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
☐	High Blood Pressure	☐	☐	Liver Problems	☐
☐	Diabetes	☐	☐	Anemia	☐
☐	High Cholesterol	☐	☐	Anxiety or Depression	☐
☐	Cancer	☐	☐	Gout	☐
☐	Thyroid Problems	☐	☐	Stroke	☐
☐	Stomach Problems	☐	☐	Kidney Stones	☐
☐	Intestinal Problems	☐	☐	Arthritis	☐
☐	Headaches	☐	☐	Prostate Problems	☐
☐	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

☐ Tetanus/TDAP _____ ☐ MMR (Measles/Mumps/Rubella) _____

☐ Hepatitis B Vaccine _____ <- Did you receive the entire series? _____

☐ Pneumonia Vaccine _____ ☐ Hepatitis A Vaccine _____ ☐ 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

Fees:
$30.00 to transfer records directly to another practice (Records for the past 3 years)
$75.00 to release records directly to the patient (This can increase based upon how many years you are requesting)

_____

Patient Name Date of Birth Phone

_____

Address City/State/Zip Code

I hereby authorize **GROTON MEDICAL ASSOCIATES** to (please check one): **Obtain** ☐ **Release** ☐

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**
Rheumatology ☐ or ☐ Primary Care

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**