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.

Patient Registration Form

Today's Date: _______________

PATIENT INFORMATION

Name: ____

Date of Birth: _________________________ Sex: ___M ___F

Home Address: ____

City: __________________________ State ________ Zip: ________

Sibling Names and Ages (ex: Jack, 9): _________________________

____

PARENT/GUARDIAN INFORMATION

Primary Family Email: _______________________________________

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

Primary Family Phone: ______________________________________

Parent Name: ___________________________ Date of Birth: ________

Mobile Phone: __________________ Work Phone: _________________

Home Address (if different from child): ____________________________

City: ____________________________ State: ________ Zip: _________

Employer: ____

Parent Name: ___________________________ Date of Birth: _________

Mobile Phone: __________________ Work Phone: _________________

Home Address (if different from child): ____________________________

City: ____________________________ State: ________ Zip: _________

Employer: ____

Alternate Contact (relative or friend): ___________________________

Alternate Contact Phone: (_____)______________________________

Relationship to patient: _______________________________________

Form Completed By:

_______________________________ _______________________________ _______________

Name (print) Signature Date

We are required to collect the following information for each patient.

Please complete this section before returning the form.

Thank you.
Francine York, DNP, APRN, FNP-BC

Your preferred language:

____

Your child's race/ethnicity (select one primary)

___ American Indian
___ Asian
___ Black/African American
___ Caucasian
___ Hispanic
___Multiracial
___Unknown
___ Other _______________
___ Decline to answer

****Return this form to the Front Desk before leaving the office. Thank you****

Patient History (ages 6 mos+)

Today's Date: ____________________

PATIENT NAME: ______________________________ DATE OF BIRTH: _____________ SEX: __M __F

HOME & SCHOOL

Who lives at home? ____

If age appropriate, does your child attend:

Daycare Preschool Elementary School or Higher None of the above

Name of School/Preschool/Daycare: ____

If none, who cares for your child/children during the day? ____

ILLNESSES

Have there been any hospitalizations? Y N

Have there been any major medical problems? Y N

Any childhood illnesses? (ex: chicken pox, measles, etc.) Y N

Fracture or other injury? Y N

If yes, please describe: ____

____

GENERAL HEALTH

Medications: ____

Allergies: ____

Special Dietary Needs: ____

REVIEW OF SYSTEMS

Has she/he had frequent problems with any of the following (please check and/or write in all that apply):

Head Headaches, dizziness, injury, other: ____

Eyes Vision problems, infection, pain, other: ____

Ears Hearing problems, infections, pain, other: ____

Nose Frequent stuffiness, easy bleeding, other: ____

Mouth Tooth decay, poor bite, other: ____

Throat Frequent sore throat, trouble swallowing, other: __________________________________

Neck Stiffness, swelling, swollen glands, other: ____

Chest Deformity, pneumonia, cough, asthma, other: ____________________________________

Heart Chest pain, blue color, shortness of breath, murmur, rheumatic fever, other: _______________

____

Abdomen Vomiting, frequent pain, diarrhea, constipation, other: ____________________________

Urinary Pain on voiding, voiding frequently, bed wetting, other: ____________________________

Skin Rash, infection, other: ____

Neurological Development problems, seizures, meningitis, other: _________________________

Endocrine Weight gain/loss, intolerance to heat/cold, thirst, hair changes (thinning, falling out), other: _________

____

Arms & Legs Deformity, abnormal walking, joint pain, joint swelling, other: _____________________

Hematological Anemia, abnormal bleeding, other: ______________________________________

Permission to Treat

I (We) ____ authorize New England Primary Care and its personnel to deliver medical services to my child/children, listed below.

(please print)

Name: ____ Date of Birth: _______________

Name: ____ Date of Birth: _______________

Name: ____ Date of Birth: _______________

Name: ____ Date of Birth: _______________

Name: ____ Date of Birth: _______________

Name: ____ Date of Birth: _______________

I (We) authorize the following people to bring my child/children in for treatment, and/or to contact in case of emergency.

Name: ___________________________ Phone: ____________________ Relationship: ______________

Name: ___________________________ Phone: ____________________ Relationship: ______________

Name: ___________________________ Phone: ____________________ Relationship: ______________

Name: ___________________________ Phone: ____________________ Relationship: ______________

____ ___________________

Signature(s) of Legal Guardian(s) Date

____ ___________________

Relationship to Patient Primary Phone

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 Reports ❒ Medication ❒ 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:_______________

Patient Name: _______________________________

Patient Date of Birth: _________________________

INSURANCE INFORMATION

Insurance Plan: ____ Effective Date: _______________

Policy Holder Name: __________________________________ Policy Holder Date of Birth: _______________ Sex: __M __F

Relationship to Patient: ____

*****PLEASE NOTE: The insurance policy holder is not automatically the Billing Guarantor.**
The parent/guardian who is present for the office visits is the Billing Guarantor, please see below***

NOTICE OF FINANCIAL RESPONSIBILITY

BILLING GUARANTOR

I understand that payment of all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I hereby grand permission to New England Primary Care to release any pertinent information to my insurance company upon request, and I also authorize payment directly to New England Primary Care.

