Welcome to New England Primary Care

We would like to thank you for choosing us as your health care provider. In order to make your visits more efficient, please read the following information, and complete the enclosed paperwork to the best of your abilities.

You must contact your insurance company and list New England Primary Care (Dr. Ian Tucker or Francine York, DNP, APRN, FNP-BC) as your primary care provider. If you do not contact your insurance company, we may not be able to assist you in scheduling tests, referring you to specialists, or filling prescriptions. This is extremely important for our office and your health care.

Please bring your insurance card and photo ID to each office visit.

Location and hours:

55 Hazard Avenue, Enfield, CT 06082

Monday and Wednesday	8:30 a.m. to 6:30 p.m.
Tuesday	8:30 a.m. to 5:30 p.m.
Friday	8:30 a.m. to 3:30 p.m.

Closed Thursday, Saturday and Sunday

Arrival:

Please arrive on time for any and all office appointments. In order to provide quality care to all patients, we need to allow adequate time for each person to see the provider. Arriving late interferes with other patient appointment times, therefore compromising their care. If you are more than 10 minutes late for your appointment, you may be asked to reschedule and return on a different day.

Cancellation:

If you should need to cancel an appointment, please contact the office as soon as you are aware of it. A missed appointment will result in a "no show" charge. We require at least 24-hour notice if a cancellation is needed, please keep in mind that if you have an emergency and must cancel the day of, we will take that into consideration.

No-Show

Appointments are confirmed daily. No show appointments will result in a charge. If you have two "no-show" appointments during the same calendar year, you may be discharged from the practice.

Payment

Copays are due at the time of each visit. You will be billed if you do not supply your copay at your office visit.

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Last Name: _____ First Name: _____

Sex: M F D.O.B. _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone _____

I would like to receive information from New England Primary Care by email Y___ N____

Marital Status: Married Single Divorced Legally Separated Widowed Partnered

List of household members (name/age):

_____

_____

_____

_____

Employer: _____ Occupation: _____

Insurance Information:

Primary Insurance: Secondary Insurance:

Insurance Co. Name: _____ Insurance Co. Name: _____

ID #: _____ ID #: _____

Group #: _____ Group #: _____

Subscriber Name: _____ Subscriber Name: _____

Subscriber D.O. B.: _____ Subscriber D.O. B.: _____

Relationship to Subscriber: _____ Relationship to Subscriber: _____

Employer: _____ Employer: _____

Last Name: _____ **First Name:** _____

Date of Birth: _____

Social History

Do you use tobacco products now or did you smoke in the past? Yes No If yes, what type: _____

How many a day? _____ How many years? _____ Age stopped? _____

If you currently use tobacco products, are you ready to quit? _____

About how much alcohol do you consume on an average day? _____ or week _____

Do you sometimes use street drugs (cocaine, marijuana, heroin, etc.)? _____

List any allergies with reaction you have to medicines, foods, insects, etc.: _____

_____

_____

Medication History:

CURRENT MEDICINES: List all medications – includes hormones, birth control pills, eye drops, vitamins, inhalers, creams, nasal sprays, supplements, and over the counter medicines ☐Check here if none

NAME OF MEDICATION	MILIGRAMS	TIMES PER DAY	NAME OF MEDICATION	MILIGRAMS	TMES PER DAY

Last Name: _____ **First Name:** _____ **D.O.B.:** _____

Family History:

Please list which relative has had the medical problem.

If your mother (m), father (f), sister (s), brother (b), or children (c) have any of the following conditions

☐ I don't know my family history

☐ I am adopted

	Family Member		Family Member		Family Member
□ Aneurysm		□ Depression		□ Mental Illness	
□ Anxiety Disorder		□ Diabetes		□ Osteoporosis	
□ Arthritis		□ Genetic Screening		□ Ovarian Cancer	
□ Asthma		□ Glaucoma		□ Parkinsonism	
□ Autoimmune Disease		□ Heart Attack		□ Prostate Cancer	
□ Birth Defects		□ Heart Disease		□ Stroke	
□ Breast Cancer		□ Hyperlipidemia		□ Substance Abuse	
□ Celiac Disease		□ High Blood Pressure		□ Sudden Death	
□ Colon Dancer		□ Kidney Disease		□ Thyroid Disease	
□ COPD		□ Learning Disabilities		□ Transient Ischemic Attack	
□ Crohn's Disease		□ Lung Cancer		□ Ulcerative Colitis	
□ Dementia		□ Melanoma			

Men:

Are you sexually active? □Yes □No
How many partners in the past 5 years? _____
Men, women, or both? _____
Do you use birth control/contraception? □Yes □No
If yes what type? _____
Do you have problems with sex or intercourse? □Yes □No
When was your last prostate screening? _____
PSA: _____ Exam: _____
Do you examine your testicles for lumps? □Yes □No
Date of last colonoscopy _____

Women:

When was your last menstrual period?_____
Do you have problems with periods? □Yes □No
Are you sexually active? □Yes □No
How many partners in the past 5 years? _____
Men, women, or both? _____
Do you use birth control/contraception? □Yes □No
If yes what type? _____
Number of pregnancies _____
Number of births _____
Date of last pap smear _____
Date of last mammogram _____
Do you check your breast for lumps? □Yes □No
Date of last bone density test? _____
Date of last colonoscopy? _____

Risk Screening:

Do you always wear seatbelts in a car? □Yes □No
Do you wear helmets when appropriate? □Yes □No
Do you wear sunscreen when appropriate? □Yes □No
Do you have working smoke and carbon monoxide detectors? □Yes □No
Do you have any unsecured firearms in your home? □Yes □No

Current Health Issues:

What health problems would you like to discuss with your provider at today's visit?

_____

_____

Print Name: _____ Signature: _____ Date: _____

Last Name: _____ **First Name:** _____ **D.O.B.:** _____

Please record any **updates** or **changes** to your medical/surgical history below.

Medical Conditions: Have you ever had any of the following medical conditions? Check all that apply.

□ Attention deficit/hyperactivity	□ Diverticulitis	□ Brain/Spinal Cord Infection
□ Allergic Rhinitis	□ Dysrhythmia	□ Heart Attack
□ Anemia	□ Eating Disorder	□ Obesity
□ Anxiety	□ Emphysema	□ Osteoporosis/Brittle Bones
□ Arthritis	□ Failure to thrive	□ Pneumonia
□ Asthma	□ Gait Disturbance	□ Psoriasis
□ Atrial Fibrillation	□ GERD/Acid Reflux	□ Peripheral Artery Disease
□ Back Pain	□ Gastrointestinal Bleeding	□ Seizures
□ Bipolar Disorder	□ Glaucoma	□ Skin Cancer
□ Benign Prostatic Hyperactivity	□ Gout	□ Spine Disorder
□ Coronary Artery Disease	□ Headaches	□ Stroke
□ Cancer	□ Hearing Loss	□ Substance Abuse
□ Cardiac Disease	□ Hematuria	□ Thromboembolism/Blood Clot
□ Cataracts	□ HIV/AIDS	□ Thyroid Disease
□ Congestive Heart Failure	□ Hyperlipidemia	□ Tremor
□ Cerebrovascular Disease	□ High Blood Pressure	□ Tuberculosis
□ Bleeding Problem	□ Hypogonadism	□ Ulcers (Gastrointestinal)
□ Chronic Bronchitis/COPD	□ Inflammatory Bowel Disease	□ Bladder Infection
□ Dementia	□ Kidney Disease	□ Chicken Pox
□ Depression	□ Kidney Stones	□ Vision Problems
□ Diabetes	□ Liver Disorder	

Any additional medical history:

_____

□ Adenoidectomy	□ Plastic Surgery	□ Pacemaker
□ Appendectomy	□ Cystoscopy	□ Parathyroid Surgery
□ Bladder Surgery	□ Eye Surgery	□ Sinus Surgery
□ Brain Surgery	□ Fracture Surgery	□ Skin Surgery
□ Breast Surgery	□ Heart Surgery	□ Spine Surgery
□ Heart Bypass	□ Hernia Repair	□ Splenectomy
□ Cardiac Valve Surgery	□ Hysterectomy	□ Thyroid Surgery
□ C-Section	□ Joint Replacement	□ Tonsillectomy
□ Carpal Tunnel Release	□ Lithotripsy	□ Tubes tied
□ Gallbladder Removal	□ Lung Surgery	□ Vascular Surgery
□ Colon/Large Intestine Surgery	□ Oophorectomy	□ Weight Loss Surgery

Any additional surgical history:

_____

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I, the undersigned, authorize ***New England Primary Care*** *to* RELEASE/OBTAIN *my health information as noted below:*

Name: Date of Birth:

I authorize **New England Primary Care** to:

RELEASE my PHI ***to:***

Name of Person or Agency:

_____

_____

Address: _____

_____

_____

Phone: _____

I authorize **New England Primary Care** to:

OBTAIN my PHI ***from:***

Name of Person or Agency:

_____

_____

Address: _____

_____

_____

Phone: _____

Dates of Treatment Covered by this Release:

❒All prior dates of service/treatment, through discharge from present date of service/treatment

❒Limited to the following date(s):

_____

Please Send Requested Information To:

❒ **New England Primary Care**

55 Hazard Avenue, Enfield, CT 06082

Fax: 860-744-2220

Information to be Released/Obtained

❒ All Records ❒ Progress Notes

❒ History/Physical ❒ Medication Reports

❒ Radiology Reports ❒ Consults Reports

❒ Lab Reports ❒ Discharge Summaries

Include: *(Indicate by initialing)*

_____ Alcohol/Drug Treatment

_____HIV Related Information

_____Mental Health Information

Expiration

❒ I do not want this authorization to expire.

❒ This authorization will expire on: _____

STATEMENT OF ACKNOWLEDGEMENT

I understand that refusal to grant permission will in no way effect my right to obtain present and future treatment, except where disclosure of such communication and records is necessary for treatment. I further understand that the Confidentiality of psychiatric, drug and/or alcohol abuse and HIV records are protected under State and Federal law and cannot be disclosed without my written authorization unless otherwise provided for by law. I understand that I may make a request to inspect and/or copy the information to be used and that the agency will provide me with a copy of this signed authorization. The information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal law.

Patient/Guarantor Signature: _____Date: _____

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24 Hour Cancellation & “No Show” Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care.

New England Primary Care reserves the right to charge the following fees for missed (“no show”) or cancelled appointments without a 24-hour advance notice absent of a compelling reason.

$50.00 for physical appointments

$25.00 for all other office appointments

Fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment.

Two “no shows” in any 12-month period may result in termination from out practice.

By signing below, you acknowledge that you received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS

I understand that the charges of this account remain the responsibility of the person signing this form, either: Patient, Guarantor, Parent, Guardian or accompanying adult.

* AS A SERVICE TO YOU AND/OR YOUR FAMILY, OUR OFFICE, NEW ENGLAND PRIMARY CARE, WILL FILE YOUR INSURANCE BENEFITS. HOWEVER, PLEASE REMEMBER THAT **INSURANCE IS NOT A GUARANTEE OF PAYMENT** AND IS NOT TO BE CONSIDERED AS A TOTAL METHOD OF PAYMENT FOR OUR SERVICES. THE **PATIENT/GUARANTOR** IS RESPONSIBLE TO PAY ANY DEDUCTIBLES, ANY UNCOVERED SERVICES OR PATIENT ESTIMATED PORTIONS ONCE INSURANCE CLAIM HAS BEEN PROCESSED.

* IF FOR ANY REASON THE INSURANCE COMPANY DOES NOT PAY, **I (THE UNDERSIGNED)** ASSUME **FULL RESPONSIBILITY** OF THE UNPAID CHARGES. IF THE INSURANCE COMPANY DOES NOT PAY BENEFITS WITHIN **90 DAYS** FROM OUR FILING DATE, THE GUARANTOR WILL BECOME RESPONSIBLE FOR THE OUTSTANDING BALANCE.

* PRICES, FEES OR BENEFITS QUOTED IN OUR OFFICE ARE ESTIMATES ONLY. FINAL CHARGES OR BENEFITS PAID BY THE INSURANCE COMPANY WILL BE BASED ON WORK PERFORMED AND CLAIMS FILED AFTER WORK HAS BEEN COMPLETED.

Initial next to each point

_____ I understand that if a check I have written for treatment is returned by the bank for insufficient funds there will be a Returned Check Fee of $40

_____ I understand that unpaid balances may be subject to 1.5% (APR 18.00%) monthly finance charge

_____ If this account becomes past due and is assigned to an attorney or collection agency, New England Primary Care is entitled to all reasonable attorney fees and/or cost of collection

_____ The undersigned agrees, whether signed as Agent, Guarantor, or Patient, that in consideration of the services to be rendered to the Patient, the patient hereby individually obligates himself to pay the amount of the account to this office in full or other satisfactory financial arrangements must be made prior to time of patient services. Further, the undersigned agrees to pay 15% attorney fees if the account is collected by or through an attorney at law.

* I authorize the release of information necessary to determine liability for payment and to obtain reimbursement of any insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled to New England Primary Care. This assignment will remain in effect until revoked by me in writing. A photocopy of this Assignment is to be considered as valid as an original.

* I fully agree to the Financial Responsibilities and Assignment of Insurance Benefits as stated above.

PLEASE READ THESE TERMS CAREFULLY

_____ _____ _____

Signature Printed Name Date