Primary Care Provider

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## **PATIENT REGISTRATION**

Please fill out the following information <u>completely</u>, to help us complete your medical record. We are required to have a picture ID at time of registration and Insurance Card. All information must be completed.

Patient Name (Last, First, N	Current Primary Care Physician  Date of Birth			
Street Address				
Preferred Phone (Home / C	Cell) (Please Indicate home	e or cell)	2 <sup>nd</sup> Phone (Home / Ce	II / Office)
Social Security #		Em	ail	
Preferred Language	Gender/Sex	Race	 Ethnicity	Marital Status
	ed by the US Gov't – Health Insuran	ce Portability & Accountabil	ity Act of 1996 (HIPAA) & Physician Qu	ality Reporting Initiative (PQRI)
		Incurance Infe	ovu ation	
		Insurance Info		
	rie	ase present Insu	rance Caru (s).	
_			= =	ted to be paid at time of
service. A service cha	arge of \$20.00 may be	charged if paym	ent is not paid at time o	of service. An insurance card
is required to be pres	ented at each visit.			
Responsible Party Name &	Relationship (If a Minor)		Date of Birth	Telephone #
1	1			1
		Employer Info	ormation	
		Employer inje	inition .	
Employer (Work) Name &	Address			Telephone #
- 7				•
	E	Imergency Conta	ct (Required)	
Name / Relationship				Telephone #
MMWIC Secretary	 Dat	e		
MMWICptreg0111jm1				

## Assignment and Release

MM	IWIC Secretary	Date		Relationship to Patient	
Pati	ent Signature	Date	-	Parent/Guardian Signature	Date
✓	Please note that a pand Notice of Priva	aper copy of our Payme cy Rights & Practices pe	ent Policy, Practic er HIPAA are ava	e Agreement, Patients' Rig ilable upon request. <b>Initia</b>	hts & Responsibilities, 1
✓	I hereby acknowle MMWIC; at its dis Notice and that I w	dge receipt of Merrimac scretion can change the vill be provided a copy t	ck Medical & Wa e terms and cond upon my request.	lk In LLC notice of Privacy litions of this Notice. I ur Initial	Practices. I understand nderstand content of the
✓	I understand my in am ultimately resp claim, and that sho that the fees are ba a charge for appo understand that co request. I underst	nsurance policy is a coronsible for the entire biould the w/c status be resed on treatment receivintments missed or cappayments are due at trand this financial policions.	ntract between m ll. The only exce reversed, that I ar ed and have no b ncelled less thar time of service. cy – Initial	y insurance company (Plan ption to this is an approved in then responsible for the earing on outcome. I also to 24 hours prior to my ap A copy of the financial p	n) and myself, and that I I worker's compensation entire bill. I understand understand there may be pointment time. I also olicy will be given upon
✓	I understand and a Department of Pul want your informa Initial	olic Health / Vaccine Pro ation release to other ago	elease vaccine info ogram. You as th encies, programs	ormation to MIIS per requir e Patient will be able to inf	rements of the orm DPH whether you
✓	I understand and prescribed in the p	authorize MMWIC acco	ess to my Pharm drugs are covered	acy Benefits to know wha d or not covered by your in	t medications have been surance plan.
✓	I also give the phappropriately as no	nysician permission to ecessary. <b>Initial</b> _	discuss my med	dical care with other phy	sicians (specialists), etc.
✓	I consent to genera Initial	l treatment, medical pro	ocedures, and me	dications prescribed by my	Physician.
<b>√</b>	appropriate insura	nce benefits - Lundersta	and Lam financial	urance coverage and assign ly responsible for all charg me (or my dependent), and authorize the provider to p e Plan / Network. <b>Initial</b>	es whether or not paid