Global Care Medical Group, P.C.

Lowell Tewksbury

Thank you for choosing Global Care Medical Group as your primary care. We are honored that you have chosen us as your health care partner. We are committed to providing you quality healthcare with respect and compassion.

Through our practice's partnership with Merrimack Valley IPA and NEQCA, We have access to and developed relationships with some of the region's most skilled medical specialist in Boston –at Tufts Medical Center and Floating Hospital for Children.

We believe that a patient centered approach will provide best possible health outcomes. In keeping with this approach, you are also responsible for taking an active role in your care.

Our referral process, as your primary care provider, we strive to provide care for most of your medical needs in our office. While we believe in keeping care local and as close to home as possible, we always refer our patients to Tufts Medical Center and Floating Hospital for Children when more complex care is needed the requires travel to Boston. We have a network of trusted community and tertiary specialist we can refer you to, please consult with one of your primary care providers before scheduling with an out of network specialist.

Thank you for your understanding

We are here to answer any questions you may have pertaining to our practice.

Sincerely

Global Care Medical Group, P.C.

Global Care Medical Group, P.C.
Lowell and Tewksbury

History & Physical

Name:_____ Date of Birth: _____
Address: _____ Occupation: _____
Tel. (Home):_____ (Work): _____ (Cell): _____

Former or present illnesses (Please check all that apply):

- ☐ Arthritis or Gout
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Blood Transfusion
- ☐ Lung Disease
- ☐ Asthma, Hay Fever
- ☐ Hives, Eczema
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Allergies (to medicines, food, etc.) _____
- ☐ Anemia
- ☐ Glaucoma
- ☐ Ulcers
- ☐ Diabetes
- ☐ Stroke
- ☐ Headaches
- ☐ Thyroid
- ☐ Venereal Disease
- ☐ Tumor/Cancer
- ☐ Psychiatric
- ☐ Epilepsy
- ☐ Blood
  - _____Legs
  - _____Lungs
- ☐ Other _____

Hospitalizations:

Date	Reason	Hospital

Medicines you are now taking (including all prescription and over-the-counter medications, i.e. aspirin, laxatives, vitamins, etc.):

_____

Date of last (write date in box below):

Chest X-Ray	Cardiogram	TB Test	Tetanus Shot	Unknown

1. Do you smoke? ☐Yes ☐No Have you ever tried to quit smoking? ☐Yes ☐No
2. Did you smoke in the past? ☐Yes ☐No Number of packs smoked per day? _____
3. Do you drink alcohol? ☐Yes ☐No How much?_____ How often? _____
4. Do you use drugs? ☐Yes ☐No How much?_____ How often? _____
5. Do you exercise? ☐Yes ☐No How much?_____ How often? _____
6. Are you married/widowed/divorced? ____ Do you have a partner? ☐Male ☐Female
7. Do you feel safe at home? ☐Yes ☐No Have you been abused sexually, emotionally or physically? _____
8. Gyn History: Onset Age _____ Regular periods? ☐Yes ☐No Menopause Age: _____
9. Number of Pregnancies: _____ Number of Live Births: _____

Blood Relatives with (Please check all that apply):

☐ Diabetes ☐ Epilepsy ☐ TB ☐ Cancer ☐ Anemia ☐ Heart Disease
☐ Ulcer ☐ Mental Illness ☐ Asthma ☐ High Blood Pressure ☐ Stroke
☐ Alcohol Problems

In Case of Emergency, please notify:
Name: _____ Relation: _____ Phone #:_____

Reviewed by: _____ Date: _____

Global Care Medical Group, P.C.

Our Financial Policy

Thank you for choosing us as your Primary Care Provider. We ask that you **carefully** read and sign the following Financial Policy

****We require a copy of <u>All</u> insurance cards and ask that you present them at <u>Each</u> visit****

Participating Insurances

We participate with many insurance companies.
Co-pays are due at time of service.

Non-Participating Insurances and Self Pay

Payment in full is required at the time of service. As a courtesy, we will bill your insurance.

