

**MINDFUL MEDICAL CARE PC**

Maria Azizian, MD FACS

100 Teaticket Hwy, Building #3

Teaticket, MA 02536

**PATIENT INFORMATION**

Last Name: First Name:

Mailing Address:

City: State: Zip Code:

Home Address (if different):

City: State: Zip Code:

Home: Cell: Work: x

DOB: Social Security: Sex:

Marital Status: Email:

Race: White/Caucasian Black/African American Asian American Native Other (Specify) Declined

Ethnicity (Circle one) Hispanic Not Hispanic or Latino Other (Specify) Declined

Primary Care Physician:

Pharmacy: Address: City:

Mail Order Pharmacy:

Preferred Lab Location:

**EMERGENCY CONTACT**

Last Name: First Name:

**Payment/Copay is expected at time of appointment per Insurance Policy, if your insurance requires a copay.**

Relationship: Phone:

Signature: Date:

**FINANCIAL RESPONSIBILITY STATEMENT** – I understand that if my insurance company requires a referral, I am responsible for obtaining it. Without said referral, I am financially responsible for all charges incurred. For and in consideration of services rendered or to be rendered to myself as a patient of Mindful Medical Care, the undersigned agrees to pay Mindful Medical Care, in full for all charges incurred. Should the account for charges be referred to a collection agency or to an attorney for collection, I shall pay reasonable attorney or collection fees and court costs as collection expenses.

**Payment/Copay is expected at time of appointment per Insurance Policy, if your insurance requires a copay. The exception is a 10 day global period following a procedure, except for major procedures. The copay is not charged during the global period unless a new problem, not related to the procedure is brought-up, in which case a copay will be charged within the 10 day period as well. All visits outside of the global period require a copay if your insurance requires it.**

**IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, PLEASE CALL OUR OFFICE TO CANCEL AND/OR RESCHEDULE AT LEAST 24 HOURS BEFORE YOU ARE SCHEDULED TO ARRIVE. OTHERWISE A $25.00 “NO SHOW” FEE WILL BE CHARGED.**

**ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF MEDICAL INFORMATION** – I authorize direct payment to Mindful Medical Care for these service rates not to exceed Mindful Medical Care regular charges. It is agreed that the payment of benefits to Mindful Medical Care shall not discharge my responsibility to pay for charges not covered by my insurance plan. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize Mindful Medical Care to disclose portions of the patients’ record, including medical records, to any person or corporation or governmental agency which is or may be liable for all or any portion of charges from Mindful Medical Care. If payment is to be made under Title XVIII of the Social Security Act, I certify that the information given by me in applying for payment is correct and authorize any owner of medical or other information about me to release to the Social Security Administration or its intermediates or carriers any information needed for this or any related Medicare claim.

**WORKMEN’S COMPENSATION OR MOTOR VEHICLE ACCIDENT** – If my medical problem is work or accident related then I am responsible for obtaining the necessary billing information from my employer or claims adjuster and must specify upon check in at EACH VISIT, how that visit is to be billed. To change a claim to workmen’s compensation or MVA, involves extensive paper work and a reduction of physician reimbursement.

**CONSENT TO TREAT** – I, the undersigned, hereby give consent for the administration and performance of any procedure or treatment that may be deemed medically necessary or advisable based on the judgment of the attending physician or their assigned designees. I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

A photocopy of this consent shall be considered as valid as the original.

Signature: Date:

**MEDICARE PATIENTS ONLY**

I request that payment of authorized Medicare benefits be made on my behalf to Mindful Medical Care for any services furnished.

I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: Date:

**CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION**

**TO FAMILY, FRIENDS, AND/OR OTHER REPRESENTATIVES**

Family/Friend Name Relationship Telephone Number

Signature: Date:

Please check all that apply of the following and sign below:

I give my permission for messages to be left on my answering regarding:

\_\_ Lab/Test Results

\_\_ Prescriptions

\_\_ Appointments

\_\_ Other

Signature: Date:

I DO NOT WISH TO BE CALLED. (A MESSAGE WILL BE LEFT TO RETURN OUR CALL)

Signature: Date:

**PRIVACY NOTICE AND PATIENT RIGHTS ACKNOWLEDGEMENT**

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and patient rights. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge having received a copy of the Mindful Medical Care’s Notice of Privacy Practices and Patient Rights.

Signature: Date: