OSTEOPATHIC HEALTHCARE OF MAINE

Patient Name _____ Parents Name (if child)_____

DOB _____Sex _____ Phone (Home) _____ (Cell) _____

Address_____ Email_____

Primary Care_____ Phone _____ Who referred you to OHM? _____

Emergency Contact _____ Relationship _____ Phone _____

Please circle: Do you have Maine Care? (YES/NO) If yes, are you a QMB participant? (YES/NO)

If this a work-related or a motor vehicle accident injury please notify our new patient coordinator at 207-835-2024.

***Please note: Patients who do not call the office to cancel within 2 business days or do not arrive for a scheduled appointment may be charged.**

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 Providers and do understand that I will be responsible for any balance for non-covered services, after my claim has been submitted and processed by my insurance.

Signature: _____ Date: _____

Please check if you give us permission to communicate about your health information:

- o I do not want any information about my healthcare communicated to family members/caregivers.
- o I give Osteopathic Healthcare of Maine permission to verbally communicate to family members/caregivers listed below:

Names: _____

Please check the specific information that may be verbally communicated to the individual(s) listed above:

- o Prescription Request
- o Billing questions
- o Referral Request
- o Appointments
- o Other (specify):

Please circle the following forms of sensitive information that you consent to release:

Mental Health (YES/NO) Substance Abuse (YES/NO) HIV/AIDS (YES/NO)

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.

Patient/Legal Guardian Signature: _____Date: _____

Osteopathic Healthcare of Maine

Notice of Privacy Practices Acknowledgment

I understand that, under the **Health Insurance Portability & Accountability Act** of 1996 **(HIPAA), I** have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment.
- Follow-up among the multiple healthcare providers who may be involved in treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received Osteopathic Healthcare of Maine's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in our waiting room). I understand that Osteopathic Healthcare of Maine has the right to change its Notice of Privacy Practices from time to time and that I may contact Osteopathic Healthcare of Maine at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that Osteopathic Healthcare of Maine restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that Osteopathic Healthcare of Maine is not required to agree to my requested restrictions, but if an agreement is reached then they are bound by such restrictions.

_____ _____

Patient Name Patient Date of Birth

_____ _____

Patient **or** Legal Guardian Signature Relationship to Patient

_____

Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the notice of privacy practices, but was unable to

obtain signature _____Date: _____