Cooley Dickinson Medical Group – Amherst Family Practice **Registration Form**

Name: _____ **Nickname/preferred name:** _____

Date of Birth: _____ **Social Security Number:** _____

Contact Information: Please make sure your information is complete in case we need to contact you about an important medical issue or a schedule change.

Address: _____

Mailing address if different: _____

Home Phone: _____ OK to leave message: Y / N

Cell Phone: _____ OK to leave message: Y / N

Work Phone: _____ OK to leave message: Y / N

Email address: _____

Preferred method of contact: printed/letters phone electronic (secure email / portal)

Emergency contact name and number:_____

Legal guardian (if applicable) _____

Who lives with you (names, birthdates, relationship to you)? _____

_____

Pharmacy (retail) _____ **Pharmacy (mail order)** _____

Gender: male female transgender If transgender, identify as: male female

Primary language: _____ **Interpreter needed?** Y / N

Marital status: married single widowed divorced legally separated partnered other_____

Race: Native American/Alaska Native Black/Afro-American Native Hawaiian/ Pacific Islander White/Caucasian Asian Other_____ **Ethnicity:** Hispanic/Latino Y / N

Advanced Directive: Organ donor Body donor Health Care Proxy Living will Power of Attorney Do Not Resuscitate MOLST Other_____

Other providers involved in your care: Dentist: _____ Eye doctor: _____

Other specialists: _____

Insurance information: Subscriber:_____ **Guarantor:**_____

Primary insurance:_____ **policy #:**_____

Secondary insurance: _____ **policy #:**_____

AMHERST FAMILY PRACTICE PATIENT INFORMATION

Name:_____DOB:_____

Previous physician: (fill out a release so we may obtain records) _____

Past or chronic illnesses/ conditions:_____

Operations/ injuries/ fractures:_____

Glasses/ contacts: Y N Braces: Y N Dentures: Y N upper lower Other:_____

Allergies/ reactions (especially to medications):_____

Medications with doses (also vitamins, aspirin, herbals, eye drops etc.):_____

Family history (medical problems of grandparents, parents, siblings, children…): _____

Education (degrees or current school and grade):_____ Military service:_____

Occupation/ job:_____ Activities/hobbies:_____ Pets:_____

Travel outside the US:_____ Exercise:_____

Tobacco per day:_____Did you ever smoke?_____Does anyone at home smoke?_____

Alcohol per week:_____ Caffeine per day:_____Calcium intake:_____

Dentist:_____ Eye doctor:_____ Other specialists:_____

If applicable, last tetanus shot:_____Pneumonia shot:_____Colonoscopy:_____PAP:_____

Mammogram:_____ Bone density:_____ TB testing:_____Vaccinations up to date? Y N

Any special concerns you want to discuss?

Amherst Family Practice
29C Cottage Street, Amherst, MA 01002
Phone: (413) 549-8888 Fax: (413) 549-8886

Cooley Dickinson Medical Group
Massachusetts General Hospital Affiliate
www.AmherstFamilyPractice.com

Anne C. Weaver, MD, Yarima S. Santiago, MD, Karen Levine, PA-C
Our doctors are Board Certified in Both Pediatrics and adult Internal Medicine

Authorization for Release of Medical Records or Information

Name of patient:_____ Date of birth:_____

Address: _____

_____ Phone: _____

☐ I request that Amherst Family Practice send records to:

☐ I request that records from the following be sent to Amherst Family Practice:

☐ I give permission for Amherst Family Practice providers to discuss my case or coordinate care with:

Doctor/ Provider/ Facility_____

Address:_____ City:_____

State:_____ Zip:_____ Phone:_____ Fax:_____

Reason: (circle one) change doctors/ coordinate or discuss care/ other_____

Records requested: All medical records, including laboratory, radiology, consults, vaccinations, and records from prior physicians except as noted:_____

These records may contain information about drug or alcohol use, venereal disease, abortion, sexual or physical abuse, mental health treatment, HIV/AIDs, or other sensitive issues. Note that all requested records may be released unless specific exceptions are noted above.

