Office Use Only: Patient ID #: _____ Provider: _____ Staff Initials:_____ 1/18

Patient Information/Communication Options
HIPAA Receipt
Authorization to Treat

Patient Name (First, MI, Last) _____ Maiden Name_____

Date of Birth _____ Sex _____ SSN#____-____-____ Email:_____

Primary Phone (_____)_____ Secondary Phone (_____)_____

Mailing Address _____
PO Box/Street City State Zip Code

Street Address _____
Street City State Zip Code

Parent's Name (if under 18) _____ Date of Birth_____

In case of Emergency, contact _____

Relationship to Patient _____ Phone _____

Health Insurance _____

I authorize Saco River Medical Group to use the following means to communicate with me:

OK to speak with these family members or others as designated:

NAME	RELATION	PHONE #
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Since 2003, a federal Act called HIPAA has been in effect that helps control the privacy of your medical care and your medical records. Attached, are your rights under this act. We will continue to respect your right to privacy. Also, we may continue to communicate, as necessary, with you or family members, by phone, as appropriate.
- If you are self-pay or have insurance that we do not bill, all charges are payable at the time of service. We will provide you the necessary information for your insurance carrier. If you have health insurance, co-pays are due at the time of service.
- I hereby authorize the Saco River Medical Group or any clinician employed at the Saco River Medical Group to furnish information to my/our insurance carrier concerning my illness and treatment. I request that payment for Medicare benefits covering services provided at the Saco River Medical Group be made on my behalf directly to the Saco River Medical Group. I authorize any holders of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.
- SPECIAL AUTHORIZATION re: Drug/Alcohol Abuse, Mental Health, and/or HIV/AIDS information. I acknowledge that data to be released MAY INCLUDE material that is protected by federal law that is applicable to one or more of the above conditions. My signature below authorizes release of all such information. This authorization will be in effect unless your office receives written notice otherwise.
- I hereby authorize clinicians of the Saco River Medical Group to provide me medical care, including diagnosis and treatment.

I agree to receive medical care as outlined above _____ Date _____
Signature

I have received Saco River Medical Group's Privacy Policy _____ Date _____
Signature

I have received and understand the Patients' Bill of Rights _____ Date _____
Signature

The usage of electronic health record requires that we obtain the following information:

Ethnicity (Please circle one): Hispanic Non Hispanic Decline

Race (Please circle one): White Black Asian Indian/Alaskan Other/multi Decline

Primary Language Spoken: English Spanish Other:____

Office Use Only: Patient ID #: _____ Provider: _____ Staff Initials:_____ 1/18