



180 Church Hill Road, Ste.#1, Leeds, Maine 04263
207-524-3501 ~ Fax: 207-524-2093
Business office fax: 207-524-2459
www.dfdrussell.org

DFD Russell Medical Centers, Inc. is an equal opportunity provider and employer

Dear Patient:

Welcome to DFD Russell Medical Center! We understand that you would like to schedule an appointment with one of our health care providers. **Please fill out and return the Registration and Records Release forms and the Income Survey & Sliding Fee Application to us as soon as possible. As soon as we receive these forms, our office will call you to schedule an appointment.** You may bring the Treatment & Consent form with you to your appointment.

Please note that we cannot fill any prescriptions, or authorize any referrals, without seeing you first. It is also our policy not to prescribe narcotics at the first visit.

If you are not insured, you will be expected to pay in full at the time of your visit. If you cannot afford to do this, we urge you to complete the sliding fee discount program application enclosed. If you qualify, you will receive services at a discounted rate based upon your household income. The application and all documentation must be received and approved before you will receive discounted services.

Should you have any questions or need assistance in completing these forms, please call registration at 207-524-3501 ext 192.

We look forward to meeting you and helping you with your health care needs.
At DFD we offer a full range of family practice services for all members of the family.

Here are some of the services that we offer:

- Care of infants, children, adolescents and adults of all ages
- Behavioral health services
- Chronic Disease Care for all chronic health conditions
 - Health education
 - Nutrition services
- Patient Assistance Program for patients of all ages
 - Assistance with applying for health care and prescription benefits
 - Assistance with community programs
- 24 hour on-call services
- Evening and weekend office hours

Together we will develop a plan on how to best meet those needs.

Sincerely,

Laurie Kane-Lewis, CEO
DFD Russell Medical Centers

DFD Russell Medical Centers

Patient Registration Form

Consent

Date _____

HIPAA R&R

Patient Information

* First Name _____ M _____ Last Name _____

Previous last name if different _____

Mailing Address _____ City _____ ST _____ Zip _____

Phone# _____ Cell # _____ Social Security# _____ Gender M F

Date of Birth _____ Language _____ Marital Status _____

Race White African American Native American Asian Other

Ethnicity Are you Hispanic/Latino? Yes No

* Employment Status Full Part Self Retired Disabled Student Unemployed

Employer _____ Phone # _____

Address _____ City _____ ST _____ Zip _____

If child, responsible party _____ Social Security # _____

Address _____ Phone _____

* Emergency Contact Person _____ Daytime Phone # _____

Relationship to Patient _____

* Are you a veteran? Yes No

* Over the past 24 months have you or a family member been employed seasonally or worked in the agricultural (farming) industry? Yes No

If so, have you applied for the Maine Migrant Health Program? Yes No

* Do you have assistance paying for prescription drugs? Yes No

If no, may we contact you regarding possible prescription drug savings? Yes No

Billing Information

* Primary Insurance _____ Effective Date _____ Copay \$ _____

Is there a PCP or doctor listed on your card? _____ If yes, who is it? _____

Ins. Address _____ City _____ ST _____ Zip _____

Group # _____ Certificate/ID # _____

Subscribers Name _____ Relationship to Patient _____

Address _____ City _____ ST _____ Zip _____

Phone # _____ Date of Birth _____ SS# _____

Employers Name _____ Phone # _____

* Secondary Insurance _____ Effective Date _____ Copay \$ _____

Address _____ City _____ ST _____ Zip _____

Group # _____ Certificate/ID # _____

Subscribers Name _____ Relationship to Patient _____

Address _____ City _____ ST _____ Zip _____

Phone # _____ Date of Birth _____ SS# _____

Employers Name _____ Phone # _____



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Consent for Treatment

I give my consent to DFD Russell Medical Center to provide general healthcare services including, but not limited to, physical examination, laboratory tests screenings, medications and other medical procedures as advised by the facility's attending physicians and healthcare professionals.

Payment Agreement

In order to have my medical bills paid, I will allow DFD Russell Medical Center to give my information to my insurance company. I also give my permission for my insurance company to pay DFD Russell Medical Center directly.

I understand that I will need to give DFD Russell Medical Centers correct insurance information and that I will be responsible for charges not covered by my health insurance.

Appointment Confirmation

I understand that DFD Russell Medical Center may call me to confirm my appointments. The call may include the date, time and location of the appointment and the provider that I am scheduled to see. A message may be left on an answering machine or given to a household member.

Household Income Survey

I understand that DFD Russell Medical Center is a federally funded health center. I will complete the attached income survey which is used to meet Federal grant funding requirements. I also understand that this information is completely confidential and will not be disclosed to any unauthorized user for any purpose.

Printed Name

Date of Birth

Signature

Today's Date

Signature of Parent / Guardian

Today's Date



John Yindra, M.D.
Medical Director

Laurie Kane, CEO

180 Church Hill Road
Leeds, Maine 04263
207-524-3501

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Dear Sliding Fee Applicant:

Attached is an application for the DFD Russell Medical Center sliding fee program. This program offers eligible patients four levels of discounts for services provided at our centers. **Please complete the application and return it to us within 30 days for processing.**

Be sure to include the information required to document family income as noted on the forms. If you do not include this information we will not be able to process your application.

The highest discounts offered are Category A and Category B, as listed on the attached Sliding Fee Discount Scale. If you qualify for one of these categories it is necessary for you to submit a MaineCare application before we can process your sliding fee application. Qualifying for MaineCare will pay for services starting with the date you are eligible. **Qualifying for our Sliding Fee Discount program will help you pay for any outstanding balances that Mainecare will not cover regardless of age of the balance.**

Our Patient Assistance Coordinator, Tia Knapp is available to assist you in completing the sliding fee application, the Maine Care application, and gathering the required income documents. Tia may be reached at 207.524.4010. Please call her if you have any questions or if you need assistance.

Our goal at DFD Russell Medical Center is to make this process go as smoothly as possible so that you can achieve significant discounts on services if you qualify for the program. Thank you for selecting us as your healthcare provider.

Sincerely,

Laurie Kane, CEO
DFD Russell Medical Center



DFD Russell Medical Center Sliding Fee Discount Application

Mail to:
180 Church Hill Rd. Ste.1
Leeds, ME 04263

This application is available to all persons, uninsured or underinsured requesting discounted services under the DFD Russell Medical Center sliding fee for services program.

Name:	Telephone No.:
Address:	

Household Members:			Income (complete one column)		
	Name	Date of Birth	Weekly	Monthly	Annual
Self					
Spouse					
Children					

Income requirement information: This application requires some form of documented household supporting income. Include income from all sources for persons supporting household, wages, tips, Social Security income and benefits, pensions, annuities, alimony, child support, income from trusts or estates, military, unemployment, self-employment, income from public aid. This income information is confidential and will be used only for the evaluation completed by our finance staff. It will not be disclosed nor will it become part of any medical record.

1. **A complete copy of your last individual income tax return (1040 form). Include all schedules and attachments.**
2. **Two recent forms of employment income, such as pay stubs, or one social security, unemployment or other benefit check stub.**
3. **Maine Care benefits status Letter, if required.**

Certification of Accuracy

I certify that the information provided above is complete and accurate and that I have disclosed all sources of household income. I understand if it is later determined that I have materially misrepresented any of this information DFD Russell Medical Center has the right to bill me for discounts previously allowed and I agree to pay all such charges.

If approved, sliding fee discounts are valid for one year from the date of approval.

Signature: _____

Date: _____

DFD use only:

Centricity Number: _____

Date received: _____

Approved by: _____

Discount category: _____

Date Approved: _____

Date to Quest: _____



For DFDR Use Only:		
Account #:	_____	
DOB:	_____	
T&C	HIPPA	R&R
Date Signed:	_____	
Initials:	_____	

Household Income Survey

DFD Russell Medical Center is a federally funded health center. This allows us to provide needed healthcare services to individuals regardless of their ability to pay. Because we receive federal grants, we are required to gather information on household size and income for the patients we serve.

PLEASE NOTE: YOUR PERSONAL INFORMATION IS CONFIDENTIAL. IT IS NOT DISCLOSED TO ANYONE AND IS ONLY USED TO DEVELOP STATISTICS REGARDING OUR USE OF FEDERAL FUNDS.

Please check one box:
Total number of individuals
Living in your household.

- | | |
|--------------------------|------------|
| <input type="checkbox"/> | 1 |
| <input type="checkbox"/> | 2 |
| <input type="checkbox"/> | 3 |
| <input type="checkbox"/> | 4 |
| <input type="checkbox"/> | 5 |
| <input type="checkbox"/> | 6 |
| <input type="checkbox"/> | 7 |
| <input type="checkbox"/> | 8 |
| <input type="checkbox"/> | 9 |
| <input type="checkbox"/> | 10 or more |

