FAMILY DOCTORS, LLC

250 Paradise Road
Swampscott, MA 01907
Tel: (781) 596-2000
www.myfamdocs.com

Please expect that some test results can take up to two weeks. If you have not received your results after two weeks, please call our office. Please do not assume your test results are normal.

Today's Date

PATIENT INFORMATION

First _____ Middle _____ Last _____ Date of Birth _____
Your Address _____
City, State and Zip Code _____
Home Telephone ( ) _____ Work Telephone ( ) _____
Sex [ ] M [ ] F Cell Phone ( ) _____
Language _____ Race _____ Ethnicity _____
Employer's Name _____
Employer's Address _____
Your Occupation _____
E-Mail Address _____
Who is your Primary Care Physician? _____
Marital Status [ ] S [ ] M [ ] D [ ] W [ ] Separated
Employment Status [ ] Employed – Full Time [ ] Employed – Part Time [ ] Not Employed [ ] Military Duty
[ ] Self Employed [ ] Retired
Student Status [ ] Full Time Student [ ] Part Time Student [ ] Not a Student
Emergency Contact _____ Telephone _____ Relationship _____
Reason you are being seen: _____
Who May We Thank for Referring You? _____

GUARANTOR INFORMATION

Is the Patient Responsible for the Bill? [ ] Yes [ ] No If no, Guarantor Name _____
Guarantor Address _____ Telephone _____
Guarantor's Date of Birth _____
Guarantor's Employer _____
Guarantor's Business Address _____ Telephone _____
E-Mail Address _____

INSURANCE INFORMATION

Please provide your insurance card(s) with this form, and /or complete below

Subscriber Name _____
Name of Insurance _____ CoPay Amount _____
Address _____
Telephone _____ Contact _____
Effective Date _____ Certificate # _____
Group Name _____ Group # _____

Please read and sign the statements on the reverse side of this form before returning to check-in. We will be pleased to answer any questions that you may have.

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Family Doctors, LLC for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information to determine these benefits payable for related services

Patient Signature _____ Date _____

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Family Doctors, LLC for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Patient, Parent or Guardian Signature (if child is under 18 years old) _____ Date _____

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations (HIPAA):

I, the undersigned understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.
- Permission to check prescription drug history from pharmacies, hospitals and other healthcare providers.

I understand and been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and prior to implementation, will mail a copy of any revised notice to the address that I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restriction to use or disclosure of my health information:

_____

_____

_____

I fully understand and accept/decline the terms of this consent.

Patient Name Printed _____

Patient Signature _____ Date _____