Orchard Medical Associates, L.L.C.

835 Worcester Street • Indian Orchard, MA 01151
Telephone: (413) 439-0609 • Fax: (413) 439-0623
Email: info@orchardmedical.org • www.orchardmedical.org
Adult & Pediatric Medicine

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____

IF MINOR, RESP. PARTY/GUARDIAN IS: _____ RELATION TO MINOR: _____

D.O.B.: _____ SEX: M F

RACE: _____ ETHNICITY: _____ LANGUAGE: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____

NAME OF EMPLOYER/SCHOOL: _____

STREET ADDRESS: _____ WORK PHONE _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMERGENCY CONTACT: _____ RELATION: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

IS THIS RELATED TO AN AUTO ACCIDENT? YES ☐ NO ☐

IF YES, PLEASE FILL OUT THE FOLLOWING:

AUTO INSURANCE CARRIER: _____
BILLING ADDRESS: _____
PHONE #: _____ DATE OF INJURY: _____
CLAIM NUMBER: _____

ATTORNEY INFORMATION

NAME OF ATTORNEY: _____
ADDRESS: _____
CITY, STATE, ZIP CODE: _____
PHONE NUMBER: _____

"NO-SHOW"/CANCELLATION POLICY

If you cannot keep your scheduled appointment, please call 24 hours in advance to avoid "no show" office charges. We reserve the right to charge for missed appointments if you do not honor this policy. If you repeatedly "NO SHOW" and/or CANCEL your appointments, we reserve the right to discharge you from care.

INSURANCE INFORMATION

PRIMARY INS. CO. NAME:_____

POLICYHOLDER NAME: _____ D.O.B. _____

RELATIONSHIP TO PATIENT:_____ SEX: M F

EMPLOYER NAME:_____

EMPLOYER'S ADDRESS:_____

SECONDARY INSURANCE INFORMATION

POLICYHOLDER NAME: _____ D.O.B. _____

RELATIONSHIP TO PATIENT:_____ SEX: M F

EMPLOYER NAME:_____

EMPLOYER'S ADDRESS:_____

AUTHORIZATION

I give permission to Orchard Medical Associates to disclose my Protected Health Information to the following individual(s). I hereby understand this listing remains in effect unless revoked by me in writing.

NAME: _____ **PHONE #:** _____**RELATION:** _____

NAME: _____ **PHONE #:** _____**RELATION:** _____

I ☐ **do** ☐ **do not** give permission to Orchard Medical Associates to leave information and instructions on my answering machine or voice mail (home, work, or cell).

I hereby understand this and give permission for disclosure, during my examination only, of my Protected Health Information to any individual I allow to accompany me into the examination room. I also understand by providing my email address. I am allowing transmittal of my Protected Health Information.

By signing below, I acknowledge that I have been given a copy of Orchard Medical Associates' Notice of Privacy Practices.

☐ Notice of Privacy Practice given — patient unable to sign ☐ Notice of Privacy Practice offered — patient declined.

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand the assignment of benefits does not lessen my financial responsibility for any charges not covered by this authorization. My insurance coverage is a contract between my insurance company and myself. I am responsible for any deductible, co-payment, or non-payment designated by my insurance. I am responsible for non-covered services, as well as obtaining and maintaining any financial referrals. I fully understand that I am responsible to pay for services rendered, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if a payment becomes 90 days past due, delinquency at the lesser of the annual rate of 12% or the maximum allowable rate, will be due on delinquent accounts from the date the payment was due. I hereby authorize payment directly to Orchard Medical Associates for all medical benefits, if any, otherwise payable to me under the terms of my health insurance policy. I also authorize release of any information necessary for processing of this or a related claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Orchard Medical Associates to release information acquired in the course of my examination and/or treatment to a consulting physician and my health insurance carrier as part of the normal process in the delivery of health care.

I HAVE VERIFIED THE ACCURACY OF ALL INSURANCE AND DEMOGRAPHIC INFORMATION, WHICH I PROVIDED AT REGISTRATION. I AGREE THAT ALL OF THE ABOVE AUTHORIZATIONS ARE VALID INDEFINITELY UNLESS OTHERWISE STATED.

SIGNATURE: _____ **DATE:** _____

If the signature above is not the patient's, please state your relationship to the patient.

YOUR NAME: _____ **RELATIONSHIP:** _____ **DATE:** _____