Broad Top Health & Wellness
BTAMC Inc.

Patient and Visitor Code of Conduct

Welcome to Broad Top Area Medical Center, Inc. (BTAMC)

At BTAMC, we are dedicated to delivering high-quality, compassionate healthcare in a safe and inclusive environment across all our locations. To foster a culture of mutual respect and safety between patients, their families, and our providers, we ask that everyone adhere to the guidelines set forth in our Patient Code of Conduct.

Patient/Visitor Responsibilities

As a patient of BTAMC you are responsible for:

- Attending scheduled appointments or notifying your provider as soon as possible if you need to cancel, in accordance with the BTAMC's Broken/Missed Appointments & Follow-Up Visits Policy.
- Providing accurate and complete information about your present symptoms, past illnesses, hospitalizations, medications and other matters related to your health
- Reporting unexpected changes in your condition to your provider(s)
- Following the treatment plan recommended by your provider, nurse, and other healthcare personnel or helping us understand why you are not able to do that at the time
- Promptly paying for services in accordance with BTAMC's Patient Accounting/Collections Policy, including copayments and deductibles due at the time of service or making arrangements to do so.
- Respecting the privacy of other patients and their protected health information.

Code of Conduct

BTAMC aims to provide a safe and healthy environment for everyone and expects patients, staff and visitors to refrain from behaviors that are disruptive or pose a threat to the rights and safety of others. The following behaviors are prohibited:

- Possession of firearms or any weapon.
- Engaging in threatening, intimidating, or abusive conduct
- Using profanity or similarly offensive language
- Criticizing staff in front of other patients or staff members
- Making disrespectful or discriminatory comments, actions or requests about others' race, accent, religion, gender, gender identity, sexual orientation or any other identities.
- Verbal aggression, including yelling or other actions which disrupt the care and treatment of our patients
- Physical assault such as hitting or unwanted touching.
- Possession or being under the influence of drugs or alcohol.
- Photographing and/or recording of staff without written consent.

If you experience or witness any of these behaviors, please report it to a member of the health care team. Our staff is dedicated to providing the highest quality of care to our patients. Please show them the respect they deserve as they carry out their duties. Patient and Visitors who do not comply with this Code of Conduct will be asked to leave. Thank you.

Broad Top Health & Wellness

NEW PATIENT REGISTRATION & MEDICAL HISTORY FORM

As a Federally Qualified Health Center (FQHC), we are required to collect the following information from every patient we serve. Per federal privacy rules, (HIPAA) this protected information is kept confidential and is not disclosed, unless authorized by the patient.
Thank you for your cooperation and choosing BTAMC as your health care provider.

Todays Date: _____

Patient Demographic Information

Last:	First:	Middle:	
Date of Birth:	Legal Sex: ☐ M ☐ F	Preferred Name:	
PO Box/Street & Apt #:	City:	State:	Zip:
Social Security #:	Home Phone:	Cell Phone:	Work Phone:

Email Address:
☐ I DO ☐ I DON'T authorize BTAMC to leave a detailed message

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

Primary Language:
☐ English ☐ Sign Language
☐ Spanish ☐ Other: _____

Homebound: ☐ Yes ☐ No

Do you need a translator: ☐ Yes ☐ No

Ethnicity:
☐ Not Hispanic ☐ Hispanic
☐ Latino/Latina ☐ Spanish
☐ Declined/Refused ☐ Other: _____ (please describe)

Race: ☐ Caucasian ☐ African American
☐ Asian ☐ American Indian/Alaska Native
☐ Hawaiian/Pacific Native
*More than one race – please select all that apply or describe: _____

Shelter Status: ☐ Houseless-Street ☐ Houseless-Shelter ☐ Doubling-up ☐ Public Housing ☐ N/A

Gender Identity: (How do you identify yourself today?)
☐ Male ☐ Transgender Male/Female-to-Male ☐ Declined/Refused
☐ Female ☐ Transgender Female/Male-to-Female ☐ Non-binary