Limited records requested: send only _____

This authorization is valid for one year. I have the right to revoke it at any time by sending written notification to Amherst Family Practice and the above-named party. I understand that a revocation is not effective if information has already been released or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed may be redisclosed by the recipient and may no longer be protected by federal or state law. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Signature: _____ Date: _____

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To any facility from whom records are being requested: if you are unable to comply with the request, or records are not available, please notify Amherst Family Practice, along with the reason for not sending records. Thank you.

COOLEY DICKINSON MEDICAL GROUP
AUTHORIZATION AND CONSENT

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits to be paid directly to CD Practice Associates, Inc (Cooley Dickinson Medical Group). I understand that I am financially responsible for any non-covered services, any deductibles, or co-payments. I authorize the release of any information requested by my insurance company. I authorize the release of information to other providers involve in my care as deemed necessary by my provider. I certify that all of the information on the registration form is true and correct.

PRIVACY NOTICE

I acknowledge that I have been offered a copy of the Cooley Dickinson Health Care Notice of Privacy Practices.

PROTECTED HEALTH INFORMATION

I understand that whoever I choose to accompany me into an exam room has my permission to hear any and all Protected Health Information discussed.

I authorize the following people to verbally discuss my Protected Health Information with my provider:

Name_____ DOB_____ Relationship_____

Name_____ DOB_____ Relationship_____

☐ Do not release/discuss any Protected Health Information to anyone other than me.

NO SHOW POLICY

Our office will remind you of your appointment 48 hours in advance. If you fail to cancel your appointment and do not show up for your scheduled time, you will be charged a $25 no show fee.

CO-PAYMENT POLICY

Your co-payment is due upon check-in for your appointment. If you are unable to make your co-payment at the time of your visit, the practice will bill you and there will be an additional $15 billing fee.

COOLEY DICKINSON MEDICAL GROUP AFFILIATION

This office is affiliated with Cooley Dickinson Medical Group, a division of Cooley Dickinson Health Care. As a patient of a practice associated with Cooley Dickinson Medical Group, I understand that information in my medical record is available to other Cooley Dickinson Health Care providers and staff involved in my care and treatment. A listing of all Cooley Dickinson Medical Group practices is available upon request.

I have read and understand all statements and policies outlined above.

_____

Patient Signature *Date*

Rev: 7/2014

Amherst Family Practice
Cooley Dickinson Medical Group
Massachusetts General Hospital Affiliate
29 Cottage Street, Suite C, Amherst, MA 01002
Anne Weaver MD, Yarima Santiago MD, Karen Levine PA-C
413-549-8888; www.AmherstFamilyPractice.com; fax 413-549-8886
Our Physicians are Board Certified in both Pediatrics and Internal Medicine

STATEMENT OF UNDERSTANDING

ASSUMPTION OF FINANCIAL RESPONSIBILITY FOR MEDICAL SERVICES

I acknowledge that I have voluntarily sought the services of Amherst Family Practice.

I accept full responsibility for paying for services provided by Amherst Family Practice.

I understand that if I carry insurance and this insurance is not truly in effect, or if the provider is not considered my primary care physician or is not a participating provider with my insurer, my insurer will not pay the provider nor reimburse me, neither for the cost of services rendered at Amherst Family Practice nor for any subsequent or ancillary services which the provider may order on my behalf. I understand that I will be responsible for payment for such services.

I further acknowledge that it is my responsibility and not the provider's to know what services are covered by my insurer. I accept full responsibility for paying for provided services if they are not covered by my insurance.

I authorize the release of all medical information necessary to process claims pertinent to my medical care.

_____ _____

Patient's Name Printed Patient's Date of Birth

_____ _____

Responsible Party's Signature Name of responsible party if not the patient

_____

Today's Date