A photocopy of this authorization shall be considered as effective and valid as the original.

NON-COVERED SERVICES

I am aware that some services performed by New England Primary Care may be considered "non-covered" by my insurance carrier or Medicaid, therefore I will become fully responsible for payment of these services.

DIVORCE/CHILD CUSTODY

New England Primary Care will not honor the specific financial arrangements set forth in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Decree from Judgement, or the like (the "Arrangements"). Since New England Primary Care is not a party to these Arrangements, it is not obligated to the financial terms of these Arrangements.

NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how protected health information will be used and disclosed. I understand that New England Primary Care has the right to change its Notice of Privacy Practices that will be effective for health information the practice already has about my child/children, as well as any they receive in the future. New England Primary Care will post a current copy of the Notice. I understand I may receive a copy of the current Notice upon request.

I have read all of the above and understand/agree to all provisions therein regarding financial responsibility, permission for treatment, and Notice of Privacy Practice.

BILLING GUARANTOR SIGNATURE/CONTACT INFORMATION

____ ____________________ Sex: __M __F

Billing Guarantor Name *(print)* **Date of Birth**

____ _______________

Address/City/State/Zip **Primary Phone**

____ _______________

Billing Guarantor Signature **Today's Date**

Relationship to Patient: Parent Legal Guardian Foster Parent Self Other

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

Patient Name(s): ______________________

____

____

Billing Guidelines

New England Primary Care billing policies and a representative list of items with potential fees and charges are outlined below. This information is to ensure you are better informed at the time of service, and prior to the arrival of a billing statement. Please speak with the office manager if you have any questions regarding this information.

- **Co-Pays**
  It is our policy to collect your insurance co-pay at check-in. This simplifies the office process and ensures the financial obligation is met at the time of service.

- **Co-Insurance/Deductibles**
  Every effort is made to fairly estimate the co-insurance or deductible owed based on the nature of the visit. It is our policy to collect these payments at the time of service.

- **Billing**
  As a courtesy, New England Primary Care bills your health insurance provider on your behalf, with the following guidelines/exceptions:
  - **Insurance Card:** It is critical that the most current insurance card is brought to every appointment. We must have the correct information at the time of service. An insurance card is similar to a credit card – the information must be current and valid in order for it to be used.
  - **Auto Insurance**: We do not bill auto insurance for visits and medical care related to an auto accident. Payment will be required at the time of service, and will provide the paperwork needed for you to submit to the auto insurance provider for reimbursement.
  - **Secondary Insurance**: New England Primary Care only bills TriCare and Medicaid from the secondary insurance government plans.

- **Combined Visits**
  If you are scheduled for a well child exam, and other health concerns are brought up that would typically require a sick visit, your insurance company may consider these as two separate visits and bill your co-pay and other charges accordingly.

- **Evening/Weekend/Holiday Surcharge**
  Some health insurance providers bill a surcharge if you see your pediatrician after normal business hours, on the weekend or on a holiday.

- **Administrative Fees**
  New England Primary Care charge various fees for the following items, which require personnel and resources to address:
  - **Copies** of Medical Records
  - **Completion** of additional school physical forms, e.g. blue/yellow forms (1st set free at visit)
  - **Special request completion** of camp or sports physical forms (free during visit)
  - **Special request** physician letters
  - **Completion** of FMLA paperwork
  - **Return check** (for insufficient funds)
  - **"No show" Fee**: Assessed if you do not show up for a scheduled appointment.

_____________________________________ _____________________________________ ______________

Parent/Guardian Name (print) Signature Date

Photography Release/Consent Form

Here at NEPC, we make every effort possible to make our patients feel special. We like to put our patients on “display” by clipping newspaper articles involving our patients; as well as, pictures from any drawings or prize winnings and posting them in the office, on our Facebook page, website, or Instagram. Please check one of the following boxes and sign below.

I AGREE and hereby grant full permission to NEPC, Fran York APRN, its staff and affiliates to use either myself or my child/children’s name(s) and photograph in any publication or advertising materials (printed or electronic). This consent also serves to waive all right of privacy or compensation, which I may have in connection with the use of my photograph and/or my child’s photograph and/or name. No photos will be used is a matter that would exploit or cause malicious representation.

Be sure to follow our social media sites to see your child’s smile!

http://newenglandprimarycare.com/

http://www.facebook.com/neprimary/

I DO NOT AGREE to have mine or my child’s information or photograph used for public viewing.

____

Child/Children’s Full Name (s)

____

Legal Guardian’s Name (Print) Relationship to Child/Children

____

Signature Date

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