Please check on box:
Total income in household

- | | | | |
|--------------------------|----------------------|--------------------------|----------------------|
| <input type="checkbox"/> | Less than \$8000 | <input type="checkbox"/> | \$26,001 to \$28,000 |
| <input type="checkbox"/> | \$8,001 to \$10,000 | <input type="checkbox"/> | \$28,001 to \$30,000 |
| <input type="checkbox"/> | \$10,001 to \$12,000 | <input type="checkbox"/> | \$30,001 to \$32,000 |
| <input type="checkbox"/> | \$12,001 to \$14,000 | <input type="checkbox"/> | \$32,001 to \$34,000 |
| <input type="checkbox"/> | \$14,001 to \$16,000 | <input type="checkbox"/> | \$34,001 to \$36,000 |
| <input type="checkbox"/> | \$16,001 to \$18,000 | <input type="checkbox"/> | \$36,001 to \$38,000 |
| <input type="checkbox"/> | \$18,001 to \$20,000 | <input type="checkbox"/> | \$38,001 to \$40,000 |
| <input type="checkbox"/> | \$20,001 to \$22,000 | <input type="checkbox"/> | \$40,001 to \$45,000 |
| <input type="checkbox"/> | \$22,001 to \$24,000 | <input type="checkbox"/> | \$45,001 to \$50,000 |
| <input type="checkbox"/> | \$24,001 to \$26,000 | <input type="checkbox"/> | More than \$50,000 |

DFD RUSSELL MEDICAL CENTER SLIDING FEE DISCOUNT SCALE

IF YOUR FAMILY SIZE IS	<u>CATEGORY A</u>	<u>CATEGORY B</u>	<u>CATEGORY C</u>	<u>CATEGORY D</u>
	YOU PAY \$8 IF YOUR INCOME IS	YOU PAY 25% OF CHARGES IF YOUR INCOME IS	YOU PAY 50% OF CHARGES IF YOUR INCOME IS	YOU PAY 75% OF CHARGES IF YOUR INCOME IS
	100%	101%-124%	125%-149%	150%-199%
1	\$10,830 or LESS	\$10,831 - 13,537	\$13,538 - 16,244	\$16,245 - 21,659
2	\$14,570 OR LESS	\$14,571 - 18,212	\$18,213 - 21,854	\$21,855 - 29,139
3	\$18,310 OR LESS	\$18,311 - 22,887	\$22,888 - 27,464	\$27,465 - 36,619
4	\$22,050 OR LESS	\$22,051 - 27,562	\$27,563 - 33,074	\$33,075 - 44,099
5	\$25,790 OR LESS	\$25,791 - 32,237	\$32,238 - 38,684	\$38,685 - 51,579
6	\$29,530 OR LESS	\$29,531 - 36,912	\$36,913 - 44,294	\$44,295 - 59,059
7	\$33,270 OR LESS	\$33,271 - 41,587	\$41,588 - 49,904	\$49,905 - 66,539
8	\$37,010 OR LESS	\$37,011 - 46,262	\$46,263 - 55,514	\$55,515 - 74,019

OVER 8
FAMILY
MEMBERS?

ADD \$3,740 FOR EACH
MEMBER

ADD \$4,675 FOR EACH
MEMBER

ADD \$5,610 FOR EACH
MEMBER

ADD \$7,480 FOR EACH
MEMBER

*** Category A - B discount levels require a copy of current Maine Care benefits status letter.**

BASED ON 2009 DHHS POVERTY GUIDELINES PUBLISHED SOURCE: Federal Register, Vol. 74, No. 14, January 23, 2009, pp. 4199-4201

APPROVED BY THE DFD RUSSELL MEDICAL CENTER BOARD OF DIRECTORS March 1, 2009



John Yindra, M.D.
Medical Director

Laurie Kane-Lewis, CEO

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Patient name

Date of birth

Patient address

I authorize the release of the following parts of my medical record: *Please check box (s) below.*

COMPLETE MEDICAL RECORD Other: _____

I authorize the release of my medical records for :

Transfer of care: _____ Other: _____

Please initial EACH area that you wish released :

I understand that I must give special permission to release MENTAL HEALTH, DRUG and/ or ALCOHOL ABUSE TREATMENT, and HIV/AIDS related records.

_____ I DO authorize release of information regarding mental health treatment.
(initial)

_____ I DO authorize release of information regarding drug or alcohol abuse treatment.
(initial)

_____ I DO authorize release of information regarding HIV/AIDS diagnosis/treatment.
(initial)

_____ I DO NOT wish to review any records before they are released.
(initial)

Please check box and sign :

Release medical records TO: DFD Russell Medical Centers

FROM Provider name: _____
Town/City _____ Telephone: _____ Fax#: _____

Signed by: _____ **Date:** _____
(Patient or legal representative signature)

This release will expire one year from date of signature

This release will expire **one year** from the above date unless otherwise changed by the patient.
This authorization can be revoked at any time with a written, signed and dated notification.