In order to serve you promptly, we need the following information. Fill out each item or put N/A (not applicable). Please Print Clearly.

WESTFORD INTERNAL MEDICINE, P.C.

My Doctor at WIM is: Dr. Azam Dr. Cohen Dr. Huynh Dr. Jacobellis Dr. McCarthy Dr. Taylor
(CIRCLE ONE)

Name: _____ **Other Name:** _____
LAST **FIRST** **MI** **(Example: Maiden name, etc)**

Date of Birth: _____/_____/_____ **Email:** _____

Home #: (_____) _____-_____ **Work # :**(_____) _____-_____ **Cell # :**(_____) _____-_____

Mailing Address: _____
Street **Apt. #** **City/State** **Zip Code**

Sex: Female Male **Marital Status:** Married Single Other: _____
(CIRCLE ONE) (CIRCLE ONE OR FILL IN)

Language: _____ **Race:** _____ ☐Decline **Ethnicity:** _____ ☐Decline
LANGUAGE REQUIRED (PLEASE ENTER OR DECLINE RACE AND ETHNICITY)

Employer: _____

Emergency Contact: _____ **Relationship to patient:** _____

Emergency Contact Tel. # (_____) _____-_____ **Cell #** (_____) _____-_____

Primary Insurance Company Name: _____

Insurance Company Address: _____
Street # or P.O. Box City/State Zip Code

Policy/ID #: _____ **Group #:** _____

Relationship to Subscriber: Self Spouse Dependent Other: _____
(Circle one) PLEASE SPECIFY

Subscriber Name: (*Only required if you are not the subscriber*) _____ **Date of Birth:** _____/_____/_____

Secondary Insurance Company Name: _____

Insurance Company Address: _____
Street # or P.O. Box City/State Zip Code

Policy/ID #: _____ **Group #:** _____

Relationship to Subscriber: Self Spouse Dependent Other: _____
(Circle one) PLEASE SPECIFY

Subscriber Name: (*Only required if you are not the subscriber*) _____ **Date of Birth:** _____/_____/_____

I understand that is my responsibility to contact my insurance company(s) with any questions regarding my coverage. **Initial**_____

Insurances vary in the amount they will pay for various services. I understand that I am ultimately responsible to pay the unpaid portion unless otherwise restricted by law or agreement with insurance. **Initial**_____

*******PLEASE TURN OVER*******

Please read carefully and sign. Your signature gives consent to bill your insurance company for services rendered in our office.

Assignment of Benefits

Authorization to pay benefits to physician: I hereby authorize payment directly to the undersigned Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for services as described.

X_____

Signature of patient **OR** legal guardian Date

Authorization to release information: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment to the insurance company or any other party involved in reimbursement for the claim.

X_____

Signature of patient **OR** legal guardian Date

I understand that Westford Internal Medicine reserves the right to charge a customary fee for missed appointments.

X_____

Signature of patient **OR** legal guardian Date

FOR MEDICARE PATIENTS ONLY

Lifetime Assignment of Medicare Benefits

I request that payment of authorized Medicare benefits be made to me or on my behalf to the above referenced Medical Practice for services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable for related services.

X_____

Signature of patient **OR** legal guardian Date

FOR OFFICE USE ONLY

X_____

Signature of patient **OR** legal guardian Date

X_____

Signature of patient **OR** legal guardian Date

Westford Internal Medicine, P.C.
Please send completed form to:
133 Littleton Road, Suite 202 Westford, MA 01886
Phone: (978) 577-1946 Fax: (978) 692-4716

PATIENT REPRESENTATIVE RELEASE AUTHORIZATION

By completing this form I authorize Westford Internal Medicine to discuss/release my protected health information to one or more representatives identified. I may add or delete up to three individuals at any time by completing this authorization. By signing this form I give permission to Westford Internal Medicine to discuss/release protected health information with the below named party(s).

1. Patient Information

Name: _____

Date of Birth: _____ Home Telephone #: _____

Street: _____

City: _____ State: _____ Zip: _____

Day/Work Telephone #: _____

2. Patient Representative(s): Please identify up to three individuals to be your Patient Representative. Please ensure that the designated individual(s) below will need to provide the following information on you prior to Westford Internal Medicine discussing/releasing personal health information on your behalf:

- Patient Name
- Patient Date of Birth
- Patient Address

In addition they will also be asked to provide their name and date of birth for identification purposes only.

Please check one of the following boxes: Add Delete

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Patient Representative Telephone #: _____

Information to be released: All medical information Other: _____

_____
(PLEASE BE SPECIFIC)

TURN OVER AND COMPLETE SECOND PAGE

Please check one of the following boxes: Add Delete

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Patient Representative Telephone #: _____

Information to be released: All medical information Other: _____

_____
(PLEASE BE SPECIFIC)

Please check one of the following boxes: Add Delete

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Patient Representative Telephone #: _____

Information to be released: All medical information Other: _____

_____
(PLEASE BE SPECIFIC)

3. Authorization

I authorize Westford Internal Medicine to discuss my medical care with the individual(s) identified above. I understand there is no expiration date, and I may add or delete up to three individuals at any time by completing a new authorization. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Westford Internal Medicine. I understand the revocation will not apply to information that has already been provided in response to this release.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____
(NOT VALID UNLESS WITNESSED)

I understand that if my medical record contains information relating to drug and/or alcohol abuse, psychiatric, venereal disease, social service, hepatitis B testing/treatment, and/or sensitive information will be released by signing:

Patient Signature: _____ Date: _____

In addition to the above signatures, I would like information relating to HIV/AIDS testing/treatment released to the above party(s).

Patient Signature: _____ Date: _____