



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, 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 – Thursday 8:30 a.m. to 6:30 p.m.

We close for lunch 12:30 p.m. to 1:30 p.m.

Friday – Sunday Closed

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.



Last Name: _____ First Name: _____

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

[] I wish to receive information via email about New England Primary Care and its affiliates.

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

Home Phone: _____ Cell Phone _____

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	TIMES 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
<input type="checkbox"/> Aneurysm		<input type="checkbox"/> Depression		<input type="checkbox"/> Mental Illness	
<input type="checkbox"/> Anxiety Disorder		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Genetic Screening		<input type="checkbox"/> Ovarian Cancer	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Glaucoma		<input type="checkbox"/> Parkinsonism	
<input type="checkbox"/> Autoimmune Disease		<input type="checkbox"/> Heart Attack		<input type="checkbox"/> Prostate Cancer	
<input type="checkbox"/> Birth Defects		<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Breast Cancer		<input type="checkbox"/> Hyperlipidemia		<input type="checkbox"/> Substance Abuse	
<input type="checkbox"/> Celiac Disease		<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Sudden Death	
<input type="checkbox"/> Colon Cancer		<input type="checkbox"/> Kidney Disease		<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> COPD		<input type="checkbox"/> Learning Disabilities		<input type="checkbox"/> Transient Ischemic Attack	
<input type="checkbox"/> Crohn's Disease		<input type="checkbox"/> Lung Cancer		<input type="checkbox"/> Ulcerative Colitis	
<input type="checkbox"/> Dementia		<input type="checkbox"/> 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 _____

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.

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

Any additional medical history:

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

Any additional surgical history:



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:

<p>I authorize New England Primary Care to: RELEASE my PHI <i>to:</i> Name of Person or Agency: _____ _____ Address: _____ _____ Phone: _____</p>	<p>I authorize New England Primary Care to: OBTAIN my PHI <i>from:</i> Name of Person or Agency: _____ _____ Address: _____ _____ Phone: _____</p>								
<p>Dates of Treatment Covered by this Release: <input type="checkbox"/> All prior dates of service/treatment, through discharge from present date of service/treatment <input type="checkbox"/> Limited to the following date(s): _____</p>	<p>Please Send Requested Information To: <input type="checkbox"/> New England Primary Care 55 Hazard Avenue, Enfield, CT 06082 Fax: 860-744-2220</p>								
<p>Information to be Released/Obtained</p> <table border="0"> <tr> <td><input type="checkbox"/> All Records</td> <td><input type="checkbox"/> Progress Notes</td> </tr> <tr> <td><input type="checkbox"/> History/Physical</td> <td><input type="checkbox"/> Medication Reports</td> </tr> <tr> <td><input type="checkbox"/> Radiology Reports</td> <td><input type="checkbox"/> Consults Reports</td> </tr> <tr> <td><input type="checkbox"/> Lab Reports</td> <td><input type="checkbox"/> Discharge Summaries</td> </tr> </table> <p>Include: (Indicate by initialing) _____ Alcohol/Drug Treatment _____ HIV Related Information _____ Mental Health Information</p>	<input type="checkbox"/> All Records	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> History/Physical	<input type="checkbox"/> Medication Reports	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Consults Reports	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Discharge Summaries	<p>Expiration</p> <p><input type="checkbox"/> I do not want this authorization to expire. <input type="checkbox"/> This authorization will expire on: _____</p>
<input type="checkbox"/> All Records	<input type="checkbox"/> Progress Notes								
<input type="checkbox"/> History/Physical	<input type="checkbox"/> Medication Reports								
<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Consults Reports								
<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Discharge Summaries								

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: _____



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



55 Hazard Avenue
Enfield, CT 06082
P: 860-744-2244
F: 860-744-2220

Notice to all patients:

When a new baby enters the world at Johnson Memorial your provider may need to leave the office to care for the little one.

This can happen with very little notice to reschedule the day's appointments. We will do everything in our power to accommodate your needs.

Your insurance will not be charge for the initial appointment.

If you have any questions, you may give me a call at 860-744-2244.

Thank you for your patience and understanding.

Cynthia Gilbert-Wilhelmsen
Office Manager
Medical Assistant

Patient's Name

Date

Patient's Signature

Parent/Guardian's Signature if patient is a minor

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.

_____ Collections Policy: I understand that mailed monthly bills are due at the time of receipt. Any bill not paid over 90 days from the original due date may be turned over to a collection agency, unless other arrangements have been made. If my account becomes assigned to a collection agency, I agree to pay all cost of collection, including a collection fee equal to 15% of the outstanding balance, court costs and attorney fees.

* 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