SOUTHEASTERN CONNECTICUT MEDICAL ASSOCIATES, PC

PATIENT INFORMATION

NAME: _____ GENDER: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

PHONE #: _____ ALTERNATE PHONE #: _____

EMAIL ADDRESS: _____

IF MINOR
RESPONSIBLE PARTY: _____ RELATIONSHIP: _____

ALLERGIES: _____

PHARMACY: _____ ADDRESS: _____

EMERGENCY CONTACT: _____ DAY PHONE: _____

NIGHT PHONE:_____

NAME/ADDRESS OF OTHER PHYSICIAN: _____

WHY DID YOU SELECT OUR OFFICE? _____

INSURANCE INFORMATION

PLEASE BRING YOUR INSURANCE CARD TO EVERY APPOINTMENT

PRIMARY INSURANCE: _____ ID #: _____

SECONDARY INSURANCE: _____ ID #: _____

**** This information is required by the Federal Government ****

Primary Language:

_____

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Patient Declined

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaii or Other Pacific Islander
- ☐ White

Signing below indicates acceptance and awareness of the following terms:

Authorization for the Release of Medical Information, Assignment of Insurance Benefits, Notification of the Privacy Provisions of HIPAA

I authorize Southeastern CT Medical Associates, PC to release any medical or other information necessary to process my insurance claims. I also assign my insurance benefits to be paid directly to Southeastern CT Medical Associates, PC according to the terms of my insurance policy.

Southeastern CT Medical Associates, PC maintains a copy of the Notice of Privacy Practices mandated by the Health Insurance Portability and Accountability Act of 1996 posted in each of its waiting rooms for review. I am aware that a summary of this Notice is available upon my request to take and review at my leisure.

Financial Responsibilities

I will be responsible for any copayments required by my insurer at the time services are provided. I understand that if I do not make my copay in the office, I will be responsible for an additional $10.00 administrative charge added to my account.

I will be responsible for any coinsurance and/or deductibles payable to Southeastern CT Medical Associates, PC as required by the terms of my insurance policy. I understand payment plans are available upon request.

If my insurance requires me to obtain a referral prior to receiving services or list my physician at Southeastern CT Medical Associates, PC as my primary care provider (PCP), I will do so or be liable for any insurance claims denied for not notifying my insurer.

I will be responsible for reporting to Southeastern CT Medical Associates, PC any contact information, demographic, or insurance coverage changes.

Contact Information

We may need to contact you by telephone about test results, appointments, or referrals. Please complete the following:

I prefer to be contacted at: Primary #_____

Secondary # _____

You may leave messages on my answering machine or voicemail at: _____Home _____Work _____Cell

You may leave messages with the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Results regarding mental health related matters or sexually transmitted diseases whether positive or negative will only be given to the Patient. Southeastern CT Medical Associates, PC will make reasonable efforts to accommodate this request. You can request a change at any time. Protected Health Information is only released in compliance with federal and state privacy regulations.

Signed: _____ Date: _____