Sexual Orientation: ☐ Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Bisexual
☐ Other: _____ ☐ Declined/Refused ☐ Uncertain/Don't Know

Insurance Coverage <u>Please provide insurance card(s)</u>

Primary Insurance Name:	Policy #:	Group #	Insurance Phone:
Insurance PO Box/Street Address:	City	State	Zip
Secondary Insurance Name:	Policy #	Group #	Insurance Phone:

Responsible Party (*if patient is not financially responsible*)

Last:	First:		Middle:
Date of Birth:	Address:	Phone:	
Social Security Number:	City	State	Zip

Relationship:
☐ Self/Same as Patient ☐ Spouse/Partner ☐ Parent ☐ Other Please Describe _____

Email Address:

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NEW PATIENT REGISTRATION & MEDICAL HISTORY FORM

Employment Information

Employment Status:

☐ Full-time ☐ Part-time ☐ Self Employed ☐ Military Veteran ☐ Retired
☐ Disabled ☐ Student ☐ Seasonal Worker without a Residence ☐ Migratory Worker with a Residence

Occupation:	Employer Name:	Phone #:

Po Box/Street Address	City	State	Zip

Patient Pharmacy Information

Pharmacy Name:	Pharmacy Telephone Number:

Address	City	State	Zip

Emergency & Non-Emergency Contacts & Consent to share personal health information

I authorize BTAMC to share my personal health information with the individuals listed below:

Name: _____ Phone: _____ Relationship: _____
☐ Emergency Contact ☐ Medical ☐ Billing ☐ Scheduling

Name: _____ Phone: _____ Relationship: _____
☐ Emergency Contact ☐ Medical ☐ Billing ☐ Scheduling

Name: _____ Phone: _____ Relationship: _____
☐ Emergency Contact ☐ Medical ☐ Billing ☐ Scheduling

Name: _____ Phone: _____ Relationship: _____
☐ Emergency Contact ☐ Medical ☐ Billing ☐ Scheduling

TREATMENT & PAYMENT AUTHORIZATION

As a patient of BTAMC, I authorize treatment for myself, or the identified minor. I consent to clinical assessment, treatment, testing or tele-health services, including audio/visual or audio only encounter. I understand BTAMC uses an integrated, team-based approach to evaluation and management. Services may include primary medical care, integrated behavioral health services, preventative or additional dental services, patient outreach support and assistance, care management services, and/or some specialty services. Additionally, our integrated care specialists may provide consultation, behavioral health assessments, counseling interventions or support services, as you and your BTAMC provider decide are appropriate. I authorize BTAMC to release my medical information for the continuum of care with other medical providers and facilities, or with insurance payors to seek reimbursement for services provided.

I understand that I am financially responsible for all service charges for myself or identified minor, whether or not the service(s) are covered by insurance. BTAMC will submit claims to my insurance company to secure payment for all services provided. I understand charges not covered by insurance such as, co-pays, co-insurance, deductibles or sliding fees are my responsibility. I understand that I may apply for Sliding Fee Discounts or set up payment arrangements with the BTAMC Billing Department. I understand any checks returned by my financial institution will incur a $25.00 charge.

Patient/Guardian Signature_____**Date**: _____

Data Entry- Staff Initials: _____**Date:** _____ **Scanned – Staff Initials:**_____**Date:** _____

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NEW PATIENT REGISTRATION & MEDICAL HISTORY FORM

PATIENT LEGAL NAME: _____ **DATE OF BIRTH:** ____/____/_____

PATIENT PREFERRED NAME: _____

Clinical Intake Information

♦ **Please briefly state in the box below the reason for your visit** ♦

How did you hear about our practice?

♦ Medical Problems – Past & Present♦

Please review the following symptoms and circle those items that are a problem for you.

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor (Dup)
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	*Migrai*ne/Headaches
Tooth problems	*High blood pressure*	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping
Back Pain	*Nerve Pain*	*Muscle aches/pain*	Stroke (CVA)	Other Causes of Chronic Pain??
Learning or Attention problems	*Lung problem?*	Other:		

♦ Past Medical History ♦

Condition / Disease	Year Began	Condition / Disease	Year Began
❑ Usual Childhood Disease (Mumps, Measles, Chicken Pox)		❑ *Cancer* Type: Location:	
❑ **Covid-19 / SARS-CoV-2**		❑ Bleeding Problems / Hemophilia / Anemia	
❑ Hypertension		❑ Brain Injury / Brain Malformation	
❑ High Cholesterol		❑ Epilepsy / Seizures	
❑ Hypothyroid (low) or Hyperthyroid (high)		❑ Depression / Anxiety / Nervousness	
❑ COPD, Emphysema or Asthma		❑ Mental Disorder / Behavioral Problem	
❑ Respiratory Disease / TB		❑ Dementia / Alzheimer's Disease	
❑ Diabetes		❑ MS / ALS / Parkinson's Disease	
❑ Reflux/GERD / Ulcers / Stomach Problems		❑ *Arthritis/Joint problems / RA / Lupus*	
❑ Heart Disease / Mitral Valve Prolapse		❑ Hepatitis / Liver Disease	
❑ Blood Clot / DVT / Pulmonary Embolus		❑ Kidney Disease	

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	Month / Yr.	Operation / Hospitalization / Injury	Month / Yr.

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc.)

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BTAMC Inc.

NEW PATIENT REGISTRATION & MEDICAL HISTORY FORM

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	Reaction	Medication / Food	Reaction

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	Strength	Number of pills taken & frequency	Medication	Strength	Number of pills taken & frequency

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month / Yr.		Month / Yr.		Month / Yr.
COVID-19 Vaccine		Mammogram		Endoscopy (EGD)	
Flu Vaccine		Pap Smear		Stent Placement	
Pneumonia Vaccine		Prostate Exam		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Heart Stress Test	
Hepatitis B Vaccine		Bone Density		Echocardiogram	
Shingles Vaccine		Eye Exam		EKG	
Gardasil Vaccine		Foot Exam		**Most Recent Lab Work**	

♦ Family Health History ♦

Please list below the health history of your genetic (blood) relatives

Relative	Living or Deceased	Current age or age at death	Cause of Death	Health Problems
Paternal Grandfather:				
Paternal Grandmother:				
Maternal Grandfather:				
Maternal Grandmother:				
Father:				
Mother:				
Sibling:				
Sibling:				
Children:				

♦ Social History ♦

What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?	Do/Did you use other nicotine products?	
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		
What is the highest grade you finished in school?		

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Broad Top Area Medical Center, Inc.

2025 SLIDING FEE SCALE DISCOUNT PROGRAM – PATIENT EDUCATION & INTEREST FORM

FEDERAL POVERTY GUIDELINES

Broad Top Area Medical Center Inc., (BTAMC) is a non-profit Federally Qualified Health Center, our Mission is to provide access to affordable, high-quality healthcare without discrimination based on one's race, color, sex, disability, age, creed, or national origin. BTAMC will provide in-scope services to all patients, regardless of their insurance status or ability to pay. Every patient may apply for our Sliding Fee Scale Discount Program (SFS) to determine qualification. Patients may choose to decline our benefit program.

