this information.

I have received or declined a copy of the a) BRHC Notice of Privacy Practices, b) Patient's Rights and Responsibilities, c) Information on the health information exchange including an opportunity to opt out, and d.) plain language summary of the BRHC Financial Assistance Policy.

These are available at the Front Desk.

I certify that I have read this form and that I am the patient, or I am duly authorized by the patient as the patient's representative to execute this form and accept its terms.

Patient Name (Please Print	Patient Signature	Date

Representative of Patient	Name/Relationship	Signature	Date

4/11/2025TLH

Bucksport Regional Health Center
110 Broadway~ Bucksport, ME (207) 469-7371
37 Commerce Park ~ Ellsworth, ME (207) 667-5604
1-800-453-3819
Fax (207) 469-7306
bucksportrhc.org

BUCKSPORT REGIONAL HEALTH CENTER
PATIENT INFORMED CONSENT FOR TELEHEALTH SERVICES

NONDISCRIMINATION STATEMENT: Bucksport Regional Health Center (BRHC) and Coastal Health Center (CHC), a practice of BRHC, comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language. BRHC and CHC do not exclude people or treat them differently because of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language.

BRHC & CHC

- Provides free aids and service to people with disabilities to communicate effectively with us, such as:
  - Qualified Sign Language Interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified Interpreters
  - Information written in other languages

If you believe that BRHC or CHC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information , veteran status, sexual orientation, sex, gender, gender identity, or expression, or language, you can file a civil rights complaint with the U.S. Department of Health & Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at: https://ocrportal/hhs.gov/ocr/portal/lobby.isf, or by mail or phone at: U.S. Department of Health & Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

BRHC PATIENT INFORMED CONSENT FOR TELEHEALTH SERVICES

What is telehealth and why would I want to use it? Telehealth uses electronic communication to provide care from a distance (from where you are located) and at the time you need care. It uses equipment that can stream live healthcare visits similar to "face-to-face." Streaming often occurs through a patient portal that shows your care team on a screen. A patient portal can also be used for written communication with your care team, which is another type of telehealth. Telehealth can be used to assess your weight, blood pressure and other types of monitoring.

How can telehealth help me? Your care team can use telehealth to examine, consult, diagnose and treat you. Telehealth can also be used to provide education, help you manage your care and help your plan for your next visit. With telehealth, your care team can work with other providers, including distant specialists. Care using telehealth may be more convenient than in person care.

MY CONSENT TO USE TELEHEALTH

My healthcare team explained to me the benefits and risks of telehealth, and the types of services that might help me. I understand my provider may use telehealth to examine, consult, diagnose, and/or treat me and that this treatment will be documented in my medical record. I know that I have the right to ask questions and receive guidelines about the services offered to me. My use of telehealth is my choice and no one else can decide that for me. I know I have the right to know who will be involved in my healthcare. This includes the people who will be with me in person and the people

who will be at the distant site to care for me. I know I also have the right to exclude anyone from either site and I have the right to object to the videotaping or other recording of a telehealth service.

I know I can stop using telehealth at any time and request the same service(s) in a face-to-face setting. I know that if I choose the face-to-face services, my care team may change.

I know that information about me may be created, stored, used or disclosed in linking me with the telehealth services. This information is protected health information and will be handled using the standards applied to all protected health information. I know I have the right to access my protected health information under state and federal law.

If I am a MaineCare beneficiary, my refusal of telehealth will not affect my MaineCare benefits. In some circumstances, MaineCare will pay me to travel to receive MaineCare covered services under the MaineCare Benefits Manual.

Permission is given for release of my medical information to provide continuity of care. I understand that I am financially responsible for any part of my bill not paid by insurance.

Risks: I know that the computer systems used to deliver telehealth are made to protect others from knowing who I am and/or anything about my health information. Rarely, equipment or security failures can occur despite these protections and my personal information could be exposed. Sometimes, technical problems or the type of health problem being treated result in the transmission of information that is not adequate for medical decision making, which may delay my treatment. In some cases, an in-person visit may be needed.

Acknowledgement: My signature below shows that I have read and understand the risks and benefits of telehealth. I have had the chance to discuss telehealth services with my healthcare team and I have no other questions or concerns.

Patient Consent: By signing this document, I consent to receive telehealth services.

SIGNATURE

I have read this form, or it has been read to me, and I understand it. I understand that I may have a copy on request.

Patient Name (Please Print)	Patient* Signature	Date
Patient Representative* Name/Relationship (Please Print)	Patient*Signature	Date

I have received or declined a copy of the a.) BRHC Notice of Privacy Practices, b.) Patient's Rights and Responsibilities, c.) Information on the health information exchange including an opportunity to opt out, and d.) plain language summary of the BRHC Financial Assistance Policy

Patient Name (Please Print)	Patient* Signature	Date
Patient Representative* Name/Relationship (Please Print)	Patient*Signature	Date

** A parent/guardian or other authorized representative is generally required to sign for a patient under the age of 18. Patients aged 14 to 17 should sign in addition to their parent/guardian or authorized representative. Indicate relationship of representative to minor patients.*

10-09-2023TLH