THE DOCTORS TREATMENT CENTER

PATIENT INFORMATION

Name: _____ Date: _____
Last First MI

DOB: ___/___/___ SSN: ___-___-___ Age: _____ Sex: (Circle) M F

Address: _____
Street Apt# City State Zip

Home: (___)_____ Cell: (___)_____ Work: (___)_____
☐ Yes, messages allowed ☐ Yes, messages allowed ☐ Yes, messages allowed

Which would you prefer we call: (Circle) Home Cell Work Email: _____

Employer: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

If you would like to authorize us to release information regarding your medical care and/or test results to someone in addition to yourself (Spouse, parent, etc) please list name below; if not please check the other box below:

☐ The following is authorized: _____
Name

☐ Please do not disclose information to anyone else.

Emergency Contact Name: _____ Phone: _____ Relationship: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____

Subscriber ID: _____ Group #: _____

Are you the primary holder of this insurance? (Circle) Yes No
If no, please complete the policy holder information below.

SECONDARY INSURANCE INFORMATION

Insurance Company: _____

Subscriber ID: _____ Group #: _____

Are you the primary holder of this insurance? (Circle) Yes No
If no, please complete the policy holder information below.

INSURANCE POLICY HOLDER (IF DIFFERENT FROM PATIENT)

Print name as it appears on your insurance card:

Name: _____ DOB: _____
Last First MI

Address: _____
Street Apt# City State Zip

Contact Number: (___)_____ Relationship to Patient: _____

I have read all of the above information and have completed it to the best of my knowledge. I will notify you of any changes in my health status or demographic information. I hereby authorize you to furnish information to insurance carriers regarding my medical status. I understand that I am responsible for any amount not covered by my insurance.

_____ _____
Signature of Patient/Guardian Date

THE DOCTORS TREATMENT CENTER of Plainville

HEALTH QUESTIONNAIRE

Name: _____ DOB: ____/____/____ Date: ___/___/___

Gender (Circle): M F For females, Circle if applicable: Pregnant Breastfeeding

Reason for visit today? _____ When did this start? _____

List all your current medications, including non-prescription drugs: _____

_____

☐ Check here if no meds
(If you have a medication list please provide it to the receptionist so we may scan it to your chart).

MEDICATION ALLERGIES: _____
☐ Check here if no known allergies

PAST MEDICAL HISTORY (Check all that apply and specify). If none apply check here ___

__ Allergies _____
__ Anxiety
__ Asthma
__ Arthritis
__ Cancer (Type) _____
__ Depression
__ Diabetes (Type) _____
__ Emphysema/COPD
__ Epilepsy/ Seizure Disorder
__ Headaches
__ Heart Disease _____
__ High Blood Pressure
__ High Cholesterol
__ Kidney Disease
__ Liver Disease
__ Stroke
__ Thyroid Disease
__ Other (specify):
_____

HOSPITALIZATION & SURGERY (Check all that apply & write in date below). If none, check here ___

__ Appendix _____
__ Adenoids _____
__ Back _____
__ Breast _____
__ Heart Surgery _____
__ Hernia _____
__ Hysterectomy _____
__ Tonsillectomy _____
__ Tubal Ligation _____
__ Vasectomy _____
__ C-Section _____
__ Other (specify) _____
_____

FAMILY HISTORY (Check all that apply and specify family member). If none, check here ___

__ Asthma _____
__ Cancer (type)_____
__ Dementia/Alzheimers _____
__ Depression _____
__ Diabetes (Type) _____
__ Heart Disease _____
__ High Blood Pressure _____
__ High Cholesterol _____
__ Stroke _____
__ Thyroid Disease _____
__ C-Section _____
__ Other _____

SOCIAL HISTORY

MARITAL STATUS: __ Single __ Married __ Divorced __ Widowed
Do you smoke? __ No __ Yes If yes, _____ packs/day
Do you drink alcoholic beverages? __ No __ Yes

For the MINOR patient:
Child lives with: __Parents
__ Grandparents
__ Other: _____

Do you use any recreational drugs or medications not prescribed to you? __ No __ Yes, _____

Primary Care Provider: _____ Pharmacy: _____

I have read the above information and consent that it is correct to the best of my knowledge. I authorize The Doctors Treatment Center and its healthcare providers to render the necessary treatment for my condition.

_____ _____
Signature of Patient/Guardian Date

NOTICE OF PRIVACY POLICIES

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. There are certain circumstances that require us to use or disclose your health information. Some of these circumstances are: to public health authorities, lawsuits, law enforcement officials, federal officials, correctional institutions, military officials (for members of the military only), Workers Compensation Health Insurance programs.

You have rights regarding your health care information. These rights include but are not limited to: communication regarding your healthcare, inspection of any health information or medical records (including billing records but not including psychotherapy notes), requesting amendments to health information, filing complaints against privacy, written consent and authorization to disclose any health or personal information to certain individuals. If you have any questions regarding this notice or our health information privacy policies please contact a member of our staff.
* A full copy of our privacy policy is provided upon request.

I have read and understand the copy of Privacy Policies Provided on this clipboard.

Signed: _____ **Date:** _____

HIPAA

The Doctors Treatment Center upholds the standards of the HIPAA laws. As a patient, we want you to know:

- We respect the privacy of your personal medical records and will do all we can to secure and protect that privacy.
- When it is appropriate and necessary, we provide the minimum necessary information to only those individuals required by law or who feel are in need of your health care information and information about treatment, payment or health care operations in order to provide health care that is in your best interest.
- You may refuse consent to use or disclose your personal health information, but this must be in writing.
- You have the right and we agree to provide you with access to your medical records in accordance with State and Federal laws.

* All full copy of our HIPAA policy is provided upon request.
I have read and understand the copy of HIPAA Policies provided on this clipboard.

Signed: _____ **Date:** _____

*If you have any questions regarding this content, please speak with a member of our staff.

Name (Please Print): _____ **DOB:** ___/___/___ **Date:** ___/___/____

THE DOCTORS TREATMENT CENTER of Plainville

240 East Street
Plainville, CT 06062
Ph: (860) 747-4541 Fax: (860) 793-1218

PAYMENT POLICY

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we participate in, payment in full is expected at each visit. If you are insured by a plan we participate in but do not have a current insurance card, payment in full for each visit is required until we can verify your coverage. When insurance is involved, we can file claims on your behalf in most cases. At times however, a portion of care is paid by the patient based on your specific plan. We will bill the responsible party for those services clearly outlined by the insurance plan that are the patient's responsibility. Knowing your insurance benefits is your right and responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. Co-Payments. All co-payments must be paid at the time of service. This arrangement is part of our contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. Non-Covered Services. Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full whether at the time of your visit or hereafter.
4. Proof of Insurance. All patients must complete our patient information forms before seeing the provider. We must obtain a copy of your photo ID and a valid current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of your claim.
5. Claims Submission. We will submit your claims and assist you in any reasonable way to help get your claims paid. You insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. The amount owed to the office as outlined in your insurance contract is your responsibility.
6. Coverage Changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
7. Financial Policy. We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and understanding of our payment policy. Co-payments and fees that you are responsible for are due in full at time of service. Should the account become delinquent, your account may be referred to a collections agency and you will be responsible for those fees. If your account is delinquent, you may be asked to seek treatment elsewhere until your account is paid. Acceptable forms of payment are cash, check (only established patients), Visa, MasterCard, Discover, American Express, and ApplePay.

By signing below you agree that you have read and understand the above information and will comply with these policies.

Signature of Patient or Representative **Date**