OSTEOPATHIC HEALTHCARE OF MAINE

Patient Name_____Legal Guardian (s)_____

DOB_____ Phone (Home)_____ (Cell)_____

Mailing address_____ Town_____State_____Zip_____

Email_____ Occupation_____

Primary Care Provider_____ Who referred you_____

Emergency Contact_____ Relationship_____ Phone_____

Please circle :

1. Do you have MaineCare? (YES / NO**)**
2. Are you dually eligible for Medicare and Medicaid/MaineCare? (YES / NO)

Please check one:

☐ I do not want any information about my healthcare communicated to family members/caregivers.

☐ I give permission to communicate to: (Please list names)_____

*Please check information that may be communicated: ☐ Prescription Request, ☐Appointments, ☐ Billing, ☐ Mental health, ☐ Substance Abuse, ☐ HIV/AIDS, ☐ Other (specify):

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 & 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 complete description of the uses and disclosures of my health information. I understand that Osteopathic Healthcare of Maine has the right to change its Notice of Privacy Practices and that I may contact Osteopathic Healthcare of Maine at any time to obtain a current copy of the Notice of Privacy Practices. 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 healthcare operations. I also understand that Osteopathic Healthcare of Maine is not required to agree to my requested restrictions, but if an agreement is reached, they are bound by such restrictions.

I have the right to revoke this authorization in writing at any time. Revocation will not cover information or material released before that date but will prevent further release of information.

I hereby confirm that I have read and understand OHM's office policies.

Patient/Legal Guardian Signature:_____Date:_____

Please see back for office policies →

Cancellations and Missed Appointments: We require at least **two business days' notice** for cancellations or rescheduling to allow us to offer your appointment time to another patient. You will receive a letter outlining our policy if an appointment is missed or canceled without adequate notice. For a second missed or late-canceled appointment, a $50.00 missed appointment fee may be charged. A third missed or late-canceled appointment within 12 months may result in a $150.00 missed appointment fee or discharge from the practice. ***** New Patients: At the provider's discretion, missing or canceling an initial appointment without adequate notice may result in a $250.00 missed appointment fee. If a new patient misses or cancels two initial appointments without adequate notice, they may not be eligible to establish care with OHM.

Prescription Refills: Please allow **two business days** to fill all prescription requests. Please contact your pharmacy to check the status of your refill. You may request prescription refills using one of the following methods: 1. Contact your pharmacy to fax a request to our office. 2.Contact our Clinical Coordinator, *Meg Dehetre, at 207-835-2021 or 207-791-7900, option 3.* 3.Speak with your provider at your next appointment. We will need your Name, date of birth, medication name, dosage, frequency, quantity requested, and pharmacy location.

Lab Results: Once we receive your results, they will be attached to your next appointment to discuss with your provider. If you are not scheduled, we will reach out to you to schedule an appointment. An appointment is needed with your provider to discuss your test results. Please note that our office staff is not authorized or trained to interpret test results.

Supplement Purchasing: Payment is required at the time of purchase. All sales are final. Supplements cannot be returned.

Minors: Children under 18 years old and not accompanied by a parent or guardian need verbal or written permission to be seen.

Assignment of Benefits: I authorize and direct my insurance carrier to issue payment directly to Osteopathic Healthcare of Maine, PA, for medical services rendered to myself and/or my dependents. I understand that I am responsible for services not covered by my insurance.

Financial Responsibility: Copays are due at the time of service. It is your responsibility to know which services your plan covers. You are responsible for any balance if your insurance denies or partially covers a service. Payments can be made via the patient portal, phone, or mail.

HMO Policies: If you have an HMO policy, **you must obtain a referral from your Primary Care Physician.** The PCP issuing your referral must match whom your insurance policy has listed, and you must have an active referral to schedule an appointment.

Collection Policy: Balances are past due 30 days after the first statement. If you need assistance paying within this time, call 207-835-2030 to arrange a payment plan. Accounts 120 days past due without a payment plan will be transferred to Thomas Collection Agency.

Credit Card Processing Authorization: You can keep a credit card on file. We will not process payments without your verbal consent.

Prompt-Pay (Self-Pay) Accounts: We are contracted with most major insurance companies and must submit claims if we are in-network with your insurer. Self-pay (prompt-pay) applies only to patients without insurance or out-of-network coverage. A credit card must be on file to qualify for the prompt-pay discount, and payment is required at the time of service.