For All Insurances

Please review your benefit listing summary that you received from your insurance company to understand your coverage

Medical Record Copy Fee

There is a fee for medical record copies in certain specified circumstances of flat fee $ 20.00

Payment Methods

Cash, checks, Mastercard, VISA, Discover, and American Express are accepted.

For certain situations, we will accept credit card payment plans.

Non-Copayment plans

If your plan does not require a copay and we participate, you are responsible for any deductible or balance that your plan indicates on the explanation of benefits.

Returned Checks

There is a $15.00 fee on all returned checks.

Choosing Global Care as your PCP

If your plan requires you to pick a Primary Care Physician, it Is your responsibility to ensure that we are listed as your PCP. If we are not, you will be responsible for any incurred charges.

Account Balances and Collection Procedures

You are responsible for timely payment of your account. Global Care Medical Group reserves the right to reschedule or deny a future appointment on delinquent accounts. If sent to collections, you may be required to pay any expense or costs relating to the collection proceeding, including reasonable attorney fees and court costs.

I understand and agree that insurance policies are an agreement between an insurance carrier and myself. I understand that this office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I authorize Global Care Medical Group, P.C., to furnish information to insurance carriers concerning my illness and treatments.

I understand that if I terminate or suspend my care and treatment, any fees including a reasonable fee as allowed by public health law for copying of medical records will be immediately due and payable. I understand that if it becomes necessary to have delinquent balances referred to an attorney or collection agency, I agree to pay any and all attorney/agency fees to collect the outstanding bills.

In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for all services rendered to the patient herein.

_____ _____
Patient Signature Date

_____ _____
Patient Print Name Date

Parent/Guardian Print Name: _____

Parent/Guardian Signature: _____

Print Patient Name if Minor: _____

(revised 08/09/16)

Global Care Medical Group, P.C.
Lowell and Tewksbury Location

Date:_____

Thank you for taking the time to complete this form. Accurate information ensures timely claim submission and helps to avoid billing problems for you and the practice.

Name:_____ Sex M___ F___ DOB:_____

Social Security #:_____ -_____ - _____ Email_____

Race:_____ Ethnicity:_____ Preferred Language:_____

Street Address/apt #_____

City:_____ State:_____ Zip:_____

Preferred phone :_____Can you receive text messages Y/N

Emergency Contact Name:_____ Emergency Contact #:_____

Pharmacy name & phone number:_____

INSURANCE INFORMATION

Guarantor Name (card holder):_____ DOB:_____

Guarantor Address:_____

City:_____ State:_____ Zip:_____

Relationship to Policy holder: Self____ Spouse____ Child____ Other____

Insurance Plan:_____

Policy #:_____ Group #:_____ Copay $:_____
(at office)

SECONDARY INSURANCE (if applicable)

Insurance Plan:_____

Policy #:_____ Group#:_____

Global Care Medical Group, P.C.

I acknowledge having received a copy of the practice's Notice of Privacy Practices.

Signature _____ Date _____

Print your name _____

CONSENT TO HEALTH INFORMATION EXCHANGE

Global Care Medical Group, PC participates in Health Information Exchanges (HIE) which are secure computer networks that allow participating health care and insurance providers nationwide to access information about you so that each provider has a complete picture of your health. Patient participation is intended to enhance coordination of care among multiple providers and may avoid the need for you to undergo duplicate tests. The information that may be provided to an information exchange includes both your medical and demographic information. Participation is optional. Please opt in or out by checking a box below and signing.

By my signature below, I hereby confirm that I have been provided written information about the Health Information Exchanges and all of my questions have been answered to my satisfaction. I understand that I may change my mind about participating in the network at any time by contacting **Global Care Medical Group, PC** I understand that I have the right to request and receive an accounting of disclosures of access to my Information through the HIE at any time. I understand that **Global Care Medical Group, PC** will not condition treatment, payment, enrollment or eligibility for benefits based on my decision to participate in this network.

