MAPLE STREET MEDICAL GROUP

281 Maple Street, East Longmeadow, MA 01028
(413) 525 - 5160

First Name:_____ Last Name:_____ M.I. ___ Date of Birth:____/____/_____

Sex: Female ____ Male ____ Maiden Name: _____ Single__ Married__ Divorced__ Widowed__

Address:_____ City:_____ State: _____ Zip Code: _____

Home Phone: (_____) _____ -_____ Cell Phone: (_____) _____-_____ Work Phone: (_____) _____- _____

Preference? ___ Home ___ Cell May We Leave Messages? YES____NO____ SSN:_____-____-_____

Email Address (for Patient Portal):_____

Language_____ Ethnicity _____ Race_____
Employed ___ Full-Time Student ___ Part-Time Student ___ Retired ___ Unemployed ___ Other: _____

Primary Doctor: _____Address and Phone #: _____
Referring Doctor: _____ Address and Phone #: _____

Your Pharmacy: _____ Address and phone # _____

Spouse / Nearest Relative/Emergency Contact

First Name:_____ Last Name: _____ M.I. ____ Date of Birth:____/____/_____

Sex: Female ____ Male _____ Relationship to you _____ SS#:_____-____-_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone: (_____) _____-_____ Cell Phone: (_____)_____-_____

Primary Insurance

Insurance Company:_____ Person Carrying Insurance:_____
Date of Birth:____/____/_____Relationship:_____ Employer: _____
Employer Address:_____ City: _____ State: _____ Zip Code: _____

Secondary Insurance

Insurance Company:_____ Person Carrying Insurance:_____
Date of Birth:____/____/_____Relationship:_____ Employer: _____
Employer Address:_____ City: _____ State: _____ Zip Code: _____

I hereby authorize the release of medical information concerning my examination and/or treatment, as needed to assign benefits. Also I authorize my insurance carrier to make payment directly to Robert S. Howe, M.D. I understand that I am fully responsible for payment of the balance of charges not paid by my medical insurance for services which I have received, including reasonable collection costs.

Patient Signature:_____ Date: ____/____/_____

How did you hear about us?? _____

Rev. 1/14

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Robert S Howe, MD, FACOG

Summary Notice of Privacy Practices

Our practice is dedicated to maintaining your privacy. In providing care to you, we create records regarding you and our treatment and services. We are required by Federal Privacy Regulations, which were created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to show that we maintain the confidentiality of your health information.

HIPAA gives force to law to several important concepts, which we have always followed. We have never disclosed patient information to any person or party without the patient's request and permission. We have always made charts available to patients: after all, the chart is ours, but it is about you. Thus, HIPAA does not change the care you will receive, nor our respect for your privacy. Our practice complies with HIPAA's regulations; you can ask to see a more detailed Privacy Policy in our office.

Your private electronic medical records are held at a secure, third party location. Our practice will use or disclose your personal information only as necessary to provide quality patient care and in our normal business operations. We will disclose your personal health information, with your consent, to other physicians with whom we may work in caring for you. We will use or disclose your personal information in order to bill and collect payment for the services you receive from us. Our practice will also use or disclose your personal information to contact you and remind you of your appointments.

In order to use or disclose your personal health information for these purposes, we are legally obliged to obtain a signed consent. It is important that you know that you have the right to request a restriction of the use or disclosure of your information to only certain individuals or certain locations. The office can provide you with an authorization form for these restrictions.

CONSENT FOR USE OF PERSONAL HEALTH INFORMATION

I hereby authorize Dr. Robert Howe's Practice to use and/or disclose my personal health information in accordance with their privacy policies to carry out my treatment, payment and health care operations.

I understand that Dr. Robert Howe's Practice has prepared a detailed Privacy Policy and that I have reviewed that policy, and can do so again at any time during normal office hours.

I have the right to request restrictions on how my personal health information if used and/or disclosed and may authorize those changes at any time.

_____ _____

Signature of patient or patient's representative Date

_____ _____

Printed name of patient or patient's representative Relationship to patient