Eligibility for Sliding Fee Discounts is based on the federal poverty level (FPL) income guidelines which are adjusted annually and operate in accordance with other federal program regulations. **ALL** patients are encouraged to apply. Uninsured and under-insured patients may qualify for the program based on their household size and their family's income. Sliding Fee Scale Discount Program applications are available at every BTAMC reception desk and on-line – visit our web site: www.broadtopmedical.com

Important discount program points are:

- The Sliding Fee Scale provides significant discounts for **Medical** and **Dental** services at every BTAMC location.
- The Sliding Fee Scale **is not** an insurance program – it is a benefit offered to ALL of our patients.
- The Sliding Fee Scale benefit period is from **March 1st to the last day of February**.
- Your eligibility is based **only** on your household size and the gross annual income for your household.
- You may qualify for the program, even if you do have third-party medical insurance and/or dental coverage.
- You will qualify for the program if your household income is below and/or up to **200 %** of the federal poverty level.
- You must apply for the program to determine your qualified Sliding Fee Scale Discount.
- You must provide proof of income along with your application such as tax forms **or** pay stubs **or** bank statements.
- You are encouraged to re-apply anytime your household income or household size changes, such as when someone loses insurance, someone becomes unemployed, or if you lose **or** add a family member – even when the change is temporary.
- **You must renew your application and submit proof of income each year to qualify for Sliding Fee Scale Discounts.**
- Applications & questions can be submitted to the office in person, by mail or via secure Email to: enrollment@broadtopmedical.com

2025 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA
* For families/households with more than 8 persons, add **$5,500** for each additional person.

ON THE TABLE BELOW PLEASE CIRCLE FAMILY SIZE & ESTIMATED ANNUAL HOUSEHOLD INCOME FOR 2025

We ask every patient to share their annual household income. We only collect aggregate information because BTAMC receives federal funding for assistance programs that benefit patients with lower incomes. Your information is confidential. Thank you!

Family Size	(<=100%)	(101% - 125%)	(126% - 150%)	(151% - 175%)	(176% - 200%)	Above 200% FPL
1	$0 - $15,650	$15,651 - $19,563	$19,654 - $23,475	$23,476 - $27,388	$27,389 - $31,300	$31,301 +
2	$0 - $21,150	$21,151 - $26,438	$26,439 - $31,725	$31,726 - $37,013	$37,014 - $42,300	$42,301 +
3	$0 - $26,650	$26,651 - $33,313	$33,314 - $39,975	$39,976 - $46,638	$46,639 - $53,300	$53,301 +
4	$0 - $32,150	$32,151 - $40,188	$40,189 - $48,225	$48,226 - $56,263	$56,264 - $64,300	$64,301 +
5	$0 - $37,650	$37,651 - $47,063	$47,064 - $56,475	$56,476 - $65,888	$65,889 - $75,300	$75,301 +
6	$0 - $43,150	$43,151 - $53,938	$53,939 - $64,725	$64,726 - $75,513	$75,514 - $86,300	$86,301 +
7	$0 - $48,650	$48,651 - $60,813	$60,814 - $72,975	$72,976 - $85,138	$85,139 - $97,300	$97,301 +
8	$0 - $54,150	$54,151 - $67,688	$67,689 - $81,225	$81,226 - $94,763	$94,764 - $108,300	$108,301 +

☐ **I understand that I may qualify for the Sliding Fee Discount Program but at this time, I choose to decline.**

☐ **Yes, I would like to apply for the sliding fee discount program, please contact me at this Phone Number: _____**

_____ _____
Print Name of Patient/Applicant **or** Parent/Guardian Signature of Patient Date

_____ _____
Patient/Applicant's Date of Birth Signature of Staff/Witness Date

rah – CAC/ 1.31.25

Broad Top Health & Wellness
BTAMC Inc.

Broad Top Area Medical Center, Inc.

