Patient Intake Form

Patient Name: ______________________ DOB: __________
Mailing Address: ______________ City: ________ State: ______ Zip: ______
Physical Address (if different from mailing): ______________________
Home Phone: __________ Cell: __________ Work: __________
Occupation: ______________________
Can we send information via email? ☐ Yes ☐ No Email: ______________
Alcoholic Beverages: ☐ Yes ☐ No If yes, average per day or week: ______________
Do we have permission to leave messages on your answering machine or with others who may answer your phone?
☐ Yes ☐ No

Contact Persons: **If the person is someone, we can discuss medical information with please list. Otherwise, we will *NOT* be able to discuss any information with them.**
Authorization will only expire with written revocation from the patient

Name: ______________ Phone #: __________ Relationship: __________
Name: ______________ Phone #: __________ Relationship: __________
Primary Care Physician/Provider: ______________ State: __________
Other Physician/Providers you would like to receive office notes:
Physician/Provider: __________ State: ____ Physician/Provider: __________ State: ____
Physician/Provider: __________ State: ____ Physician/Provider: __________ State: ____
Parent/Guardian #1 Name: ______________ Relationship: __________
Mailing Address: ______________ City: ________ State: ______ Zip: ______
Physical Address (if different from mailing): ______________________
Home Phone: __________ Cell: __________ Work: __________
Parent/Guardian #2 Name: ______________ Relationship: __________
Mailing Address: ______________ City: ________ State: ______ Zip: ______
Physical Address (if different from mailing): ______________________
Home Phone: __________ Cell: __________ Work: __________
Parent/Guardian #1 Name: ______________ Relationship: __________
Mailing Address: ______________ City: ________ State: ______ Zip: ______
Physical Address (if different from mailing): ______________________
Home Phone: __________ Cell: __________ Work: __________
Insurance - Primary Carrier: ______________________
Subscriber Name: ______________________ DOB: __________
Insurance - Secondary Carrier: ______________________
Subscriber Name: ______________________ DOB: __________

By signing below, you are authorizing and validating all of the above information.

Patient signature or responsible party: ______________________ Date: __________

35 Walker Street, Suite 200 • Kittery, ME 03904 | 14 Manchester Square, Suite 210 • Portsmouth, NH 03801
P 207-475-0100 • F 855-654-3271

Financial Policy

Healthcare is expensive and a universal concern for employers, patient families and medical providers. As a small, independent practice, we are committed to continue to support patient families by providing caring medical care and services. To do this, we will maintain a firm financial policy. So that expectations are clear between practice and the patient family, the following represents the obligations of the patient.

- The **co-pay** is due at the time of service and $5 processing fee will be applied to all co-pays made afterwards.
- **Coinsurance** and **deductible** amounts, to be paid by the patient, are due upon receipt of the statement. If that balance is more than $100, we can arrange a payment plan to extend over a set number of months.
- Patients paying for services should be prepared to pay full amount at the time of service or ar-range a payment plan. Payments made beyond the agreed number of months will be subject to $10 processing fee for each month a balance remains.
- **Returned checks** will be subject to a $35 processing fee.
- Appointments cancelled with less than one business day notice and any **no-shows**, will be charged a $20 fee.
- It is the patient's responsibility to resolve all insurance denials directly with the insurance company when the denial is through no fault of our practice.
- If an account remains unpaid without an agreement in place, it will be sent to a collection agency.

Please sign below to indicate you have read and understand these policies. Thank you.

Patient signature or responsible party: ____ Date: ______________

Please check response:

Would you like access to patient portal? ☐ Yes ☐ No *(This will give access to send messages only.)*

Would you like a reminder? ☐ Call #: __________ ☐ Text #: _________ ☐ No

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