C.B.C. Medical &Walk-In Center
16 Pine Street Unit 5
Lowell, MA 01851
(978) 454-9703

PERMISSION TO RELEASE MEDICAL INFORMATION

I give permission for CBC Medical & Walk-In Center to release my medical information to the following people: (Example-spouse)

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

I give permission to call me at home:
(Check one) Yes _____ No _____ Phone _____

I give permission for CBC Medical & Walk-In Center to leave messages on my home answering machine:
(Check one) Yes _____ No _____

I give permission for CBC Medical & Walk-In Center to call me at work:
(Check one) Yes _____ No _____ Phone _____

I give permission for CBC Medical & Walk-In Center to leave messages on my work answering machine:
(Check one) Yes _____ No _____ Phone _____

I give permission for CBC Medical & Walk-In Center to contact me by email:
(Check one) Yes. _____ No _____ Email _____

I give permission for CBC Medical & Walk-In Center to send messages about my medical condition by email:
(Check one) Yes _____ No _____

_____ _____ _____
Signature Print Name Date

CBC Medical and Walk In Center
Registration Form

NAME: (First)_____(MI)_____(Last)_____ Birth Date: _____

ADDRESS:_____ (city, state, zip)_____

PHONE:(Home)_____ (Cell) _____ (Work)_____

EMAIL ADRESS:_____

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 _____
SUBSCRIBER DOB_____
RELATIONSHIP TO PATIENT _____
POLICY # _____
GROUP # _____

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 CBC Medical Center and Walk-in Center. 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 OF YOUR APPOINTMENT WILL RESULT IN A $75 FEE**

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

Signature of Patient:_____ Date:_____

CBC MEDICAL & WALK IN CENTER
16 PINE STREET UNIT 5
LOWELL, MA 01851
PH (978) 454-9703 FAX (978) 937-7978

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 arrangements 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

_____

Print Patient Name

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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 inconvenience for everyone!

As a courtesy to our patients, reminder calls are made one to two business days prior to the scheduled appointment. However, it is your responsibility to remember and make appropriate 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 cancel 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: _____
(Please print)

Signature: _____ Date: _____

9/21/06