

PATIENT INFO FORM Today's Date _____ page 1 of 3

Name: _____

Birthdate: _____ Social Security# _____

Ethnicity (check one) Hispanic: _____ Non-Hispanic: _____ Other: _____

Preferred Contact Method: _____
(example: home phone, cell phone or regular mail)

Home Address:

(street, city, state & zip code)

Home Phone# _____ Work # _____ Cell# _____

PATIENT Employer

Name: _____ Occupation: _____

Emergency Contact Name & Phone # _____

Emergency Contact's Relationship to patient: _____

***Our office uses an electronic system to submit your non-narcotic prescription requests directly to your pharmacy. Do we have your permission to enter your prescriptions and obtain your medication history through this system? _____

What is your pharmacy name & phone number? _____

Primary Care Doctor Name & Phone #: _____

Primary Insurance: _____ ID#: _____

Group # _____ Policy holder name: _____

Secondary Insurance: _____

Secondary Insurance ID # _____ Group # _____

Secondary Insurance Subscriber Name: _____

WAYNE B. GLAZIER, M.D., B. G. PARULKAR, M.D. & ROBERT J. CHERRY, M.D.
CATHERINE HAYES, N.P., B.C. & CAROLE C. LYMAN, A.P.R.N., B.C.
MAIN OFFICE: 85 PRESCOTT STREET, SUITE 304, WORCESTER, MA 01605
PHONE: 508-753-7259 FAX: 508-753-9577

PATIENT INFO FORM
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PRINT NAME: _____ Date: _____

BY SIGNING THIS FORM, YOU ACKNOWLEDGE THAT THIS MEDICAL PRACTICE HAS INFORMED YOU OF ITS PRIVACY PRACTICES INFORMATION. THE COMPLETE POLICY IS POSTED IN A BINDER ON THE TABLE TO THE LEFT OF THE RECEPTION ROOM WINDOW. THIS NOTICE EXPLAINS HOW HEALTH INFORMATION IS HANDLED. A FEDERAL LAW ABOUT MEDICAL PRIVACY CALLED "HIPAA" REQUIRES THAT ALL MEDICAL OFFICES INFORM THEIR PATIENTS OF THEIR PRIVACY POLICIES. AN ABBREVIATED VERSION OF THAT POLICY IS LISTED BELOW:

PLEASE NOTE, OUR OFFICE ROUTINELY SENDS NOTICES TO PATIENTS REGARDING LAB RESULTS, APPOINTMENTS AND BILLING ISSUES. WE ALSO MAKE PHONE CALLS TO THE NUMBERS YOU HAVE GIVEN US REGARDING THE SAME ISSUES. IF YOU HAVE ANY RESTRICTIONS ON HOW WE COMMUNICATE WITH YOU, PLEASE LIST THOSE RESTRICTIONS BELOW:

PATIENT OR GUARDIAN SIGNATURE

DATE SIGNED

BELOW IS FOR OUR OFFICE USE ONLY:

IF PATIENT DID NOT SIGN, EXPLAIN WHY BELOW:

STAFF NAME & INITIALS: _____

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PATIENT FINANCIAL POLICIES

OUR OFFICE IS DEDICATED TO PROVIDING THE BEST POSSIBLE CARE & SERVICE TO YOU. WE REGARD YOUR UNDERSTANDING OF OUR FINANCIAL POLICIES AS AN ESSENTIAL ELEMENT OF YOUR CARE. AS A COURTESY, OUR OFFICE WILL BILL YOUR INSURANCE COMPANY FOR SERVICES PROVIDED TO YOU. IF YOUR INSURANCE COMPANY DOES NOT REIMBURSE OUR OFFICE WITHIN A REASONABLE AMOUNT OF TIME (TWO MONTHS IS CONSIDERED THE MAXIMUM PROCESSING PERIOD), YOU WILL BE BILLED FOR THE VISIT(S). IF, AT A LATER DATE, WE RECEIVE PAYMENT FROM YOUR INSURER WE WILL REFUND ANY OVERPAYMENT DIRECTLY TO YOU. IF YOUR INSURANCE COMPANY REQUIRES COPAYMENTS FOR OFFICE VISITS, THAT PAYMENT IS DUE AT THE TIME OF YOUR VISIT. IF OUR OFFICE HAS TO BILL YOU FOR THAT COPAY, PLEASE BE ADVISED THAT THERE WILL BE A \$5.00 BILLING FEE ATTACHED TO EACH PATIENT BILL SENT.

*****INSURANCE REFERRALS*****

IF YOUR INSURANCE REQUIRES REFERRALS FOR SPECIALIST VISITS, IT IS YOUR RESPONSIBILITY TO OBTAIN THAT REFERRAL PRIOR TO YOUR VISIT. IF THE REFERRAL IS NOT ON FILE AT THE TIME OF THE VISIT, WE WOULD HAVE TO RESCHEDULE YOUR VISIT.

*****NONCOVERED SERVICES & BALANCES*****

NOT ALL SERVICES PERFORMED BY THE DOCTOR ARE GUARANTEED TO BE COVERED BY YOUR INSURANCE COMPANY. IT IS YOUR RESPONSIBILITY TO VERIFY COVERAGE FOR SERVICES EXPECTED TO BE PERFORMED BY YOUR DOCTORS. IN THE EVENT THAT A CHARGE IS REJECTED BY YOUR INSURANCE, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THAT CHARGE. ALSO, IF YOUR INSURANCE DOES NOT COVER 100% OF YOUR CHARGES, YOU ARE RESPONSIBLE FOR ANY BALANCE DUE. IF YOU HAVE ANY QUESTIONS REGARDING YOUR BILL, PLEASE CALL OUR OFFICE AND ASK FOR ANJI. IF OUR OFFICE HAS TO SEND ANY PATIENT DUE BALANCES ON YOUR ACCOUNT TO OUR ATTORNEY FOR COLLECTION, YOU WILL BE RESPONSIBLE FOR ALL COLLECTION COSTS AND ACTUAL ATTORNEY FEES.

*****PLEASE NOTE*****

WE CHARGE A \$25.00 NO SHOW FEE FOR PATIENTS WHO FAIL TO GIVE 48 HOURS NOTICE OF APPOINTMENT CANCELLATIONS.

****YOUR SIGNATURE IS REQUIRED TO VERIFY THAT YOU HAVE READ AND UNDERSTAND THE ABOVE POLICIES.**

PATIENT NAME (PLEASE PRINT)

(PATIENT SIGNATURE)

IF PATIENT IS UNDER 18, LEGAL GUARDIAN MUST SIGN BELOW:

WHAT IS RELATIONSHIP OF GUARDIAN TO PATIENT? _____