COMPASS MEDICAL PC
Exceptional Medicine. Compassionate Care.

ELECTRONIC FORM DISCLAIMER: Compass Medical is deeply committed to protecting our patient's rights to privacy and safeguarding patient information. Please know we are working hard to bring our patients secure electronic messaging in the near future, however, at this time, we do not offer secure messaging. Therefore, please do not attempt to fill out this form and send it back to Compass Medical electronically. Please bring the completed form with you to your next visit. If you attempt to send this form back via fax, email, or any other means, you expressly assume all risk of any unauthorized disclosure of your information.

Welcome to Compass Medical!

We are honored you chose us as your healthcare provider! We are excited to begin our partnership with you and look forward to creating an exceptional experience for you and your family.

This New Patient Information Packet is designed to collect the information necessary to begin our partnership. It also contains important information for you as our patient. In an effort to streamline the registration process, please complete, sign and return the following items prior to your first appointment:

- ☐ Patient Registration Form
- ☐ Payment Policy
- ☐ Family Health History and Medication List Form
- ☐ List of Current Specialists

In addition, please contact your previous Primary Care Provider to request your medical records be transferred to your new Compass Medical office. If your insurance company requires you to designate a primary care provider, please call your insurance company today to inform them of your new Compass Medical provider. Also, please remember to bring your insurance card and photo ID with you to your first appointment.

At Compass Medical, our goal is to provide exceptional medicine and compassionate care to each and every patient, every time. Our outstanding medical teams work together in internal medicine, family medicine, urgent care, radiology, cardiology, diabetic education, nutrition, podiatry, physiatry and behavioral health to effectively coordinate our patients' care. Linked by our award winning, state-of-the-art electronic medical record system, Compass Medical makes it easy to visit an in-house specialist or urgent care provider. In addition, all Compass Medical patients have access to our in-house lab located in East Bridgewater.

Compass Medical is an affiliate of Steward Health Care System, the largest community care organization in New England with high quality community hospitals and specialists. Our team based approach to healthcare allows us to effectively manage your health and wellness, both internally within the organization and externally with partners such as Steward Health Care System. Between in-house specialists and external partners, Compass Medical has the ability to guide patients to high quality services and meet all of your medical needs. Please discuss any specialty needs with your Provider during your visit.

Compass Medical works diligently to ensure your clinical experience is exceptional-every time. In an effort to measure your patient experience, we have teamed up with Press Ganey Associates to collect and evaluate patient feedback. After visiting with your PCP, you may receive a patient satisfaction survey in the mail or by email after your office visit. Completing these surveys provides Compass Medical with extremely important feedback and we look forward to hearing about your experience through these surveys.

It is with the greatest pleasure that we welcome you to Compass Medical and look forward to exceeding your expectations at each and every visit. For any additional information, please visit our website at www.CompassMedical.net.

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PATIENT REGISTRATION

Date: _____ PCP Name: _____ Account #: _____

Patient Information

First Name: _____ MI: _____ Last Name: _____

If a child, Parent's First Name: _____ MI: _____ Last Name: _____

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

Please select a primary phone number by checking the appropriate box below:

Home Phone: ☐ _____ Cell Phone: ☐ _____ Work Phone: ☐ _____

Birth Date: _____ Sex (M/F): _____

Email Address: _____

By giving Compass Medical, P.C. my email address, I understand I am giving them permission to send me health related information through my email with the confidence of knowing that I may safely unsubscribe at any time.

Preferred form of contact *(please check one)*:

Letter ☐ Email ☐

Patient Demographics

Studies have shown there are health differences among different racial and ethnic groups. Your answers will help us make informed clinical decisions for improved delivery of your health care. Providing this information is voluntary and will be kept confidential and will only be used to meet the needs of the patients we serve.

I. Which of the following best describes your race?
Please select one:

- ☐ Black
- ☐ Native American
- ☐ Native Hawaiian
- ☐ Oriental/Asian
- ☐ Pacific Islander
- ☐ White
- ☐ Informed Refusal
- ☐ Other: _____

II. Which of the following best describes your ethnicity?

- ☐ Not Hispanic or Latino/a
- ☐ Hispanic or Latino/a
- ☐ Informed Refusal
- ☐ Other: _____

III. Preferred language
Please select one:

- ☐ English
- ☐ Spanish
- ☐ Portuguese
- ☐ Chinese
- ☐ Cape Verdean Creole
- ☐ Haitian Creole
- ☐ Urdu
- ☐ American Sign Language
- ☐ Informed Refusal
- ☐ Other: _____

Patient Employment *(please circle one)*

Employed Retired Unemployed Other

Employer: _____ Occupation: _____ Date of Employment: _____

PLEASE COMPLETE REVERSE SIDE

Person Responsible For Any Balances Not Covered By Insurance

First Name: _____ Last Name: _____ Driver's License: _____

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

My financial responsibilities under any insurance plan(s) have been explained to me. I herby grant Compass Medical, P.C. permission to have necessary information released to my insurance carrier. If my stated insurance does not cover provided medical services, I agree to be personally and fully responsible for payment. I authorize payment of Medical Benefits to Compass Medical, P.C.

Statement To Permit Payment of Medicare Benefits to Provider, Physicians and Patient
(For Medicare Patients use only)

Name of Beneficiary (Patient) _____ HICN # (Medicare #): _____
I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in Compass Medical, P.C. including physician services. I authorize any holder of medical or other information about me be released to the Centers for Medicare and Medicaid and its agents any information needed to determine these benefits or benefits for related services.

_____ _____
Patient Signature Date

Insurance Information

Primary Insurance

Subscriber Name: _____ Relationship to Patient: _____

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

Phone: _____ Birth Date: _____

Name of Insurance Co: _____ Insurance ID: _____

Policy #: _____ Group #: _____ Effective Date: _____

Secondary Insurance

Subscriber Name: _____ Relationship to Patient: _____

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

Phone: _____ Birth Date: _____

Name of Insurance Co: _____ Insurance ID: _____

Policy #: _____ Group #: _____ Effective Date: _____

Emergency Contact

First Name: _____ MI: _____ Last Name: _____

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

Phone: _____ Home Work Mobile

Relationship to Patient *(please circle one)*: Parent Spouse Child Sibling Grandparent Other: _____

How did you hear about us? *(please circle one)*

Friend Relative Newspaper Website Internet

Compass Patient/Employee: _____ Advertisement: _____

Event: _____ Other: _____

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PAYMENT POLICY

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be forwarded to you upon request.

1. **INSURANCE.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage or prior to scheduling a physical or screening test to verify coverage for these services. It is your responsibility to verify that the physician and/or facility in which you are seeking treatment is an authorized provider under your insurance plan. A current provider listing should be made available to you by your employer, insurance company or insurance company's web-site.

2. **CO-PAYMENTS AND DEDUCTIBLES.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients may be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **NON-COVERED SERVICES.** Please be aware that some-and perhaps all- of the services you receive may be non-covered or not considered reasonable or necessary by your insurance carrier. This may include physicals and screening tests. Please be aware that in the event of a scheduled annual physical, if the physician finds a new problem or an unstable chronic medical condition that requires further evaluation, an office visit may be billed in addition to the physical charge. However, some insurance carriers will not cover both services on the same day. Therefore, you may be billed for the portion not covered by the insurance carrier.

4. **UNINSURED.** Patients with no insurance are expected to pay for their office visit at the time of service. Any additional charges for ancillary services will be billed to the patient.

5. **PROOF OF INSURANCE.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license or other form of valid photo identification and your current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for any charges. Your insurance card must be presented at each visit.

6. **CLAIMS SUBMISSION.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim may be your responsibility if your insurance company does not pay your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

7. **COVERAGE CHANGES.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. We will not be responsible for any denied claims due to filing deadlines if new insurance information was not given at the time of service.

8. **WORKERS' COMPENSATION AND AUTOMOBILE ACCIDENTS.** In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you may be asked to either reschedule your appointment or pay for your visit at the time of service.

9. **REFERRALS.** If you have an HMO plan with which we are contracted, you need to obtain a referral from your primary care physician prior to your appointment. If we have not received a referral prior to your arrival at the office, you will be rescheduled or asked to sign a waiver assuming all financial liability for the visit.

10. **NONPAYMENT.** Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing. Compass Medical reserves the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances until the balance is paid in full. In addition, providers may no longer be able to continue providing you with care because of nonpayment. If your account balance becomes 90 days past due, further steps to collect this debt may be taken, including reporting the account to a collection agency. If the provider is unable to continue providing care because of nonpayment, you will be notified by mail that you have 30 days to pay the balance in full or find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis or until you are no longer in an acute phase of treatment or in the process of medical workup for diagnosis.

11. **MISSED APPOINTMENTS.** Please be aware that your office *may* charge a fee for any appointments not canceled within 24 hours. For more information on your site's specific policy, please contact your site directly. Any fees incurred due to missed appointments without prior cancelation will be your responsibility and billed directly to you.

12. **PAYMENT OPTIONS.** We accept MasterCard, Visa, cash, checks or debit cards. We also can set up a budget payment plan if your entire balance cannot be paid in full within 30 days. Please contact our Billing Department at (508) 350-2450 to set up a budget plan.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES.

_____ _____

Signature of patient or responsible party **Date**

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Name: _____ **Date of Birth**: _____ **Date**: _____

MEDICATION HISTORY

Please list all prescription medications, over-the-counter medications, herbal supplements, etc. that you take. Please use back of page if need additional space.

	Medication Name	**Dose** (ex: 25 mg)	**How do you take this medication?** (ex: one tablet twice per day)	**What do you take this for?** (ex: blood pressure)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Preferred Pharmacy Name & Location: _____ **Phone**: _____

SURGICAL HISTORY

Please list all surgical procedures you have had in your lifetime.

SURGERY	**DATE**

FAMILY HISTORY

Please list your biological family members who are/were affected by following conditions.

FAMILY MEMBER	DOB	DIAGNOSIS (Mark all that apply with the year of diagnosis)			OTHER CONDITION
Mother ☐ Living ☐ Deceased		_____ Breast Cancer _____ Colon Cancer _____ Ovarian Cancer	_____ Endometrial Cancer _____ DM _____ Heart Disease	_____ Hypertension _____ Mental Illness _____ Addiction	
Father ☐ Living ☐ Deceased		_____ Breast Cancer _____ Colon Cancer _____ Ovarian Cancer	_____ Endometrial Cancer _____ DM _____ Heart Disease	_____ Hypertension _____ Mental Illness _____ Addiction	
Sister 1 ☐ Living ☐ Deceased		_____ Breast Cancer _____ Colon Cancer _____ Ovarian Cancer	_____ Endometrial Cancer _____ DM _____ Heart Disease	_____ Hypertension _____ Mental Illness _____ Addiction	
Brother 1 ☐ Living ☐ Deceased		_____ Breast Cancer _____ Colon Cancer _____ Ovarian Cancer	_____ Endometrial Cancer _____ DM _____ Heart Disease	_____ Hypertension _____ Mental Illness _____ Addiction	
Sister 2 ☐ Living ☐ Deceased		_____ Breast Cancer _____ Colon Cancer _____ Ovarian Cancer	_____ Endometrial Cancer _____ DM _____ Heart Disease	_____ Hypertension _____ Mental Illness _____ Addiction	
Brother 2 ☐ Living ☐ Deceased		_____ Breast Cancer _____ Colon Cancer _____ Ovarian Cancer	_____ Endometrial Cancer _____ DM _____ Heart Disease	_____ Hypertension _____ Mental Illness _____ Addiction	
Sister 3 ☐ Living ☐ Deceased		_____ Breast Cancer _____ Colon Cancer _____ Ovarian Cancer	_____ Endometrial Cancer _____ DM _____ Heart Disease	_____ Hypertension _____ Mental Illness _____ Addiction	
Brother 3 ☐ Living ☐ Deceased		_____ Breast Cancer _____ Colon Cancer _____ Ovarian Cancer	_____ Endometrial Cancer _____ DM _____ Heart Disease	_____ Hypertension _____ Mental Illness _____ Addiction	
Maternal Grandmother ☐ Living ☐ Deceased		_____ Breast Cancer _____ Colon Cancer _____ Ovarian Cancer	_____ Endometrial Cancer _____ DM _____ Heart Disease	_____ Hypertension _____ Mental Illness _____ Addiction	
Maternal Grandfather ☐ Living ☐ Deceased		_____ Breast Cancer _____ Colon Cancer _____ Ovarian Cancer	_____ Endometrial Cancer _____ DM _____ Heart Disease	_____ Hypertension _____ Mental Illness _____ Addiction	
Maternal Aunt ☐ Living ☐ Deceased		_____ Breast Cancer _____ Colon Cancer _____ Ovarian Cancer	_____ Endometrial Cancer _____ DM _____ Heart Disease	_____ Hypertension _____ Mental Illness _____ Addiction	
Maternal Uncle ☐ Living ☐ Deceased		_____ Breast Cancer _____ Colon Cancer _____ Ovarian Cancer	_____ Endometrial Cancer _____ DM _____ Heart Disease	_____ Hypertension _____ Mental Illness _____ Addiction	
Paternal Grandmother ☐ Living ☐ Deceased		_____ Breast Cancer _____ Colon Cancer _____ Ovarian Cancer	_____ Endometrial Cancer _____ DM _____ Heart Disease	_____ Hypertension _____ Mental Illness _____ Addiction	
Paternal Grandfather ☐ Living ☐ Deceased		_____ Breast Cancer _____ Colon Cancer _____ Ovarian Cancer	_____ Endometrial Cancer _____ DM _____ Heart Disease	_____ Hypertension _____ Mental Illness _____ Addiction	
Paternal Aunt ☐ Living ☐ Deceased		_____ Breast Cancer _____ Colon Cancer _____ Ovarian Cancer	_____ Endometrial Cancer _____ DM _____ Heart Disease	_____ Hypertension _____ Mental Illness _____ Addiction	
Paternal Uncle ☐ Living ☐ Deceased		_____ Breast Cancer _____ Colon Cancer _____ Ovarian Cancer	_____ Endometrial Cancer _____ DM _____ Heart Disease	_____ Hypertension _____ Mental Illness _____ Addiction	
Daughter ☐ Living ☐ Deceased		_____ Breast Cancer _____ Colon Cancer _____ Ovarian Cancer	_____ Endometrial Cancer _____ DM _____ Heart Disease	_____ Hypertension _____ Mental Illness _____ Addiction	
Son ☐ Living ☐ Deceased		_____ Breast Cancer _____ Colon Cancer _____ Ovarian Cancer	_____ Endometrial Cancer _____ DM _____ Heart Disease	_____ Hypertension _____ Mental Illness _____ Addiction	