OSTEOPATHIC HEALTHCARE OF MAINE

Patient Name:______________________________________DOB_______________ Sex_____________

Address_______________________________City___________________State________Zip____________

Occupation___________________________________Employer____________________________________

Relationship Status: S P M D W

Parent's Name (if child)____ DOB_______________

***Is this a work related injury? Y N Has your employer been informed? Y N

Date of Injury_____________ Claim #_____________ Adjuster________________ Phone______________

Nurse Case Manager_______________ Phone__________ Attorney_______________ Phone_____________

***Is this an injury the result of an accident? Y N Date of Accident__________ Claim #______________

Med Pay Info ____

Primary Care Physician_____________________________________ Phone__________________________

INSURANCE:

Primary Insurance ____

Policy ID Number_____________________________ Group Number_______________________________

**Did you receive a referral if required by your insurance? _______ Number of visits authorized___________

Secondary Insurance____

Policy ID Number_____________________________ Group Number_______________________________

ASSIGNMENT OF BENEFITS:

Co-payments are due at the time of service. I authorize payment of medical benefits from my insurance provider to **Osteopathic Healthcare of Maine** for services provided by Dr. Hankinson, Dr. Wu, Dr. Gilson, Dr. Hilton, & Dr. Jeffrey Greenfield, and do understand that I will be responsible for any balance, including a balance for any non-covered services, after my claims have been submitted and processed by insurance.
I also understand that 24-hour notice of cancellation is required. If notice is not given, I may be charged a fee for missed appointment.

____ _______________________________

SIGNATURE **DATE**

PATIENT NOTIFICATION

Circle One

Cell: ________________________________ Okay to leave message? Yes / No

Okay to send Text Message? Yes / No

Home: ________________________________ Okay to leave message? Yes / No

Work: ________________________________ Okay to leave message? Yes / No

Emergency Contact: ________________________ Contact Telephone: ________________________

Relationship to Patient:______________________________

Select One:

□ **I do <u>not</u> want any information about my healthcare communicated to family members/caregivers.**

□ **I give Osteopathic Healthcare of Maine permission to verbally communicate to family members/caregivers listed below.**

Name: ____

Name: ____

Please check the box next to the specific information that may be **<u>verbally</u>** communicated to the individual(s) listed above:

□ Prescription Request
□ Referral Request
□ Request/Confirm/Cancel Appointments
□ Other (specify): ____________________

This authorization expires 12 months from the date hereof. I have the right to revoke this authorization in writing at any time. Revocation will not cover information/material released prior to that date, but will present further release of information.

If you would like to grant permission to Osteopathic Healthcare of Maine to discuss AIDS/HIV, Alcohol and/or Drug Abuse, or Mental Health with anyone but yourself, please request a *Medical Release Form.*

Patient Signature: ____Date: ________________________

Parent/Legal Guardian Signature: ____________________________Date: ________________________