

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.

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.

Today's Date: _____

Patient Demographic Information				
Last:	First:	Middle:		
Date of Birth:	Legal Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Preferred Name:		
PO Box/Street & Apt #:		City:	State:	Zip:
Social Security #:	Home Phone:	Cell Phone:	Work Phone:	
Email Address: <input type="checkbox"/> I DO <input type="checkbox"/> I DON'T authorize BTAMC to leave a detailed message				
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Sign Language <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____ Do you need a translator: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Native *if more than one race – please select all that apply		Ethnicity: <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Latino/Latina <input type="checkbox"/> Spanish <input type="checkbox"/> Declined/Refused <input type="checkbox"/> Other: _____ (please describe)		
Shelter Status: <input type="checkbox"/> Houseless-Street <input type="checkbox"/> Houseless-Shelter <input type="checkbox"/> Doubling-up <input type="checkbox"/> N/A				

Insurance Coverage <input type="checkbox"/> <u>Copy of insurance card(s) provided</u>			
Primary Insurance Name:	Policy #:	Group #	State:
Secondary Insurance Name:	Policy #	Group #	State:

Responsible Party (if patient is not financially responsible)			
Last:	First:	Middle:	
Date of Birth:	Relationship: <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Parent <input type="checkbox"/> Other Please Describe	Phone:	
Address:		City	State Zip

Employment Information			
Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Self Employed <input type="checkbox"/> Military Veteran <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Seasonal Worker <input type="checkbox"/> Migratory Worker <input type="checkbox"/> Disabled			
Occupation:	Employer Name:	Phone #:	
Po Box/Street 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 and/or appointment reminders

Name: _____ Phone: _____ Relationship: _____
 Emergency Contact Medical Billing Scheduling and/or appointment reminders

Name: _____ Phone: _____ Relationship: _____
 Emergency Contact Medical Billing Scheduling and/or appointment reminders

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:** _____

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

PATIENT PREFERRED NAME: _____

Clinical/Medical History

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

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

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

◆ Other Physicians and Specialists ◆

(i.e., Women's Care, Dermatology, Gastro, Orthopedics, Urology, Psychiatry, Eye doctor, etc.)

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◆ Patient Pharmacy Information ◆

Pharmacy Name:	Pharmacy Telephone Number:
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◆ Medications, Vitamins and Herbal Supplements ◆					
Medication	Strength	Number of pills taken & frequency	Medication	Strength	Number of pills taken & frequency

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

◆ 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?		

Broad Top Area Medical Center, Inc.

2026 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

2026 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

* For families/households with more than 8 persons, add **\$5,680** for each additional person.

ON THE TABLE BELOW, PLEASE **CIRCLE** FAMILY SIZE & ESTIMATED ANNUAL HOUSEHOLD INCOME FOR **2026**

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 - \$15,960	\$15,961 - \$19,950	\$19,951 - \$23,940	\$23,941 - \$27,930	\$27,931 - \$31,920	\$31,921 +
2	\$0 - \$21,640	\$21,641 - \$27,050	\$27,051 - \$32,460	\$32,461 - \$37,870	\$37,871 - \$43,280	\$43,281 +
3	\$0 - \$27,320	\$27,321 - \$34,150	\$34,151 - \$40,980	\$40,981 - \$47,810	\$47,811 - \$51,640	\$51,641 +
4	\$0 - \$33,000	\$33,001 - \$41,250	\$41,251 - \$49,500	\$49,501 - \$57,750	\$57,751 - \$66,000	\$66,001 +
5	\$0 - \$38,680	\$38,681 - \$48,350	\$48,351 - \$58,020	\$58,021 - \$67,690	\$67,691 - \$77,360	\$77,361 +
6	\$0 - \$44,360	\$44,361 - \$55,450	\$55,451 - \$66,540	\$66,541 - \$77,630	\$77,631 - \$88,720	\$88,721 +
7	\$0 - \$50,040	\$50,041 - \$62,550	\$62,551 - \$75,060	\$75,061 - \$87,570	\$87,570 - \$100,080	\$100,081 +
8	\$0 - \$55,720	\$55,721 - \$69,650	\$69,651 - \$83,580	\$83,581 - \$97,510	\$97,511 - \$111,440	\$111,441 +

