

PATIENT REGISTRATION FORM

PATIENT NAME: _____ DATE: _____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
TELEPHONE: _____ SEX: M F DATE OF BIRTH _____
SSN: _____ WORK PHONE NO: _____
PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____
EMERGENCY CONTACT NAME AND PHONE NO.: _____
PREFERED PHARMACY: _____

INSURANCE INFORMATION

1) PRIMARY HEALTH INSURANCE PLAN NAME: _____
INSURANCE ID#: _____ GROUP ID#: _____
SUBSCRIBER'S NAME (if different than patient) _____
SUBSCRIBER'S SS# _____ DOB: _____
2) SECONDARY INSURANCE PLAN NAME: _____
INSURANCE ID#: _____ GROUP ID#: _____
SUBSCRIBER'S NAME (if different than patient) _____
SUBSCRIBER'S SS# _____ DOB: _____

This section only needs to be filled out if patient is under the age of 18.

MOTHER'S NAME: _____ FATHER'S NAME: _____
STREET ADDRESS: _____ STREET ADDRESS: _____
City, State, ZIP: _____ City, State, ZIP: _____
SS#: _____ DOB: _____ SS#: _____ DOB: _____

MAINE RECOVERY CENTER FINANCIAL POLICY

It is our office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you, as checked and initial it.

_____ **Patient with Insurance:** You are responsible for deductibles, copays, noncovered services, coinsurance, and items considered “not medically necessary” by your insurance company. Co-payment amounts will be collected at the time services are rendered. The remaining balance should be paid within 30 days of receipt of statement. If payment cannot be made at each visit, notify the front desk staff prior to visit to meet with our billing specialist.

_____ **Patient without Insurance (Private Pay):** Please make payment for your care at each patient visit upon checking in. If payment cannot be made at each visit, notify the front desk prior to visit to meet with our billing specialist.

_____ **Medicare:** Our office will submit your Medicare charges to Medicare and your secondary insurance, if applicable. You are responsible for deductibles, copays and any noncovered services.

_____ **Patient without proof of Insurance:** If you do not have evidence of health insurance at the time of visit, cash payment will be required at the time of visit. If we then receive the appropriate insurance/claim information and obtain payment, your cash payment will be refunded promptly.

_____ **Non-participating provider:** We do not participate with _____
If we do not participate with your individual insurance, payment for your care should be made at each patient visit. If payment cannot be made at each visit, notify the front desk staff prior to first visit to meet with our billing specialist.

GUARANTEE OF PAYMENT

Please initial each section on the line provided.

_____ I understand that I am responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities.

NOTE: The guarantor of each account is ultimately responsible for payment in full of the account. Current, accurate information regarding guarantor and insurance coverage must be provided.

_____ I have been advised that if my health insurance carrier/HMO/Medicaid/Medicare plan claims that the services I received today are not considered reasonable and medically necessary for my care, I will be responsible for payment of these services.

_____ I understand that if I am participating in an HMO plan, my primary care physician (PCP) must authorize services that I requested and received today. I have been advised that if I did not notify my PCP in advance for a referral authorization, my HMO plan may deny payment for services and thus, I will become responsible for payment of all services.

_____ I authorize payment of benefits from my insurance carriers directly to Maine Recovery Center. [If I choose not to initial this item, the benefit payments will be paid to me and I will be responsible for paying Maine Recovery Center].

_____ I understand three or more missed or cancelled appointments (with less than a 24 hour notice) in a twelve month period will require a \$75 re-instatement fee before I can make any additional appointments. I also understand this is a one-time privilege. Any repeat offenses will make me subject to dismissal from the practice.

_____ **Minor Patients only:**

The adult accompanying a minor or the parents/guardians are responsible for payment at the time of service.

**PAYMENT IS REQUIRED AT TIME OF SERVICE.
THERE WILL BE A \$25.00 FEE FOR RETURNED CHECKS.
For your convenience, we also accept VISA and MasterCard.**

I have read and understand my financial responsibilities as outlined in both pages of this Maine Recovery Center Financial Policy document.

X _____
Patient's signature

Date

Patient's Printed Name

Printed name of person signing on behalf of patient

Relationship to patient

MAINE RECOVERY CENTER CONSENT FORM / PRIVACY NOTICE
Please initial each section on the line provided.

_____ **Consent for Treatment:**

I consent to diagnostic procedures and medical care as necessary in the judgement of my doctor. I understand that my doctor will explain to me the purpose of, the benefits, and the usual risks and hazards involved in the diagnosis and treatment of any illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

_____ **Medical Release Authorization:**

With my consent, Maine Recovery Center may use and disclose protected health information about me to carry out treatment, payment and healthcare operations as noted below.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

To review the more comprehensive version of this notice or if you have any questions please call the office at (207) 213-4256.

