

**Mountain View Family Practice, PC**  
**570 Baldwinville Road, Baldwinville, MA 1436**  
**Telephone: (978) 939-2133 Fax: (833) 906-2588**  
**Gretchen L. Kelley, MD**

**Kelly M. Clow, FNP-BC Sarah Gile, PA Alison Hietala, FNP-BC**

PCP:

**PATIENT INFORMATION**

Patient's Last name:		Race/Ethnicity:		Marital Status (circle one)	
First name:		· Non-Hispanic or Latino		Single / Mar / Div / Sep / Wid	
Middle name:		· Hispanic or Latino			
		· Asian			
		· African American			
		· Other      · Decline			
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Mailing Address:		Social Security No.:	Home Phone #:		( )
City:		State:	Zip:	Cell Phone #:	
				( )	
Email Address:					

**IF PATIENT UNDER THE AGE OF 18**

Mother's Name or Legal Guardian	Relationship to patient:	Home phone #:	Cell phone #:
		( )	( )
Mother's Address if different from the child:			
Father's Name or Legal Guardian	Relationship to patient:	Home phone #:	Cell phone #:
		( )	( )
Father's Address if different from the child:			

**INSURANCE INFORMATION**

(Please give your insurance card to the receptionist)

Person Responsible for bill:	Birth Date:	Address (if different):	Home phone #:
	/ /		Cell phone #:
Name of Primary Insurance:			
Subscriber's name:	Birth date:	Group no.:	Policy #:
	/ /		
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child <input type="checkbox"/> Other
Name of secondary insurance (if applicable):			
Subscriber's name:	Birth date:	Group no.:	Policy no.:
	/ /		
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child <input type="checkbox"/> Other

**IN CASE OF EMERGENCY**

Name of local friend or relative (not living at the same address):	Relationship to patient:	Home phone #:	Cell phone #:
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The above information is true to the best of my knowledge.

\_\_\_\_\_  
*Patient/Guardian signature*

\_\_\_\_\_  
*Date*

**ACKNOWLEDGEMENT OF PATIENT  
BILLING RESPONSIBILITIES**

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn this service over to collection for non-payment after 90 days, the patient is then responsible for the bill, interest and collection and attorney fees.

**AUTHORIZATION TO PAY BENEFITS TO PROVIDER:**

I hereby authorize payment directly to Mountain View Family Practice for my charges.

**AUTHORIZATION TO RELEASE INFORMATION:**

I hereby authorize Mountain View Family Practice to release any information which may include SUD acquired in the course of my examination or treatment to my insurance company in any form which may include but is not limited to electronically, fax or mail.

**MEDICARE STATEMENT (if applicable):**

- This claim will be submitted to Medicare for you by our office.
- Medicare may not cover some services which the patient will be responsible to pay. Such identified services include yearly physicals. In addition, you will be responsible for your yearly Medicare deductible & coinsurance if you do not subscribe to a supplemental policy that covers the deductible or coinsurance. We do not accept Medicare assignments.

Initial: \_\_\_\_\_  Self  Other \_\_\_\_\_ (relationship)

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

I have been presented with a copy of the Notice of Privacy Practices which includes February 15, 2026, addendum detailing how my PHI and SUD records may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information.

Date:	Signature:	Relationship to Patient:
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**ACKNOWLEDGEMENT OF RECEIPT OF PAYMENT POLICY**

I have been presented with the Mountain View Family Practice, PC Payment Policy outlining their billing practices and my responsibilities for any non-covered balances.

Initial: \_\_\_\_\_  Self  Other \_\_\_\_\_ (relationship)

Date:	Signature:	Relationship to Patient:
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