Patient Registration

Please fill out **completely, to help us complete your medical record.** P**icture ID** and Insurance card needed.

Patient Name (Last, First, MI | **Date of Birth** | **Current Primary Care Physician**

Street Address | **City, State, Zip** | **Preferred Phone (Home)**

Email | **Social Security #** | **Martial Status** | **Preferred Language** | **Gender/Sex** | **Race** | **Ethnicity**

Please note: **Questions mandated by the US Gov't – Health Insurance Portability & Accountability Act of 1996 (HIPAA) & Physician Quality Reporting Initiative (PQRI)**

Insurance Information

Please present Insurance Card (s) at each visit. All co-pays are required and expected to be paid at time of service.

Guarantor Name & Relationship (If a Minor) | **Date of Birth** | **Telephone #**

Emergency Contact (Required) and Release of Information to a Family Member or Personal Rep

1. _____ _____

2. _____ _____

Name / Relationship | **Telephone #**

Please check off the appropriate box, to indicate a family or appropriate member, initial and date. This authorization can be changed or revoked at any time by notifying the office.

- ☐ **I authorize MMWIC to communicate my health care to the following family member (FM) / personal representative (PR). This authorization allows this office to speak to your family or PR about scheduling and your health condition(s).**
- ☐ **To release medical record information to your family or PR, such as progress notes, prescriptions, labs, test reports.**
- ☐ **Authorization to pick up prescription(s). (Please note- a picture ID is required by your FM/PR when picking up prescription.**

Assignment and Release

___ I consent to general treatment, medical procedures, and medications prescribed by my Physician, and allow discussion of my medical care with other physicians (specialists), etc. appropriately.

___ I consent and authorize MMWIC access to my Pharmacy Benefits to know what medications have been prescribed in the past and to know which drugs are covered or not covered by your insurance plan.

___ I understand my insurance policy is a contract between my insurance company (Plan) and myself, and that I am ultimately responsible for the bill. I authorize the Practice to release information necessary to secure payment of benefits, and allow the provider to followinsurance guidelines regarding claims, Quality Data reporting.

___ I understand and authorize MMWIC to release vaccine information to MIIS per requirements of the Department of Public Health / Vaccine Program. You as the Patient will be able to inform DPH whether you want your information release to other agencies, programs.

___ I hereby acknowledge Merrimack Medical & Walk In LLC notice of Privacy Practices. I understand MMWIC; at its discretion can change the terms and conditions of this Notice.

Please note that a paper copy of our Payment Policy, Practice Agreement, Patients' Rights & Responsibilities, and Notice of Privacy Rights & Practices per HIPAA are available upon request.

Patient Signature | **Date** | **Parent/Guardian Signature if under ago 18** | **Date**

MMWIC Secretary | **Date** | **Relationship to Patient**