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

PATIENT NAME: _____ DOB: _____
ADDRESS: _____ SS#: _____ - _____ - _____
_____
PHONE#: _____ EMAIL ADDRESS: _____

I, HEREBY AUTHORIZED THE FOLLOWING:

Name of Practitioner/Facility:_____

Address: _____

Phone & Fax: _____

To RELEASE information TO and OR Exchange records with: Broad Top Area Medical Center, Inc.
****CIRCLE Office of choice and direct all records to this office****

☐ **Broad Top Medical Center**
4133 Medical Center Drive, PO Box 127
Broad Top, PA 16621-9001
Phone: 814-635-2916
Fax: (814) 635-2918

☐ **Trough Creek Medical Center**
358 Seminary Street, PO Box 158
Cassville, PA 16623-6203
Phone: 814-448-9226
Fax: 814-448-2068

☐ **Primary Care Center**
790 Bryan Street, Suite 2
Huntingdon, PA 16652-2410
Phone: 814-907-3400
Fax: 814-907-3500

☐ **Belleville Wellness Center**
375 S. Kishacoquillas Street
Belleville, PA 17004-8620
Phone: 717-935-2065
Fax: 717-935-5560

☐ **Huntingdon Family Care Center**
835 Washington Street, PO Box 185
Huntingdon, PA 16652-1725
Phone: 814-506-8114
Fax: 814-506-8553 or 814-506-8623

☐ **Family Wellness Center**
419 14th Street
Huntingdon, PA 16652-1726
Phone: 814-643-3205
Fax: 814-643-6903

☐ **Mount Union Medical Center**
95 S. Park Street
Mount Union, PA 17066-1334
Phone: 814-542-8627
Fax: 814-542-5444

☐ **Pediatric & Family Healthcare**
6311 Margy Drive, Suite 2
Huntingdon, PA 16652-6934
Phone: 814-506-8490
Fax: 814-506-8493

☐ **Walk-In Clinic**
6678 Towne Center Blvd.
Huntingdon, PA 16652-6934
Phone: 814-643-1232
Fax: 814-643-4267

☐ **Juniata Valley BTAMC Clinic**
846 Medical Center Drive, PO Box 355
Alexandria, PA 16611-2936
Telephone: 814-667-7400
Fax: 814-667-7395

☐ **Southern Huntingdon County Medical Center**
626 Water Street, Suite 1, PO Box 40
Orbisonia, PA 17243-9432
Phone: 814-447-5556
Fax: 814-584-5741

☐ **Southern Huntingdon County Dental Clinic**
626 Water Street, Suite 2, PO BOX 146
Orbisonia, PA 17243-9432
Phone: 814-447-3159
Fax: 814-447-3195

The extent or nature of information to be released is indicated below:

_____ COMPLETE DENTAL RECORDS
_____ COMPLETE MEDICAL RECORDS
_____ OFFICE NOTES (DATES) _____
_____ OPERATIVE REPORT
_____ DISCHARGE SUMMARY
_____ INPATIENT CARE (DATES OF SERVICE) _____
_____ EMERGENCY CARE (DATES OF SERVICE) _____

_____ X-RAYS
_____ LABORATORY
_____ MEDICATION LISTS
_____ HISTORY & PHYSICAL
_____ OTHER: _____

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AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

The purpose for release of the above information is indicated below:

_____ CONTINUED CARE _____TRANSFER _____ INSURANCE _____ LEGAL _____ OTHER

If other is checked, please specify reason needed:
_____

I _____ GIVE CONSENT TO THE RELEASE OF THESE RECORDS, WHICH I UNDERSTAND MAY INCLUDE PSYCHIATRIC INFORMATION, DRUG AND ALCOHOL INFORMATION, AND/OR HIV/AIDS INFORMATION.

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated, and signed communication to the facility. This consent will expire in one year from the date signed, unless otherwise stated as follows: _____.
I understand that I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

X_____ DATE SIGNED: _____
(Signature of PATIENT)

X_____ WITNESS: _____
(Signature of Parent, Guardian, or Legal Representative)

If signed by other than the patient, state relationship and reason for patient's inability to sign:

_____

Verbal consent requires the signature of two witnesses:

_____ _____
Signature of Witness (1) Date Signature of Witness (2) Date

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer will be protected by the Health Insurance Portability and Accountability Act.

A copy of this authorization has been ___ **Accepted** ___ **Rejected** by the Patient/Representative.