BILLERICA MEDICAL

Internal Medicine- Functional Medicine- Women's Health

PERMISSION TO RELEASE MEDICAL INFORMATION

I give permission for Billerica Medical to relase my medical information to the following people: (Example-spouse or relative)

Name	Relationship To You	Phone Number
_____	_____	_____
_____	_____	_____

I give permission for Billerica Medical to call me at home:

(Check one) Yes _____ No _____ Phone _____

I give permission for Billerica Medical to leave messages on my home answering machine:

(Check one) Yes _____ No _____

I give permission for Billerica Medical to call me at work:

(Check one) Yes _____ No _____ Phone _____

I give permission for Billerica Medical to leave messages on my work answering machine:

(Check one) Yes _____ No _____ Phone _____

I give permission for Billerica Medical to contact me by email:

(Check one) Yes _____ No _____ Email _____

I give permission for Billerica Medical to send messages about my medical condition by email:

(Check one) Yes _____ No _____

_____	_____	_____
Signature	Print Name	Date

199 Boston Road
North Billerica, MA 01862
Ph# 978-670-1300 www.BILLERICAMEDICAL.com Fax# 978-528-2024

BILLERICA MEDICAL HEALTH CENTER

Internal Medicine- Functional Medicine- Women's Health

NAME: (First) _____(MI)_____(Last)_____DOB:_____

ADDRESS:_____ (city,state,zip)_____

PHONE:(HOME)_____(Cell)_____(Work)_____

EMAIL ADDRESS:_____

SOCIAL SECURITY NUMBER: _____ - _____ - _____

MARITAL STATUS: (circle one) Married - Single - Divorced - Widowed

RACE: Black- Hispanic- Native American- Asian- White- Other_____

LANGUAGE:_____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____ PHONE#_____

EMPLOYMENT INFORMATION:

EMPLOYER NAME:_____ PHONE #:_____

ADDRESS:_____(city,state,zip)_____

PRIMARY INSURANCE: _____

SUBSCRIBER NAME:_____

RELATIONSHIP TO PATIENT:_____ POLICY#:_____

GROUP#:_____ SECONDARY INSURANCE:_____

SUBSCRIBER NAME:_____SUBCRIBER (DOB):_____

RELATIONSHIPT TO PATIENT: _____ POLICY#:_____

PHARMACY NAME AND LOCATION:_____

I authorize the release of any medical or other information necessary to process claim. I authorize insurance payment to be made directly to Billerica Medical. I understand that I am personally responsible for all deductibles and charges denied by my insurance. Any lab or incidental charges at this or future visits will be my responsibility. FAILURE TO PROVIDE A 24-HOUR NOTICE OF CANCELLATION O YOUR APPOINTMENT WILL RESULTS IN A $75 FEE.

I have received a copy of the patient privacy rights as outlined by HIPAA.

Signature of Patient: _____ Date:_____

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Authorization to Release Health Information To Billerica Medical

Patient Name: _____ Date of Birth: _____

Address: _____

_____

I authorize: _____

_____

_____

To release the following information to: *Billerica Medical*
199 Boston Road
Billerica, Ma 01862

_____ Complete medical records, or
Clinical summary _____ Test results _____
Consults from others _____ Oth(specify) _____

I authorize release of documents that may contain information about:

Alcohol or drug abuse	_____	Blood alcohol test results	_____
Mental Health information	_____	Sexual assault	_____
Venereal disease	_____	Domestic violence	_____
HIV or Aids	_____	Genetic testing	_____
Illegitimate birth, abnormal births fetal deaths	_____		

This authorization will remain in effect for 1 year after the signature date. I understand that I may revoke this authorization at any time by providing this office with a written and signed statement to that effect.

Signature:_____ Date: _____

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APPOINTMENT CANCELLATIONS

When we set aside time for you, we turn away other patients that wish to see the doctor. This means that both you and the other patient(s) are delayed in receiving care. Likewise the doctor wastes their time when a patient doesn't come in for their appointment. A missed appointment is an incovenience for everyone!

As a courtesy to our patients, reminder calls are made one to two business day prior to the scheduled appointment. However, it is your responsibility to remember and make appropiate arrangements to keep your appointment. If for any reason you cannot keep/make your appointment please call the office at least the day before.

Missed appointments are a serious concern. Our policy is that any patient who fails to notify us of a cancellation will be charged a fee of $75.00. Further, patients that with less than prior day's notice on more than three occasions will be dismissed from the practice.

I have read, understood and agreed to the policies described above.

Name:_____

Signature:_____ Date:_____

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INSURANCE COVERAGE INFORMATION

Services provided to you today may or may not be covered by your insurance carrier. It is the patient's responsibility to be aware of what their insurance carrier will and will not cover.

Some insurance carriers will not cover services for the following:

Physicals
School Physicals
Immunizations
Travel Immunizations
Counseling
Contraceptive Management

I understand that I am personally responsible for all deductibles and any charges denied by my insurance carrier. I will pay my patient balance within 30 days of receipt of my statement from Joshi Medical Services, P.C. unless arragement are made with the billing office.

I authorize the release of any medical or other information necessary to process this claim

I have read the above information agree to these policies.

Signature:_____ Date:_____

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Welcome to Billerica Medical

We are a primary care office dedicated to the highest quality of care for adult patient. There are two providers in the office. Dr.Ashok Joshi and NP Sweta Chotrani.

WE ARE HERE TO SERVE YOU. Our entire staff is here to serve and meet our patient's needs. In order to minimize human errors and provide better communication with other providers, we utilize the latest technology with electronic medical records.

OFFICE HOURS: The office is open from Mondays and Tuesdays, 8am-6pm Wednesdays and Thursdays 8am-5pm and Fridays, 7:45am-3pm.

SAME DAY SICK APPONTMENTS: We will make every attempt to see an acutely ill patient on the same day that they call as quickly as we can; however, we cannot guarantee a specific provider.

CANCELLATION POLICY: Please be aware there is a $75.00 cancellation fee for appointments cancelled within 24 hours, since last minute cancellations do unfortunately take up availability for patients that medically need them.

IF YOU NEED MEDICATION REFILLS OR REFERRALS: We ask if you simply need a refill on a medication that is not a controlled substance to call your pharmacy directly with the request and the pharmacist will then electronically send our office the information for approval. Please assure accurate prescription information is given. We try to address patient concerns immediately; however, some may take more time than others. Our office policy for referrals and prescriptions is to be completed within 24-48 hours. (Please note some referrals may take longer to schedule depending on Insurance and Specialist requested). This gives us time to complete these tasks in the event that any Prior Authorizations may be needed, emergencies or computer problems may occur.

We are happy that you have chosen our office for your primary health care needs. Please let us know if you have any questions or concerns regarding your care. We will always address every issue, and maintain a happy and professional office environment. Thank you, and stay healthy!

I have read, understood and agreed to the policies described above.

_____ _____

Signature Date

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