

Groton Medical Associates

Seeing new provider for: _____ Internal Medicine AND/OR _____ Rheumatology

Name: _____ Preferred Name: _____

Date of Birth: ____/____/____ Social Security Number: ____-____-____

Mailing Address: _____

Town/City: _____ Zip Code: _____

Primary Phone Number: (____) ____-____ Secondary Phone Number: (____) ____-____

Email Address: _____

Marital Status (circle one): Married Single Divorced Separated Widowed

Language: _____ Race: _____ Ethnicity _____

Emergency Contact: _____ Relationship to patient: _____

Emergency Contact Tel. #: (____) ____-____ Alternative #: (____) ____-____

Primary Insurance Information Name: _____

Please attach a copy of your insurance card(s) if possible

Address: _____

Policy ID #: _____ Group #: _____

Subscriber Name: (Only required if you are not the subscriber) _____ Date of birth: ____/____/____

Relationship to Subscriber: Self Spouse Other: _____

Secondary Insurance Information Name: _____

Address: _____

Policy ID #: _____ Group #: _____

Subscriber Name: (Only required if you are not the subscriber) _____ Date of birth: ____/____/____

Relationship to Subscriber: Self Spouse Other: _____

Name of current/old PCP: _____ Office phone # _____

Assignment of Benefits:

Authorization to pay benefits to physician: I hereby authorize payment of medical benefits to named provider for professional services rendered. I authorize release of my medical information necessary to process my claim.

Signature: _____ Date: ____/____/____

Groton Medical Health History Form:

Name: _____ Date of Birth: ____/____/____

Medical History:

(Please check the appropriate column if you have ever been diagnosed with the following illnesses)

YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure		Liver Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes		Anemia	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol		Anxiety or Depression	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer		Gout	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems		Stroke	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Problems		Kidney Stones	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal Problems		Arthritis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches		Prostate Problems	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems		Asthma/Lung Problems	

Any other problems?

Have you been hospitalized? If so what was the reason?

Immunizations: Check if you have had the vaccine, if you know the date please add

<input type="checkbox"/>	Tetanus/TDAP _____	<input type="checkbox"/>	MMR (Measles/Mumps/Rubella) _____		
<input type="checkbox"/>	Hepatitis B Vaccine _____	<- Did you receive the entire series? _____			
<input type="checkbox"/>	Pneumonia Vaccine _____	<input type="checkbox"/>	Hepatitis A Vaccine _____	<input type="checkbox"/>	Meningococcal _____

Medications: Please list ALL of the medications you are presently taking: include vitamins, herbs, supplements, and medication you need occasionally (Tylenol, allergy medication, etc.)

Do you have any allergies?

Do you see any specialists currently? Who?

PATIENT BILL OF RIGHTS

Groton Medical Associates

100 Boston Road, Suite E

Groton, MA 01450

Groton Medical Associates is pleased to inform you that Massachusetts law protects your rights as a patient/MGL 111 section 70E. This document is intended to serve as explanation of your rights while a patient in our office.

If you have concerns about your care, please speak with the staff so that your concerns can be resolved as soon as possible. We support your rights as a patient and want you to be aware of them. In turn, we ask that you respect the same rights of other patients.

As a patient you have right to:

- Be treated with respect and to have your questions answered courteously and helpfully.
- Receive medical care without discrimination.
- Receive medical information and explanation about any test, treatment choices, or alternatives in order to make informed healthcare decisions.
- Accept or refuse medical tests or care at any time.
- Confidentiality; in regards to your health and any care provided, to the extent provided by law.
- Name someone to speak for you if you are unable to make your own healthcare decisions.
- Receive an explanation of charges.
- Have your medical conditions assessed and managed effectively.

Any patient who believes his or her rights have been violated may submit complaints and questions to:

Groton Medical Associates
100 Boston Road
Groton, MA 01450
(978)448-4300

Boards of Registration in Medicine
10 West Street, 2cd Floor
Boston, MA 02111
(617)727-1788

Department of Public Health
Healthcare Quality Division
10 West Street, 5th Floor
Boston, MA 02111
(617)753-8000

STANDARD AUTHORIZATION TO USE AND DISCLOSURE OF PHI

Groton Medical Associates

100 Boston Road, Suite E

Groton, MA 01450

Information to be Used or Disclosed

The information covered by this authorization includes:

PLEASE CHECK ONE

- All medical information
- Limited medical information as described below:

Please list the person(s) to Whom Information May Be Disclosed: (i.e spouse, parent, friend)

Name: _____

If you would like **no one** to be listed please check this box:

Expiration Date of Authorization

This authorization is effective through (check one) __/__/____ OR NO expiration unless revoked or terminated by the person or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Office to terminate this authorization.

Potential to Re-disclosure

Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

Our practice will not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs this authorization.

Name of Patient (Type/Print)	Date of Birth
-------------------------------------	----------------------

Signature of Patient	Date Signed
-----------------------------	--------------------

Signature of Patient's Representative (if applicable)	Relationship
--	---------------------

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

Groton Medical Associates

100 Boston Road, Suite E

Groton, MA 01450

I hereby acknowledge that I have received, or have been given the opportunity to receive, a copy of Groton Medical Associates Notice of Privacy Practices. By signing below, I am "only" giving acknowledgement that I have received, or have had the opportunity to receive, the Notice of our Privacy Practices.

_____ / ____ / ____
Patient Name (Print/Type) **Date of Birth**

_____ / ____ / ____
Signature of Patient **Date**

WAIVER STATEMENT

Groton Medical Associates

100 Boston Road, Suite E

Groton, MA 01450

If your insurance is invalid on the date of service for any appointment at Groton Medical Associates, you are responsible for the entire bill. Payment plans can be made upon your request and must be addressed/set up before your appointment.

Please read and sign the following statement:

"I have been informed by my physicians or his/her representatives that if my insurance(s) denies payment for services rendered, I agree to be personally and fully responsible for payments."

Signature: _____

Print Name: _____

Date: _____/_____/_____

REQUEST FOR RELEASE OF MEDICAL RECORDS

Groton Medical Associates

100 Boston Road, Suite E

Groton, MA 01450

T: (978)448-4300 F: (978)448-4040

*****Records are to be received and/or transferred by paper copies only*****

Patient

Name

Date of Birth

Phone:

Address

City/State/Zip Code

I hereby authorize **GROTON MEDICAL ASSOCIATES** to (please check one): **Obtain** **Release**
(Please **mail** records if they exceed 10 pages):

From:

To:

Physician Name/Practice Name

Physician Name/Practice Name

Address

Address

City/State/Zip

City/State/Zip

Telephone/Fax Number

Telephone/Fax Number

Are you (please check one):

Transferring out of Groton Medical **Yes** **No**

New Patient **Yes** **No**

By signing below, you have specifically authorized the release of the following types of highly confidential information contained in your medical record, if any:

(NOTE: Please cross out any items below if **you do not want the information disclosed**)

Information about HIV/AIDS status

Information about genetic testing

Information about Venereal Diseases

Abortion consent forms

Mammography Records

Information about family planning services

Information about research involving controlled substances

Information related to mental health community program records

Information about treatment of substance abuse (drug or alcohol)

Information related to confidential communications with a psychotherapist, psychologist, social worker, sexual counselor, or other allied mental health or professional human services.

If you are requesting that only a portion of your medical records be released, please describe the information to be released (i.e labs, immunization records, diagnostic imaging report):

Signature of Patient/Personal Representative

Date