SACO RIVER MEDICAL GROUP

New Patient Information
HIPAA Receipt
Authorization to Treat

Patient Name (First, MI, Last) _____MaidenName_____

Date of Birth _____Sex _____ SS# _____

Primary Phone (_____)_____ Secondary Phone (_____)_____

Mailing Address _____

PO Box/Street City State Zip Code

Street Address _____

Street City State Zip Code

Parent's Name (if under 18) _____Date of Birth_____

Incase of Emergency, contact _____

Relationship to Patient _____ Phone _____

Health Insurance _____

Since 2003, a federal Act called HIPAA has been in effect that helps control the privacy of your medical care and your medical records. Attached, are your rights under this act. We will continue to respect your right to privacy. Also, we may continue to communicate, as necessary, with you or family members, by phone, as appropriate.

_____

If you are self-pay or have insurance that we do not bill, all charges are payable at the time of service. We will provide you the necessary information for your insurance carrier. If you have health insurance, co-pays are due at the time of service.

_____

I hereby authorize the Saco River Medical Group or any clinician employed at the Saco River Medical Group to furnish information to my/our insurance carrier concerning my illness and treatment. I request that payment for Medicare benefits covering services provided at the Saco River Medical Group be made on my behalf directly to the Saco River Medical Group. I authorize any holders of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____

SPECIAL AUTHORIZATION re: Drug/Alcohol Abuse, Mental Health, and/or HIV/AIDS information. I acknowledge that data to be released MAY INCLUDE material that is protected by federal law that is applicable to one or more of the above conditions. My signature below authorizes release of all such information. This authorization will be in effect unless your office receives written notice otherwise.

_____

I hereby authorize clinicians of the Saco River Medical Group to provide me medical care, including diagnosis and treatment.

I agree to receive medical care as outlined above _____Date _____

Signature

I have received Saco River Medical Group's Privacy Policy _____Date _____

Signature

I have received and understand the Patients' Bill of Rights _____Date _____

Signature

Patient Information Confirmation & Preferred Communication Options

Name (First, MI, Last) _____ Date of Birth _____

Mailing Address_____
PO Box/Street City State Zip Code

Primary Phone: _____Secondary Phone: _____

E-Mail: _____

The introduction and usage of electronic health record requires that we obtain the following information:

Ethnicity *(Please circle one):* Hispanic Non Hispanic Decline

Race (*Please circle one):*

White Black Asian Indian/Alaskan Other/multi Decline

Primary Language Spoken: English Other:_____

Person Responsible for payment: Self_____ Other_____

I authorize Saco River Medical Group to use the following means to communicate with me:
OK to speak with these family members or others as designated:

NAME	**RELATION**	**PHONE #**
_____	_____	_____
_____	_____	_____
_____	_____	_____

___ DO NOT Speak with others

Signature: _____ Date: _____
This agreement may be reviewed or changed at any time.

SACO RIVER MEDICAL GROUP

Financial Agreement

Thank you for choosing the Saco River Medical Group. Your health and well being is important to us. We are dedicated to being your medical home in a caring primary care practice. Please read the policies below in order to understand your financial responsibilities for your medical care.

I agree and understand to the following administrative policies:

- My account is to be kept current. **Payment on accounts with outstanding balances is expected at every visit.**
- If I am a self-pay or sliding-fee scale patient, payment in full is due at the time of service.
- Returned Check Fee: If a check is returned due to insufficient funds, a fee of $25.00 will be charged to my account.

I agree and understand to the following policies regarding insurance:

- It is my responsibility to inform Saco River Medical Group of any changes to my insurance policy so that my coverage can be verified prior to my appointment.
- I understand it is my responsibility to familiarize myself with my insurance benefits and coverage.
- I understand that Saco River Medical Group will submit my insurance claim as a courtesy for reimbursement.
- I understand that not all services provided to me will be covered by my insurance plan, and that, regardless of my benefits or coverage, I am responsible for any unpaid amount by my insurance.
- It is the policy of Saco River Medical Group to accept co-payments on the day of my appointment unless prior financial agreements have been made with the billing department.

Cancellation Policy: If you need to cancel an appointment, we ask that you notify our office 2 business days in advance. We ask for notice of a cancelled appointment so we can fill that valuable time slot. Failure to notify our office 2 business days prior will result in a non-refundable fee of $75.00 that is not covered by insurance, Medicare or Medicaid. We understand that unforeseen circumstances may arise that may make your keeping the appointment impossible, but please remember to cancel your appointment in advance.

If you have any questions in regard to this policy or the above information, please do not hesitate to ask us.

I have read and agree to the above terms of the Financial Agreement and agree to meet all financial obligations related to my medical care.

_____ _____

Patient Name Name of Parent/Guardian

_____ _____

Signature Date