☐ OPT IN/AGREE TO SHARE ☐ OPT OUT/DO NOT SHARE

Printed Name of Patient/Responsible Person

Date

Signature of Patient/Responsible Person

Relationship to Patient

Am/Pm

Witness Signature

Date/Time

Am/Pm

Interpreter Signature/Language

Date/Time

GLOBAL CARE MEDICAL GROUP

595 PAWTUCKET BLVD 3RD FLOOR LOWELL, MA 01854
600 CLARK RD 2ND FLOOR TEWKSBURY,MA 01876
TEL: 978-453-8261 FAX: 978-453-7911

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

PATIENT'S NAME: _____ DATE OF BIRTH: _____ TEL NO: _____

ADRESS: _____ CITY: _____ STATE: _____ ZIP: _____

I AUTHORIZE: _____
NAME OF PHYSICIAN, FACILITY OR PERSON

_____ _____ _____ _____
STREET CITY STATE ZIP

TO RELEASE PROTECTED HEALTH INFORMATION, CONTAINED IN THE MEDICAL RECORD OF THE ABOVE-NAMED TO THE FOLLOWING:

PROVIDER/FACILITY: _____

_____ _____ _____ _____
STREET CITY STATE ZIP

SENSITIVE HEALTH INFORMARTION:
If the information to be disclosed contains any of the following types of information listed below, additional laws and/or signature requirements may apply. I understand and agree that this information will be sent to the provider at the location noted above UNLESS I place my initials in the applicable space next to the type of records:

___ MENTAL HEALTH TREATMENT RECORDS
___ GENETIC TESTING
___ HIV/AIDS TEST RESULTS
___ SEXUALLY TRANSMITTED DISEASE (STD) TREATMENT RECORDS
___ ALCOHOL/DRUG ABUSE TREATMENT RECORDS
___ DOMESTIC ABUSE

INFORMATION TO BE RELEASED: CHECK ALL THAT APPLY

DATES OF TREATMENT TO BE RELEASED: _____ TO _____

___ OFFICE NOTES ___ LABORATORY RESULTS ___ IMMUNIZATION RECORD

___ OTHER: _____ ___ COMPLETE RECORD ___ X-RAY (REPORTS ONLY)

PURPOSE OF RELEASE: ___ MEDICAL CARE ___ TRANSFERRING OUT OF PRATICE ___ OTHER: _____

I understand the once this health information is disclosed, the releasing facility cannot guarantee that the recipient will not re-disclose my health information to a third party. Such third party may not be required to abide by this authorization or applicable federal and state law governing the use of and disclosure of my health information. I understand that I may refuse to sign or may revoke this authorization in writing at any time and for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of my treatment. I understand that this authorization will expire 90 days from the date of said unless I provide a written notice of revocation to the releasing facility noted above.

_____ _____
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE

_____ _____
PRINTED NAME OF THE PATIENT OR AUTHORIZED REPRESENTATIVE RELATIONSHIP TO PATIENT

the Privacy Officer at our practice. You may also initiate the transfer of your records to another person by completing a written authorization form.

PATIENT RIGHTS

Right to Inspect and Copy Records. You have the right to inspect and obtain a copy of your health information, including medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the practice. We may charge a fee for the costs of copying, mailing or other supplies. If you would like an electronic copy of your health information, we will provide one to you as long as we can readily produce such information in the form requested. In some limited circumstances, we may deny the request. Under federal law, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information related to medical research where you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

Right to Amend Records. If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment in writing. If we deny your request, we will provide a written notice that explains our reasons. You will have the right to have certain information related to your request included in your records.

Right to an Accounting of Disclosures. You have a right to request an "accounting of disclosures" every 12 months, except for disclosures made with the patient's or personal representatives written authorization; for purposes of treatment, payment, healthcare operations; required by law, or six (6) years prior to the date of the request. To obtain a request form for an accounting of disclosures, please write to the Privacy Officer.

Right to Receive Notification of a Breach. You have the right to be notified within sixty (60) days of the discovery of a breach of your unsecured protected health information if there is more than a low probability the information has been compromised.

Right to Request Restrictions. You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to family or friends involved in your care. Your request must state the specific restrictions requested and to whom you want the restriction to apply. Your physician is not required to agree to your request except if you request that the physician not disclose Protected Health Information to your health plan when you have paid in full out of pocket.

