



New Patient Registration Form

PATIENT INFORMATION:

Last name: _____ First name: _____ Middle initial: _____

DOB: _____ Sex : _____ Social security #: _____

Address: _____ City: _____ State: _____ ZIP: _____

Mailing address if different from above: _____

Home #: _____ Cell #: _____ (please check preferred #)

Marital Status: _____ Email address: _____

Patient previous provider: _____ location: _____

Occupation: _____

Employer: _____ Phone #: _____

Address: _____ City: _____ State: _____ ZIP: _____

Emergency Contact: _____ Phone #: _____

Relationship to patient: _____

CONTACT INFORMATION FOR RESPONSIBLE PARTY/SPOUSE/PARENT

(If info same as above, leave blank)

Last name: _____ First name: _____ Middle initial: _____

Relationship to patient: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home #: _____ Cell #: _____ Please check preferred #

Email address: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Subscriber: _____

Insurance ID# & Group # _____

Secondary Insurance: _____ Subscriber: _____

Insurance ID# & Group # _____

Patient Last name: _____ First name: _____ Middle initial: _____

HEALTH HISTORY:

Do you have any acute issues that need to be addressed?

History of: (please circle all that apply)

Cancer

Hypertension

Diabetes

Chronic Pain

Other:

Allergies:

Comments:

MEDICATION LIST:

Name	Dose	Frequency

PERFERRED PHARMACY:

Name:

 Location:

 Phone #:

"Please note that submitting the registration form does not guarantee enrollment with **Sunapee Harbor Health**. Our team will review your information and follow up with you shortly regarding next steps."

Signature:

 Date:

Relationship to Patient:



Authorization for Release of Medical Records to
Sunapee Harbor Health, 6 Holmes Lane, Sunapee, NH 03782
Phone: (603) 384-3684 fax: (833) 455-7488

Last name _____ First name _____ DOB _____
Address _____

I authorize Sunapee Harbor Health to obtain from:

Doctor or hospital name **Fax #**

Address

any information about my health and health care, including the diagnosis, treatment, or examination

rendered to me during the period from: _____ **to** _____

I expressly authorize and consent to the disclosure of my health information related to (check all that apply):

☐ Alcohol/substance use ☐ Mental health ☐ STIs including HIV/AIDS ☐ Genetic testing/counseling

CONFIDENTIALITY POLICY (PLEASE READ BEFORE SIGNING)

Medical records are maintained to serve the patient and the health care team in accordance with all applicable legal and regulatory requirements. The information contained in medical records is considered highly confidential. All patient care information shall be regarded as confidential and available only to authorized users. The phrase "medical records" includes any protected health information (PHI), which includes test results, any medical reports, the medical record itself, claim files, and any correspondence relating to the care of a patient. Any disclosure of my protected health information to a different name, class of person, address, or fax number will require a separate authorization.

I have the right to revoke this authorization in writing, except to the extent that action has already been taken in reliance on this authorization. For the revocation of this authorization to be effective, the above name(s) or class of person(s) must receive the revocation in writing.

This authorization shall expire one year from the date signed. After one year, a new authorization form is needed to continually disclose my PHI. I understand this authorization is voluntary and may refuse to sign it.

I fully understand and accept the terms of this authorization. A copy of this authorization is valid as an original.

Patient or authorized representative signature: _____ **Date** _____

Patient or authorized representative name: _____



Concierge Practice Patient Agreement

Notice: Membership fees WAIVED for patients with active MEDICARE and/or MEDICAID coverage.

This Agreement is entered between Sunapee Harbor Health and
_____ (“Patient”).

1. Purpose

- The Practice agrees to provide enhanced, personalized medical services to the Patient in exchange for a membership fee, as outlined below. Co-pays, deductibles, coinsurance, etc. will also apply.

