Modern Care Medical Group, LLC
FAMILY PRACTICE
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# PATIENT REGISTRATION FORM (Page 1)

It is our pleasure to welcome you to Modern Care Medical Group Family Practice and we look forward to serving you as your Primary Care Provider. Please fill out the following registration information including as much detail as possible. Please do not hesitate to ask our staff for assistance.

**Provider:** ☐ **Dr. Los**

**Social Security** # _____ - ____ - _____ Date of Birth ____ / ____ / _____ ☐ Male ☐ Female

**Last Name**: _____ Middle: _____ First: _____

Street Address: _____ Apt/Suite _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____ Preferred: ☐ Home ☐ Cell

Email: _____ Preferred reminder method: ☐ Phone ☐ Email

**Occupation**: _____ **Employer:** _____

**Martial Status**: ☐ Single ☐ Married

Spouse's Last Name: _____ Middle: _____ First: _____

Work Phone #: _____ Cell #: _____

**If you have Medicare, are you or your spouse currently working?** ☐ **Yes** ☐ **No**

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**<u>Insurance Details</u> (A copy of your Insurance Card will be kept on file – please advise if changes)**

**Primary Insurance information:** ☐ Self ☐ Spouse ☐ Child ☐ Other _____

**Name of insurance**: _____ **Policy #:** _____

Secondary Insurance information: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of insurance: _____ Policy #: _____

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**<u>Emergency Contact</u>:**

**Last Name**: _____ Middle Initial: _____ First: _____

**Phone #**: _____ Relationship: _____

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**PATIENT REGISTRATION FORM (Page 2)**

It is the policy of Modern Care Medical Group to communicate only with the patient using contact information provided by the patient. HIPAA of 1996 establishes the right for patients to request alternative methods of communication from our office.

If there is anyone other then yourself that you would like Modern Care Medical Group to release information to, please list them below. Please check the information that you authorize them to receive.

Name: _____ ☐ Medical Info. ☐ Billing Info.

Phone #: _____ Relationship: _____

If this request changes, you are responsible to contact Modern Care Medical Group of any change.

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**Receipt Acknowledgement of Notice of Information Privacy Procedures**

I (Patient's Name) _____ have received a copy of Modern Care

Medical Group's Notice of Information Privacy Practices.

**Signature of Patient**: _____ **Date**: _____

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## Consent for Treatment & Acknowledgment of Patient Billing Responsibilities

I/we hereby authorize Modern Care Medical Group (MCMG) to administer diagnostic, medical procedures, and treatments as may be necessary for proper health care.
I authorize release of any medical information in possession of MCMG to any consultant medical personnel for the purpose of rendering treatment to myself to continue my care.
All professional services rendered are the responsibility of the patient. MCMG will file your insurance at time of service however, if your insurance requires you to pay a deductible or co-insurance, you are responsible to pay these costs at time of service.

I hereby authorize payment directly to MCMG for my charges.

I understand that I am ultimately responsible for charges incurred at MCMG regardless of third party liability. I agree that MCMG may release any medical information necessary for filing my claim. If you do not have insurance, payment is required in full at time of service.

We accept cash, credit card or personal Check. Fees will be charged for any returned check due to insufficient funds or for any other reason the check is not accepted.

**I understand and agree with the above policies of Modern Care Medical Group and I understand my responsibilities to pay all non-covered balances.**

**Patient's Signature:** _____ **Date:** _____

**(If patient is Minor)**
**Representative Signature**_____ **Relationship:**_____

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# PATIENT FINANCIAL POLICY

Please read this information carefully. It explains in detail your financial responsibilities as a patient of Modern Care Medical Group. Patients that are non-compliant with the following policies may be discharged from the practice. Any questions regarding this policy can be discussed with our staff.

**1. Current Information**
As a patient at Modern Care Medical Group, you are required to notify our staff of any changes in your patient information, such as insurance, benefits, employer, patient name, home address and/or contact numbers. You will be asked to present your current insurance cards at each appointment.

**2. Payment at Time of Service**
If your insurance plan requires you to pay a co-payment, it will be collected during check-in. Patients that fail to bring their insurance card on two or more occasions may be required to reschedule their non-urgent appointment. If you are a self-pay patient or your insurance information cannot be verified prior to your appointment, you will be required to pay in full at the time of service. If your insurance plan requires payment of an annual deductible and/or co-insurance (i.e. 80/20 plans), payment will be calculated and due at check out. We accept cash, credit cards and personal checks.

**3. Claims filling**
As a courtesy to our patients, we file claims with your insurance company and also coordinate benefits with secondary payers. You will be responsible for timely payment of any patient balances as directed by your insurance. You will also be responsible in the event that the claim is disputed or unpaid.

**4. Patient Billing and. Collections**
Patients that receive a statement from our office are expected to remit full payment upon receipt, unless previous payment arrangements were made with our billing office. If your account must be referred to an outside collection agency for non-payment, a fee equal to 30-50% of the outstanding balance will be added to your account to cover the expense incurred from the agency. The fee percentage varies based on age of the outstanding balance. Patients in collections must make payment arrangements prior to scheduling another appointment with our office. IF YOU RECEIVE A BILLING STATEMENT THAT YOU DO NOT UNDERSTAND, PLEASE CONTACT OUR OFFICE FOR ASSISTANCE SO THAT THE ACCOUNT CAN BE RESOLVED.

