

Care New England Medical Group  
Primary Care

1405 South County Trail | Suite 510  
East Greenwich, RI 02818  
(401) 736-4570 | (401) 921-6931 fax

Welcome to Care New England Medical Group Primary Care, a Patient Centered Medical Home. We are dedicated to providing you with convenient, compassionate, and comprehensive health care. In order to coordinate your health needs, please note:

- We see patients on Monday through Friday, 8:30 AM to 5:00 PM with the exception of our extended evening hours once a week till 7:00pm. Phones are answered Monday through Friday from 8:30 AM to 5:00 PM.
- We will make every attempt to answer your questions and report important test results as quickly as possible. We aim to provide you with the information and tools to help you best manage your health, including patient education and resources that will be beneficial.
- If you are ill please call us to arrange an office visit. Typically we will find an appointment for you that day or within 24 hours. If your regular physician is not available, you will be offered an appointment with another physician in the practice.
- An answering service takes your calls when the office is closed. A doctor is available 24 hours a day who will be contacted by the answering service if you need them. If you are not called back within 30 minutes, please call again and request a second page. Any life threatening issues should be called directly to 911.
- If you are unable to keep your appointment, please call our office as soon as possible so that the schedule can be changed. If you are more than 15 minutes late for your appointment, we may need to reschedule your appointment. If you miss 3 or more appointments without canceling (or rescheduling with less than 24 hours notice) we reserve the right to ask you to find another primary care provider.
- Rarely a scheduled appointment may need to be changed. In that event, we will make every effort to contact you as soon as possible to reschedule your visit to a convenient time.
- Please bring all of your insurance information with you to each visit. If you have questions about your insurance, please contact your insurance provider.
- All of your medical information and the details of your office visits are confidential and will not be shared with anyone without your consent.
- For your safety, no controlled substance will be prescribed on weekends, holidays, or after hours.
- If you are hospitalized, Care New England Medical Group Primary Care will help coordinate your medical care at Kent Hospital. We make every effort to communicate with other specialists involved in your care. If you have been hospitalized, please make sure to schedule a follow up visit when you get home. We also want to see you in the office after emergency room visits. If you see a specialist, please make them aware that we are your primary care physician and ask them to send us any results or tests.
- Copayments are expected at the time of your visit. We accept cash, checks, Visa, and Mastercard.
- Any verbal or physical abuse of the staff will be not be tolerated and will lead to dismissal from the practice.
- **If you do not show for your appointment you will be charged a \$30.00 fee.**

We look forward to seeing you in our office. Please let us know what we can do for you to make your visits here pleasant and efficient. Thank you!

Welcome, the Physicians and Staff

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First Name		M.I.	Last Name	
Address		City	State	Zip
Home Phone	Work Phone	Cell #	SS#	
Birth Date	Sex M F	E-Mail Address	Marital Status (circle one) S M W D Sep	Employer Status FT/PT
If Minor, Name of Parent or Guardian		Referred By	Preferred Language (if other than English)	
Race: (circle one) White Black/African American Asian American Indian Other Unknown			Ethnicity: Hispanic Non-Hispanic Hispanic Unknown	
<b>Insurance Information (Please bring insurance card(s) with you to your appointment)</b>				
<b>Primary Insurance Company</b>		ID#	Group #	
Address	City	State/Zip	Subscriber's Name	
<b>Secondary Insurance Company</b>		ID#	Group#	
Address	City	State/Zip	Subscriber's Name	
<b>Subscriber Information (if other than patient) – Must have SSN and DOB of subscriber</b>				
Name/ First	M.I.	Last		
Address	City	State	Zip	
Home Phone	Work Phone	Cell Phone		
Relationship to Patient	SS#	DOB		

**Pharmacy Information**

Name			
Address	City	State	Zip
Phone			

**Previous Medical Provider**

Name/ First	Last		
Address	City	State	Zip
Phone			

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**ACKNOWLEDGMENT OF DELIVERY**

**NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received a copy of Care New England Medical Group "Notice of Privacy Practices". I understand that this document describes how my medical information may be used and disclosed and how I can obtain access to the information.