2. As a member, you receive

- Same-day or next-day appointments: no waiting weeks to be seen when something comes up.
- Small panel size: The national ratio of primary care providers is 101 to a 100,000 population (HRSA, 2025). We will use a weighted complexity scale to determine each provider's panel size and estimate a maximum of 600-900 patients per PA.
- Direct access to your provider via phone, text, or email for questions, concerns, and follow-up--without going through a call center. The peace of mind that comes with knowing when to avoid urgent care and high co-pays is amazing. When appropriate, these calls can be converted to Telehealth.
- Unhurried appointments with a provider who knows your history, your goals, and your life.
- Having extended appointment times was truly a luxury of the past that needs to be part of the present.
- Telehealth appointments when clinically appropriate. You must already be seen as an established patient first and be within the State of NH.
- Athena Medical Record is bi-directional, which means it will flow in both directions with the local community's Electronic Health Record system. Orders will be loaded automatically to the hospital of your choice for services with no delays, including labs, imaging, and specialists.
- Comprehensive annual wellness visits include preventative screenings, lab reviews, and personalized health planning.
- Chronic disease management for conditions like hypertension, diabetes, and thyroid disease proactively monitored, not just treated at appointments.
- Care coordination with specialists, ensuring seamless communication and continuity across your entire healthcare team.
- Acute sick visits handled promptly, keeping you out of urgent care and the ER when possible. We understand the high co-pays and long waits at urgent cares and ERs and want to avoid this whenever appropriate.
- Transparent, straightforward care: we accept insurance for covered services while your membership fee ensures enhanced access and attention.
- We encourage a mindset of proactive care and recommend a minimum of twice-annual visits to review your medical needs if you are under age 65 and once every four months if 65 or older. Of course, we are there for additional visits.
- After hours availability to your provider: no call service as it will go directly to our phones.

- Book your own appointments online at your convenience: we will be there to answer the phone and schedule appointments but it's often after normal business hours when the day slows down and you have time to plan. Being able to go onto the portal and book your own appointments at your own convenience gives you control over your schedule.
- DOT exams in-house for members
- Fast turnaround on forms such as camp, work, FMLA, and insurance.
- Phone calls returned by provider or nursing staff.
- Local wellness events and classes at no additional cost for members: we are exploring the need for CPR classes, safe sitter classes, community lectures, and video uploads on medical topics for your review on your own time.
- Advanced Primary Care Management (APCM) through Medicare--credentialing pending.
- Monthly check-in by your medical team for Medicare recipients to review your chart or make personal contact to make sure your health care needs are being met. No additional cost to the patient, as this is a government-sponsored program. Again, all credentialing is pending at this time; however, we are excited to offer this new program to the community.

3. Membership Fees

Notice: Membership fees WAIVED for patients with active MEDICARE and/or MEDICAID coverage.

- If paid prior to December 31, 2026 (price protection for 3 years)
INDIVIDUAL MEMBERSHIP \$150/year
COUPLE MEMBERSHIP \$250/year
FAMILY MEMBERSHIP \$300/year (Includes spouse and unlimited dependent children through age 22)
- If paid between Dec 31, 2026 – May 31, 2026 (no price protection)
INDIVIDUAL MEMBERSHIP \$200/year
COUPLE MEMBERSHIP \$350/year
FAMILY MEMBERSHIP \$450/year
- Standard Membership fees effective June 1, 2027:
INDIVIDUAL MEMBERSHIP \$300/year
COUPLE MEMBERSHIP \$500/year
FAMILY MEMBERSHIP \$700/year

Payment Due: Prior to first visit.

- The fee covers only the enhanced access and services listed above; it does not replace insurance or cover hospital, specialist, or emergency care costs.

4. Term & Renewal

This Agreement is effective for [12 months] from the start date.

- Renewal requires payment of the membership fee before the new term begins.

5. Termination

- By Patient – Patient may terminate this Agreement with 30 days' written notice.
- By Practice – Practice may terminate for non-payment, repeated missed appointments, or conduct that disrupts care.
- Refunds – Membership may be cancelled at any time, however membership fees are non-refundable

6. Patient Responsibilities

- Provide accurate and updated medical information.
- Follow medical advice and treatment plans as agreed.
- Adhere to the terms and agreements in this contract.

7. Limitations

- This is not an insurance plan.
- Sunapee Harbor Health does not guarantee specific medical outcomes.

I agree to the terms of this agreement.

"Please note that signing this agreement does not guarantee enrollment with **Sunapee Harbor Health**. Our team will review your information and follow up with you shortly regarding next steps."

Signature of Patient/Guardian

_____ Date _____