**5. No shows**
For patients that fail to come to their scheduled appointment and do not notify our office of the need to cancel the appointment, a $30.00 NO-SHOW charge will be added to their account. This Charge will be the patient's responsibility as insurance companies will not pay this charge. **Please notify our office if you cannot keep your appointment, so that other patients in need of medical care can be seen.**

**6. Returned Checks and Fees**
When we receive a returned check from any patient a $25.00 fee will be assessed, to the extent permitted by law. Personal checks will no longer be accepted from patients that write two bad checks. Payment will then be required to be made in cash or by credit card.

| _____ | _____ | _____ |
|---|---|---|
| **Patient Name** | **Patient signature of Policy Understanding** | **Date.** |

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## AUTHORIZATION TO OBTAIN, USE OR DISCLOSE INFORMATION

Patient Name: _____ Date of Birth: _____

Address:_____ Tel: _____

Insurance Plan: _____

Insurance Policy/ID #: _____ SSN: _____-_____-_____

1) I hereby authorize and request the disclosure of the above named individual's healthcare information to the following Medical Practice Group for the sole purpose of coordinating my medical care:

**Modern Care Medical Group, LLC**
**1075 Westford Street (Suite 204)**
**Lowell, MA, 01851**
**Phone: 978-452-2000**
**Fax: 978-452-2001**

2) I further authorize the above listed Medical Practice Group to obtain medical records including, but not limited to: Treatment, Test Results, Images, Lab Results, ER, Hospital & Specialists records, etc to support the continuity of my medical care.

3) I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4) I understand that I have a right to revoke this authorization at any time and, upon doing so, I must do so in writing and present it to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

5) I understand that once the above information is disclosed, the recipient may re-disclose it and federal privacy laws or regulations may not protect it and the information.

6) I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.

_____ _____
Signature of patient and/or legal representative Date

Relationship to Patient: _____

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## PREVIOUS PROVIDER INFORMATION

Please provide previous Primary Care Provider information to allow us to request previous medical history from them on your behalf, enabling us to continue care as authorized by your consent recorded on the Modern Care Medical Group Form "Authorization to Use and Obtain Patient Information".

Primary Care Provider Name: _____

Practice/Group Name: _____

Address:_____

City _____ Zip: _____

Office Phone Number: _____

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Specialist Type: _____

Specialist Name: _____

Practice/Group Name: _____

Address:_____

City _____ Zip: _____

Office Phone Number: _____

---

Specialist Type: _____

Specialist Name: _____

Practice/Group Name: _____

Address:_____

City _____ Zip: _____

Office Phone Number: _____

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# Adult Medical History Information Form

## Medical Information

**Name:**_____ **DOB:**_____ **Age:**____

**Medical History**

*Please check any chronic medical problems or serious illness/injuries

| | Yourself | Relative (Please list) |
|---|---|---|
| 1. High Blood Pressure | ☐ | ☐ |
| 2. High Cholesterol | ☐ | ☐ |
| 3. Diabetes | ☐ | ☐ |
| 4. Obesity | ☐ | ☐ |
| 5. Heart Disease | ☐ | ☐ |
| 6. Thyroid disorder | ☐ | ☐ |
| 7. Sleep Apnea | ☐ | ☐ |
| 8. Cancer | ☐ | ☐ |
| 9. Asthma | ☐ | ☐ |
| 10. Seizures | ☐ | ☐ |
| 11. Stroke | ☐ | ☐ |
| 12. Arthritis | ☐ | ☐ |
| 13. Anemia | ☐ | ☐ |
| 14. Hepatitis A/B/C | ☐ | ☐ |
| 15. Kidney Disease | ☐ | ☐ |
| 16. Depression | ☐ | ☐ |
| 17. Anxiety | ☐ | ☐ |
| 18. Bipolar | ☐ | ☐ |
| 19. Chronic Pain | ☐ | ☐ |
| 20. Broken bones | ☐ | ☐ |
| 21. Blood transfusions | ☐ | ☐ |
| 22. Other: _____ | ☐ | ☐ |

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## History of Surgeries/Hospitalizations

*Please check any Surgeries that YOU had in the past.

| | Yourself | | | Yourself |
|---|---|---|---|---|
| 1. Tonsils | ☐ | | 2. Hernias _____ | ☐ |
| 3. Appendix | ☐ | | 4. Tubal Ligation | ☐ |
| 5. Gall Bladder | ☐ | | 6. Mental Problems | ☐ |
| 7. Motor Vehicle Accidents _____ | ☐ | | 8. Other:_____ _____ | ☐ |

## List current Medications ☐ None

_____

_____

_____

_____

## Allergies:

*Please check all that apply to YOU

| | Yourself | | | Yourself |
|---|---|---|---|---|
| 1. Penicillin | ☐ | | 2. Sulfas | ☐ |
| 3. Bees | ☐ | | 4. Latex | ☐ |
| 5. Food: _____ _____ | ☐ | | 6. Other:_____ _____ | ☐ |

## Social History:

1. Are you: ☐ Married ☐ Single ☐ Divorced ☐ Widow?
2. Do you have children? ☐ Yes ☐ No How many: Sons____ Daughters ____
3. Occupation: _____
4. Do you smoke? ☐ Yes ☐ No How many: ____ pack/day
5. Do you drink Alcohol ☐ Yes ☐ No How many: ____ Drinks/week
6. Do you use any recreational drugs? ☐ Marijuana ☐ Cocaine ☐ Ecstasy ☐ Prescr. Drugs
7. History of Previous Rehab Program? ☐ Alcohol ☐ Drugs