The effective date of this notice is August 2014

Maine Recovery Center is required by law to protect the privacy of patient information and to provide notice to individuals of our privacy practices. We must abide by the terms of this notice. We reserve the right to change this notice. If we make changes to this notice we will provide patients with a revised notice.

Practice Privacy Policy

At Maine Recovery Center your privacy is one of our top priorities. Our doctors and staff are bound to honor and respect the patient information entrusted to us.

We must commit to protecting your privacy by abiding by the policies we have established. This notice outlines how we will use or disclose your protected health information.

Patient Health Care Information Use & Disclosure

Your protected health information will be used to treat you, to work with your insurance company for payment purposes, and to carry out healthcare operations. Healthcare operations may include uses and disclosures necessary to manage our practice and assure quality health care.

Otherwise we will not release your health information to other people, unless you specifically authorize us to do so, in writing. You may revoke this authorization at any time by submitting a request to us in writing.

HealthInfoNet: We participate in HealthInfoNet, the statewide health information exchange (HIE) designated by the State of Maine. The HIE is a secure computer system for health care providers to view and share your important health information to support treatment and continuity of care. For example, if you are admitted to a health care facility not affiliated with ours, health care providers there will be able to see important health information held in our electronic medical record systems.

Your record in the HIE includes medicines (prescriptions), lab and test results, imaging reports, conditions, diagnoses or health problems. To ensure your health information is entered into the correct record, also included are identifiers such as your full name, birth date and social security number. All information contained in the HIE is kept private and used in accordance with applicable state and federal laws and regulations. The information is accessible to participating providers to support treatment and healthcare operations such as mandated disease reporting to the Maine Centers for Disease Control and Prevention.

You do not have to participate in the HIE to receive care. For more information about HealthInfoNet and your choices regarding participation, visit www.hinonet.org or call toll-free 1-866-592-4352.

Otherwise we will not release your health information to other people, unless you specifically authorize us to do so, in writing. You may revoke this authorization at any time by submitting a request to us in writing.

_____ Consent for Contact:

With my consent, Maine Recovery Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others). Such items may also be mailed to my home or other designated location.

_____ Consent for text message and/or email contact:

With my consent, Maine Recovery Center may send lab and appointment reminder messages to my through a text message to my cellular phone or email address.

My cell phone number is: _____ Email: _____

Practice Duties - Regarding your health care information

Maine Recovery Center is required by law to maintain the privacy of protected health information and to provide patients with notice of its legal duties and privacy practices with respect to protected health information.

Maine Recovery Center is required to abide by the terms of the notice in effect. We reserve the right to change these policies and we must inform you of these changes. We will inform you of these changes when you arrive at our practice for treatment.

If you have a concern about how your protected health information has been handled by our practice, the managing partner will review your complaint. You will receive written notification informing you of the action taken in response to your concern.

There will be no retaliation against a patient for filing a complaint. If you feel your complaint is not resolved, you may file a complaint with the Secretary of Health and Human Services.

Patient Rights - Regarding their health care information

The patient has the right to request the practice to restrict use and disclosure of protected health information. Maine Recovery Center is not required to agree to the requested restrictions.

The patient has the right to receive confidential communications of protected health information.

Generally, the patient has the right to inspect and request a copy of their protected health information (additional fees may apply).

The patient has the right to request an amendment to their protected health information in the practice medical record.

The patient has the right to receive a paper copy of this notice.

By signing this notice, I am consenting to Maine Recovery Center use and disclosure of my protected health information to carry out treatment, payment and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Maine Recovery Center may decline to provide treatment to me.

X _____
Patient's signature

Date

Patient's Printed Name

Printed name of person signing on behalf of patient

Relationship to patient

Initial Visit Patient Questionnaire

Name: _____

Date: _____

DOB: _____ Primary Care Provider: _____

Referring Provider: _____

What type of dependence are you seeking treatment for? _____

Please tell us more about your use history.

What substances have you been using?

How much do you normally use? How often do you use?

When was your last use?

What treatment have you had for your current problem? If current treatment, please explain what it is and where you go:

Counseling/Therapy	NA/AA
Inpatient/Outpatient Programs	Psychiatry
Methadone	Suboxone
Other	

Have you seen any other providers, and/or are you currently seeing other providers? If yes, please list and explain: _____

Trauma history: Is there any underlying pain issues or injuries? If yes, please explain: _____

If pain is of concern:

Please circle the **ONE** number on the line below that describes the overall amount of pain you are experiencing today:

no pain -----worst pain imaginable
 0 1 2 3 4 5 6 7 8 9 10

Please circle the **ONE** number on the line below that describes the worst your pain has been in the last month:

no pain -----worst pain imaginable
 0 1 2 3 4 5 6 7 8 9 10

Please circle the **ONE** number on the line below that describes the least your pain has been in the last month:

no pain -----worst pain imaginable
 0 1 2 3 4 5 6 7 8 9 10

Please circle the number on the line below that describes your ability to sleep at night:

didn't sleep-----fell asleep immediately
 a wink 0 1 2 3 4 5 6 7 8 9 10 and slept all night

Check the box that best describes your emotional health (check ONE):

<input type="checkbox"/>	Happy/cheerful	<input type="checkbox"/>	Optimistic	<input type="checkbox"/>	Anxious	<input type="checkbox"/>	Worried
<input type="checkbox"/>	Angry	<input type="checkbox"/>	Depressed	<input type="checkbox"/>	Suicidal	<input type="checkbox"/>	Compulsive
<input type="checkbox"/>	Indifferent	<input type="checkbox"/>	Hopeless	<input type="checkbox"/>	Frustrated	<input type="checkbox"/>	Panicked
<input type="checkbox"/>	Other (please explain):						

Please look at the following Quality of Life Scale and circle ONE number between 0 and 10 that best describes your current level of function.

0	Stay in bed all day; feel hopeless and helpless about life
1	Stay in bed at least half the day; have no contact with outside world
2	Get out of bed but don't get dressed; stay at home all day
3	Get dressed in the morning; minimal activities at home; contact with friends via phone or email
4	Do simple chores around the house; minimal activities outside of home two days a week
5	Struggle but fulfill daily home responsibilities; no outside activity; not able to work/volunteer
6	Work/volunteer limited hours; take part in limited social activities on weekends
7	Work/volunteer for a few hours daily; can be active at least 5 hours a day; can make plans to do simple activities on weekends
8	Work/volunteer for at least 6 hours daily; have energy to make plans for one evening social activity during the week; active on weekends
9	Work/volunteer/be active 8 hours daily; take part in family life; outside social activities limited
10	Go to work/volunteer each day; normal daily activities each day; have a social life outside of work; take an active part in family life

Past Medical History: Please check any conditions you have or have had in the past:

AIDS/HIV positive	Alcoholism	Anemia	Anorexia
Appendicitis	Arthritis	Asthma	Bleeding disorders
Blood clots	Cancer	Diabetes	Drug dependency
Emphysema	Epilepsy/seizures	Glaucoma	Goiter
Osteoporosis	Gout	Heart disease	High cholesterol
High blood pressure	Kidney disease	Liver disease/Hepatitis	Migraines
Prostate problems	Psychiatric care	Acid reflux (GERD)	Stomach ulcers
Stroke	Thyroid problems	Irritable Bowel	Depression

Comments: _____

Past Surgical History: Please list all surgeries you have had and the approximate year:

Medications: Please list all of the medications (with dosages if possible) you are taking. Include over-the-counter medications as well.

Allergies: Are you allergic to any medications/substances? no yes: _____

Social History: Do you smoke or chew tobacco? no yes _____ packs per day for _____ years

Did you ever smoke or chew tobacco? no yes When did you quit? _____

Occupation (current or previous): _____

Are you working: Full-time Part-time Retired Disabled through Social Security, year: _____

Not currently working because of pain

Family History: Have your relatives had any of the following medical problems?

Blood Relative	Arthritis	Migraines	Cancer	Joint Problems	Osteoporosis
Mother					
Father					
Brother/Sister					
Children					
Grandparents					

Review of Systems: Please check any problems you are **now having** or have had **repeatedly** in the last month

Fatigue	Fever	Weight Change	Weakness
Headaches	Dizziness	Head injury	Confusion
Vision changes	Hearing Loss	Ear aches	Sinus trouble
Trouble swallowing	Jaw pain	Chest pain/pressure	Shortness of breath
Rapid heart beat	Irregular heart beat	Calf pain with walking	Swelling of ankles
Blood clots	Chronic cough	Coughing up blood	Wheezing
Poor appetite	Heartburn/Indigestion	Belly pain	Diarrhea
Constipation	Rectal bleeding	Nausea/vomiting	Poor bowel control
Painful urination	Poor bladder control	Difficulty urinating	Rash/Hives
Painful/swollen joints	Back pain	Arm or leg pain	Difficulty walking
Convulsions/seizures	Numbness/tingling	Weakness arms/legs	Difficulty sleeping
Depression	Anxiety	Excess thirst/urination	Easy bruising/bleeding
Other (please describe):			

Comments: _____

What is your goal for today's visit? _____

You authorize the release of office notes to your primary care physician and referring physician by signing here:

 Patient Signature

Reviewed by: _____

Date: _____