OSTEOPATHIC HEALTHCARE OF MAINE

Patient Name_____ DOB_____ Sex_____

Address_____City_____State_____Zip_____

Occupation_____Employer_____

Relationship Status: S P M D W Who referred you to OHM? _____

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_____

Is a referral required by your insurance? _____ Number of visits authorized_____

Do you have a Deductible?_____

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.

_____ _____

SIGNATURE **DATE**

PATIENT NOTIFICATION

Patients who do not give a 24-hour notice or do not arrive for a scheduled appointment may be charged a missed appointment fee.

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:_____

*******NEED TO COMPLETE THIS SECTION*******

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
□ Billing questions
□ 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 prevent 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: _____