Right to Request Confidential Communications. You have the right to request that we contact you about your medical matters in a more confidential way, such as calling you at work instead of at home. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.

Right to Have Someone Act on Your Behalf. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

Right to Obtain a Copy of Notices. If you are receiving this Notice electronically, you have the right to a paper copy of this Notice.

Right to File a Complaint. If you believe your privacy rights have been violated by us, you may file a complaint with us by calling the Privacy Officer at 978-453-8261, or with the Secretary of the Department of Health and Human Services. We will not withhold treatment or take action against you for filing a complaint.

Use and Disclosures Where Special Protections May Apply. Some kinds of information, such as alcohol and substance abuse treatment, HIV-related, mental health, psychotherapy, and genetic information, are considered so sensitive that state or federal laws provide special protections for them. Therefore, some parts of this general Notice of Privacy Practices may not apply to these types of information. If you have questions or concerns about the ways these types of information may be used or disclosed, please speak with your health care provider.

Global Care Medical Group, P.C.

Lowell and Tewksbury

Health Insurance Portability and Accountability Act of 1996

HIPAA OMNIBUS NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

Revised: March 25, 2013

Practice Administrator

By signing the Acknowledgement form you are only acknowledging that you received, or have been given the opportunity to receive, a copy of our Notice of Privacy Practices.

HIPAA Omnibus
Notice of Privacy Practices

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your Protected Health Information (PHI) to carry out Treatment, Payment or Health Care Operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. Please review it carefully.

We reserve the right to change this notice at any time and to make the revised or changed notice effective in the future. A copy of our current notice will always be posted in the waiting area. You may also obtain your own copy by accessing our website at www.globalcaremedical .com or calling the Privacy Officer at 978-453-8261

Some examples of **Protected Health Information** include information about your past, present or future physical or mental health condition, genetic information, or information about your health care benefits under an insurance plan, each when combined with identifying information such as your name, address, social security number or phone number.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

There are some situations when we do not need your written authorization before using your health information or sharing it with others, including:

Treatment: We may use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. For example, your Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your Protected Health Information may be used, as needed, to obtain payment for your health care services after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

Healthcare Operations: We may use or disclose, as-needed, your Protected Health Information in order to support the business activities of our practice, for example: quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities.

Appointment Reminders and Health-related Benefits and Services: We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your Protected Health Information for **fundraising activities**, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

Friends and Family Involved in Your Care: If you have not voiced an objection, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for your care, including following your death.

Business Associate: We may disclose your health information to contractors, agents and other "business associates" who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, a billing company, an accounting firm, or a law firm that provides professional advice to us. Business associates are required by law to abide by the HIPAA regulations.

Proof of Immunization: We may disclose proof of immunization to a school about a student or prospective student of the school, as required by State or other law. Authorization (which may be oral) may be obtained from a parent, guardian, or other person acting in loco parentis, or by the adult or emancipated minor.

Incidental Disclosures: While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

Emergencies or Public Need:
We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you.

We may use or disclose your Protected Health Information in the following situations without your authorization: as required by law, public health issues, communicable diseases, abuse, neglect or domestic violence, health oversight, lawsuits and disputes, law enforcement, to avert a serious and imminent threat to health or safety, national security and intelligence activities or protective services, military and veterans, inmates and correctional institutions, workers' compensation, coroners, medical examiners and funeral directors, organ and tissue donation, and other required uses and disclosures. We may release some health information about you to your employer if you employer hires us to provide you with a physical exam and we discover that you have a work related injury or disease that your employer must know about in order to comply with employment laws. Under the law, we must also disclose your Protected Health Information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

REQUIREMENT FOR WRITTEN AUTHORIZATION

There are certain situations where we must obtain your written authorization before using your health information or sharing it, including:

Most Uses of Psychotherapy Notes, when appropriate.

Marketing: We may not disclose any of your health information for marketing purposes if our practice will receive direct or indirect financial payment not reasonably related to our practice's cost of making the communication.

Sale of Protected Health Information: We will not sell your Protected Health Information to third parties.

You may revoke the written authorization, at any time, except when we have already relied upon it. To revoke a written authorization, please write to