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

Broad Top Area Medical Center, Inc. (BTAMC)

I authorize the use/disclosure of information as described below:

Name: _____ Date of Birth: ____/____/____
Last First Middle
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ - _____ - _____

I authorize BTAMC to: **Release My Records To:** **OR:** **Request My Records From:**

Name: _____ Phone: _____ - _____ - _____ Fax: _____ - _____ - _____
 Address: _____ City: _____ State: _____ Zip: _____

Information to Release or Request: **Date(s) of Service:** ____/____/____ to ____/____/____

<input type="checkbox"/> Complete Medical Record	<input type="checkbox"/> X-RAY/Imaging	<input type="checkbox"/> Laboratory	<input type="checkbox"/> Medication List
<input type="checkbox"/> Complete Dental Record	<input type="checkbox"/> Inpatient Care	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Emergency Room
<input type="checkbox"/> Immunization Records	<input type="checkbox"/> Office Notes	<input type="checkbox"/> Inpatient Care	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Drug/Alcohol Treatment Records	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Other (Specify): _____

**I understand that my express consent is required below to release information regarding mental health, substance use disorder treatment, or HIV/AIDS-related information.*

Purpose of Disclosure/Release:
 Continued Care Personal Legal Insurance Other (Specify): _____

- I understand the following:
- I understand this consent is voluntary and that I may refuse to sign this authorization at any time. Refusing to sign this authorization will not affect my treatment, payment of my claim, health insurance enrollment, or eligibility for benefits. I understand that this authorization will expire in ninety (90) days or when the records are released for the requested data. Any requests after this date will need a separate authorization. I may take back (revoke) this authorization, in writing, and understand that some records may have been released before the authorization was withdrawn.
 - I understand BTAMC will provide access to or copies of requested medical records **within thirty (30)** days of receiving a valid authorization, in accordance with applicable federal and state laws.
 - I understand that once my records are released to individuals or entities other than healthcare providers, health plans, or government agencies/contractors, the information may be redisclosed by the recipient and will no longer be protected under federal privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA).
 - I can get a copy of this form after I sign it.
 - I am entitled to receive my medical records in electronic format, if available.
 - I understand that my records are protected under HIPAA, The Federal Privacy Act, The Federal Alcohol and Drug Abuse Act, the Pennsylvania Confidentiality of the HIV Related Information Act, and therefore cannot be disclosed without my written permission unless otherwise provided for in the regulations.

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 authorized the following person to pick up my records. **NOTE: Photo identification will be required to pick up records.**
 Name: _____ Pick up Date : ____/____/____

If available, I request my records in electronic format
 Email (Address): _____

X _____ /____/____
 Signature of Patient or Legal Representative Authorized to Sign for Patient. Date

 Printed Name of Patient or Legal Representative Authorized to Sign for Patient. Relationship if other than patient

X _____ /____/____
 Signature of Authorized Person to Pick Up Records Date



Broad Top Area Medical Center, Inc. Location Address's & Phone Numbers

Broad Top Medical Center

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

Belleville Wellness Center

375 S. Kishacoquillas Street
Belleville, PA 17004-8620
Phone: 717-935-4011
Fax: 717-935-4012

Mount Union Medical Center

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

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 Dental Clinic

626 Water Street, Suite 2, PO BOX 146
Orbisonia, PA 17243-9432
Phone: 814-447-3159
Fax: 814-447-3195

Trough Creek Medical Center

358 Seminary Street, PO Box 158
Cassville, PA 16623-6203
Phone: 814-448-9226
Fax: 814-448-2068

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

Pediatric & Family Healthcare

6311 Margy Drive, Suite 2
Huntingdon, PA 16652-6934
Phone: 814-506-8490
Fax: 814-506-8493

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

Primary Care Center

790 Bryan Street, Suite 2
Huntingdon, PA 16652-2410
Phone: 814-907-3400
Fax: 814-907-3500

Family Wellness Center

419 14th Street
Huntingdon, PA 16652-1726
Phone: 814-643-3205
Fax: 814-643-6903

Walk-In Clinic

6678 Towne Center Blvd.
Huntingdon, PA 16652-6934
Phone: 814-643-1232
Fax: 814-643-4267