\_\_\_\_\_  
PATIENT NAME (Please Print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS SIGNATURE

\_\_\_\_\_  
DATE

Patient unable to accept or understand the Care New England Medical Group "Notice of Privacy Practices" at this time.

Patient's Representative (Print Name): \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Patient Representatives' Signature: \_\_\_\_\_

\_\_\_\_\_ No patient representative available

\_\_\_\_\_ Patient refuses "Notice of Privacy Practices"

\_\_\_\_\_  
WITNESS SIGNATURE

\_\_\_\_\_  
DATE

I GIVE THE FOLLOWING INDIVIDUALS PERMISSION TO RECEIVE ANY AND ALL INFORMATION FROM MY ELECTRONIC MEDICAL RECORDS. THIS AUTHORIZATION SHALL INCLUDE CORRESPONDENCE BY TELEPHONE CONVERSATION, PRINTED RECORD, AND IN PERSON WITH THE STAFF AND/OR PROVIDERS AT CARE NEW ENGLAND MEDICAL GROUP.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relation

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relation

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

# Care New England Medical Group

## Primary Care

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### Patient Authorization Record

Patient Name: _____	Medical Record # _____
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#### CONSENT TO TREATMENT:

I understand that my care will be provided according to my attending physician's orders. I understand that when I request care for my medical condition, I am generally consenting to other medical treatments such as x-ray examination, laboratory tests and minor procedures that my physician may order.

#### AUTHORIZATION FOR RELEASE OF INFORMATION TO PAYERS AND/OR CAREGIVERS:

I authorize Care New England Medical Group Primary Care, and any physician providing care to me, to release to any person/corporation who is or may be responsible for payment of the Physician charges.

I authorize caregivers access to my prior Care New England Medical Group Primary Care medical records which may include treatment for alcohol, drug abuse, mental illness and HIV Testing.

I understand that Care New England Medical Group Primary Care will forward copies of all or part of my medical record to physicians participating in my care, to any facility to which I am transferred, and to my insurer or to whomever is responsible for paying for my healthcare.

If my care is related to an accident at work, I understand that my employer's Worker's Compensation carrier will also have access to information contained in my medical record. Such information to be released may include, but not be limited to, diagnosis information relating to treatment of a mental illness, alcohol and/or drug abuse.

#### ASSIGNMENT OF BENEFITS:

I authorize my insurers to pay my benefits, which would otherwise be payable to me, directly to Care New England Medical Group Primary Care and to all the physicians providing professional services to me. I understand that I am financially responsible to Care New England Medical Group Primary Care for charges not covered by insurance carriers.

#### MEDICARE RECIPIENTS ONLY:

I certify that the information given by me in applying for payment of medical benefits under Title XVIII of the Social Security Act is correct.

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Healthcare Financing Administration, or it's intermediaries or carriers, any information needed for this or related Medicare claims.

I request the payment of authorized benefits to be made on my behalf to Care New England Medical Group Primary Care or any physician providing service during my treatment.

I understand that I can request a copy of the itemized bill for services rendered to me by contacting the Care New England Medical Group Primary Care.

Important message acknowledgement given to:  Patient  Representative \_\_\_\_\_  
 Patient unable to accept or understand at this time (No representative available).

SIGNATURE: I have read the information above or have had it read to me. I understand the information and have had my questions answered to my satisfaction. My signature below verifies that I have voluntarily consented to the above. I have crossed out those statements that **I DO NOT AGREE** with by drawing a single line through it, placing my initials and today's date next to the statement.

Signature of Patient \_\_\_\_\_ Date/Time \_\_\_\_\_

Signature of Authorized Representative \_\_\_\_\_ Date/Time \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Reason \_\_\_\_\_

Required if patient is a minor or is unable to consent.

Signature of Witness \_\_\_\_\_

Signature of second witness \_\_\_\_\_