

Houghs Neck Snug Harbor Hull North Quincy Taunton

Patient Information

Patient's Name: Last First Middle Initial Date of Birth: month day year

Address: Street Apartment # Birthplace: Home Phone: City State Zip Cell Phone:

Occupation: Work Phone:

Employer: Social Security #

Are you Head of Household? Yes No Please check if you are: Male Female

Number of Dependents: Marital Status Single Married Divorced/Separated Widow

Primary Language Race/Ethnicity White Asian Black/Hispanic Native American

Secondary Language Hispanic Other Refused

Email Address

Do you have insurance? Yes No Please check the patient's relationship to Insurance Card Holder Self Spouse Child Other

Insurance information

Subscriber: Name of person who gets this insurance Subscriber's date of birth Subscriber's telephone #

Insurance Plan: Name of Insurance Plan Doctor or Health Center Name listed on your card ID number Group Number Group Name

Second Please check the patient's relationship to subscriber:

Insurance Plan: Name of person who gets this insurance Self Spouse Child Other

Subscriber: Name of Insurance Plan ID number Group Number Group Name

Emergency and Authorization Information

If patient is a child: Parent/Guardian's Name Billing Address if different from above address

PERSON YOU WANT CALLED IN AN EMERGENCY:

Name Relationship Work Phone Address Home Phone Cell Phone

I hereby authorize the staff of Manet Community Health Center, Inc., to render such services as deemed necessary to me/my child listed above. I also authorize the release of all necessary information to insurance companies and other payers and assign to Manet Community Health Center, Inc. the authority to claim and collect insurance benefits. I will be financially responsible for any charges incurred for services not covered by my insurance plan. I acknowledge that I have received notice that I may receive a copy of Manet Community Health Center's Patients Privacy Rights and the Privacy Policies and Practices upon request.

I give my consent for the use of telehealth in my medical care and I understand that a copy of the Telehealth Policy can be provided upon request.

Patient Signature or Circle if Parent/Guardian/Other Today's Date Please indicate relationship if Other



Manet Community Health Center  
 9 Bicknell Street  
 Quincy MA 02169  
 Secured Fax Line:  
 317-454-8573  
 317-454-8567

*Authorization to Release Protected Health Information*

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email: \_\_\_\_\_ Phone: (H): \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

I hereby authorize Manet Community Health Center, Inc. to  Send myhealth information from: (Please list below)

Name (of facility): \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax#: \_\_\_\_\_ Email: \_\_\_\_\_

Format of information to be released: (please check box)  Paper  Fax  Encrypted CD

I wish to pick up my records: (medical records will contact you when ready for pick-up)

Please specify information to be released or obtained. Check all that apply. Only checked items will be released.

- Complete Records  Partial Records (last two years)  Lab Results  Immunizations  Medication List
- Imaging Reports  Prenatal/GYN Records  Eye Records

Release of information regarding specific consent. The following categories of information in your medical record will not be released without your specific authorization, indicated by initialing each appropriate category:

- Behavioral/Mental Health  HIV/AIDS Results/Treatment  Domestic Violence  Abortion  Genetic Testing
- Sexually Transmitted Disease  Alcohol/Drug Abuse  Rape Sexual Assault  Child/Elder/Disabled Abuse

Purpose for requested Information:  Legal  Insurance  Specialist/Procedure  Transferring out of Manet  Other

By signing this authorization, I understand that:

- This authorization will remain in effect for 90 days after the above date or as specified: \_\_\_\_\_
- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations
- I have the right to revoke this authorization at any time. Revocation must be made in writing to the Medical Records Department. Revocation will apply to information that has already been disclosed in response to the authorization.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization
- I also understand that this information may be re-disclosed by the recipient if the recipient is not required to follow the privacy regulations or statutes.

I have read and understand the terms of this authorization.

\_\_\_\_\_  
 Patient/Parent/Legal Guardian Signature Date

**Manet Community Health Center, Inc.**

**"Please provide email address for Patient Portal."**

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE**

Manet Community Health Center will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to your personal health information. You have the right to review this notice prior to signing this acknowledgement. The terms of this notice may change with time and we will always post the current notice at our facilities and have copies for distribution. You may ask us to restrict the use and disclosure of your personal health information. However, we are not required to agree to such a request, but if we do agree, we are bound by law to the agreed upon restrictions.

There are times when our patients request that their health care provider include a friend or member of their family in their health care decisions. Please list any family member or friend to whom we may speak or share your personal health information (PHI).

- 1) Do not share my personal health information with anyone but me:
- 2) The health center staff has my permission to leave personal health information as a message on my answering machine:   
\_\_\_\_\_ (Initials)
- 3) The health center staff has my permission to share my personal health information with the following person(s):
- 4)

|    | Name | Phone | Relationship |
|----|------|-------|--------------|
| 1) |      |       |              |
| 2) |      |       |              |

**I acknowledge that I have been given the opportunity to receive, review and ask questions regarding Manet Community Health Center's Notice of Privacy Practice.**

**Date:** \_\_\_\_\_ **Patient Date of Birth:** \_\_\_\_\_

**Name:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of patient or legal representative**

\_\_\_\_\_  
**Relationship to Patient**

|  |
|--|
| <p>For internal use only:<br/>MCHC has made a good faith effort to obtain the patient's acknowledgement, but the patient's signature was not obtained for the following reason(s):</p> <p>_____</p> <p>_____</p> <p>Staff Signature:</p> |
|--|