CABOT MEDICAL CARE

PATIENT INFORMATION **(USE DARK BLUE OR BLACK INK)**

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Patient's Last Name_____First_____MI____DOB____/___/____

SS#_____ Address_____City_____

State_____Zip Code_____ E-mail_____

Home Phone(____)_____Cell (____)_____Work(___)_____

Preferred Contact: Home #, Cell#, Work#, Portal **Preferred Reminder: Home #, Cell#, Work#, Text, Portal**

My Primary Care Doctor is: Dr. Blair Dr. Cerrato Dr. Robertson Dr. Merrick Dr. Shotts Dr. Stamp

Preferred Pharmacy Name and Location_____

Spouse's Name_____ Phone(_____)_____

Emergency Contact _____Phone (_____)_____Relationship_____

If the patient is a minor, please provide the following information on the patient's parent or guardian:

Father's Name_____SS#_____DOB_____Phone(____)_____

Mother's Name_____SS#_____DOB_____Phone(____)_____

Billing Address (if different) **_____ City_____ State_____ Zip_____**

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Our office will bill your insurances as a courtesy. However, all services rendered are the financial responsibility of the patient. If your account becomes delinquent there will be a collection fee added to the balance. Should you have any changes in your personal or health insurance information, Cabot Medical Care must be notified.

HIPAA Authorization

I hereby designate the following person (s) to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me. This agreement will remain in place until such time as you the patient revoke this in writing.

_____ _____

Print name of personal representative Relationship

_____ _____

Print name of personal representative Relationship

_____ _____

Print name of personal representative Relationship

_____ _____

Signature Date

PLEASE CONTINUE ON THE REVERSE SIDE

DISCLOSURE AND CONSENT

Our office will bill you insurances as a courtesy. However, all services rendered are the financial responsibility of the patient. If your account becomes delinquent there will be a collection fee added to the balance. Should you have any changes in your personal or health insurance information, Cabot Medical Care must be notified.

I, hereby, authorize the doctors of Cabot Medical Care to furnish any and all information concerning my illness, diagnosis and treatment to insurance carriers, hospitals and other physicians, pharmacies, laboratories, physical therapist and any other health related entities and to receive any and all information concerning my illness, diagnosis and treatment and medications for insurance carriers, hospitals, other physicians, pharmacies, laboratories, physical therapist and any other health related entities. I, hereby, assign to the doctors all payments for medical services rendered to my dependents or myself. I understand that this authorization will remain in effect for as long as my dependents or I remain a patient.

Signature_____**Date**_____

(Verified all information above is correct)

HIPAA

We will use and disclose your protected health information for treatment, payment and healthcare operations. We request that you read our notice of privacy practices.

I have received a copy of Cabot Medical Care's Notice of Privacy Practices.

Signature_____**Date**_____