Mountain View Family Practice, PC
570 Baldwinville Road, Baldwinville, MA 1436
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Gretchen L. Kelley, MD Kelly E. Hoisington, DO
Kelly M. Clow, FNP-BC Sarah Gile, PA Amanda Susa, FNP-BC

	PCP:

PATIENT INFORMATION

Patient's Last name: First name: Middle name:	Race/Ethnicity: · Non-Hispanic or Latino · Hispanic or Latino · Asian · African American · Other · Decline		Marital Status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ 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:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):

Subscriber's name:	Birth date: / /	Group no.:	Policy no.:	

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address):	Relationship to patient:	Home phone #:	Cell phone #:

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 the undersigned provider for my charges.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the undersigned provider to release any information acquired in the course of my examination or treatment to my insurance company either by mail or by FAX.

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. 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 detailing how my health information may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information.

Initial: _____ □ Self □ Other _____ (relationship)

ACKNOWLEGEMENT OF RECEIPT OF MOUNTAIN VIEW FAMILY PRACTICE, PC 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: