MARLBORO INTERNAL MEDICINE
RELATIONSHIP ■ RESPECT ■ RESULTS

Lalita Matta, MD | Estrela Chaves, NP, CDE
65 FREMONT STREET | MARLBOROUGH, MA 01752
P: 508-303-8553 | F: 508-303-0665

PATIENT REGISTRATION FORM

PERSONAL INFORMATION

Name of Patient: _____ Maiden Name: _____
Social Security No.: _____ Date of Birth: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Mobile Phone: _____
Work Phone: _____ Email Address: _____
Race/ Ethnicity: _____ Marital Status: _____ Gender: M: ____ F: ____
Occupation: _____ Employer Name: _____
Primary/ Preferred Language: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Phone: _____
Emergency Contact Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance: _____ Member ID: _____
Subscriber Name(If not patient): _____ Subscriber DOB: _____
Subscriber Relationship to Patient: _____
Additional Insurance: _____

APPOINTMENT REMINDER

Voicemail ☐ or Text ☐

Voice Mail: _____ Text: _____

PHARMACY INFORMATION

Pharmacy Name: _____ City: _____
Pharmacy Phone: _____

Do you use mail order? Y __ N __ Name: _____

MEDICAL RECORD ACCESS

For Access to your medical records through our website, Please check box: ☐

_____ _____
Signature of Patient **Date**

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Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form you acknowledge that this Medical Practice has given you a copy of its Notice of Privacy Practices. This notice explains how your health information will be handled by HIPPA, the New Federal law concerning medical privacy requires this notice.

I have received a copy of this Notice of Privacy Practices. The Medical Practice has given me the opportunity to ask any questions about this notice and all my questions have been answered.

_____
Patient's Name (Please Print)

_____ _____
Signature of Patient or Guardian **Date Signed**

PROVIDER USE ONLY

If patient was not able to sign due to an emergency, or did not want to sign, please document if patient was given the notice and the reason why the patient did not sign below.

Patient was given the notice _____Yes _____No

Reason signature was not obtained:

_____
_____
_____

_____ _____
Staff Signature **Date**

FORMCCB

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

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

I hereby authorize medical providers and personnel of **Marlboro Internal Medicine** to discuss my protected health information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

____ Information regarding the patient's diagnosis and treatment for HIV/AIDS
____ Psychotherapy notes from a Psychiatrist or Psychotherapist
____ Treatment for alcohol or drug abuse reports

- I understand that I have the right to revoke this authorization, in writing, at any time.
- I understand that such revocation is not effective to the extent that the Clinic has relied on the use or disclosure of the protected health information.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand that I have the right to refuse to sign this authorization.

_____ _____
Signature of Patient / Personal Representative **Name of Patient / Personal Representative**

_____ _____
Date **Description of Personal Representative's Authority**

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Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize Marlboro Internal Medicine and its affiliated Providers to view my external prescription history via the RxHub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____ _____

Signature of Patient **Date**

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Patient Privacy
At Marlboro Internal Medicine, your privacy is a priority. We follow strict federal and state guidelines to maintain the confidentiality of your medical (protected health) information.

Protected Health Information
Protected health information (PHI) is any information about your past, present or future health care, or payment for that care that could be used to identify you.

Members of our workforce and our business associates may only access the minimum amount of PHI that they need to complete their assigned tasks.

Uses and disclosures of PHI
When you visit Marlboro Internal Medicine, we use and disclose your PHI to treat you, to obtain payment for services and to conduct normal business known as health care operations. We may also share information with a contracted business associate who must meet our privacy requirements. Examples of how we use and disclose your information include:

- **Treatment** – We document each visit. This documentation may include your test results, diagnoses, medications and your response to medications. This allows your provider, medical assistants and other clinical staff to provide the best care to meet your needs.
- **Payment** – We document services and supplies you receive at each visit so that you, your insurance company or another third party can pay us. We may tell your health plan about upcoming treatment or services that require prior approval.
- **Health care operations** – Medical information may be used in an effort to continually improve the quality and effectiveness of the health care and service that we provide.

We may also use information to:
- Recommend treatment alternatives
- Tell you about health benefits and services
- Communicate with family or friends involved in your care, with your permission
- Contact you about health education events

There are several circumstances when we are permitted or required to disclose medical information without your signed permission. These situations may include:

- For public health activities, such as tracking diseases or medical devices
- To protect victims of abuse or neglect
- For federal and state health oversight activities such as fraud investigations
- For judicial or administrative proceedings
- If required by law or for law enforcement
- To coroners, medical examiners and funeral directors
- To avert serious threat to public health or safety
- For specialized government functions, such as national security and intelligence
- To workers' compensation if you are injured at work
- To a correctional institution if you are an inmate
- For research following strict review to ensure protection of information

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Other uses and disclosures not previously described may only be done with your signed authorization. You may revoke your authorization, in writing, at any time.

Our Responsibilities
Marlboro Internal Medicine is required by law to maintain the privacy of your medical information, provide this notice of our duties and privacy practices, and abide by the terms of the notice currently in effect.

We reserve the right to change privacy practices and make the new practices effective for all information we maintain. Revised notices with be posted in our facility, our website and will be available from your health care provider.

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Your Rights
You have the right to:

- Request that we restrict how we use or disclose your medical information(we are not required to abide by your request)
- Request that we use a specific telephone number or address to communicate with you
- Inspect and copy your medical information (fees will apply)*
- Request amendment to your medical information (reason required)*
- Choose not to bill your health insurance for any test or office visit
- Receive an accounting of how your medical information was disclosed (excludes disclosure for treatment, payment, health care operations and some required disclosures; fees may apply)*
- Obtain a paper copy of this notice even you receive it electronic
- Register a complain – see below

*Request must be in writing

To Contact Us
If you have questions about this notice or if you would like to exercise your rights or if you feel your privacy right has been violated, contact Andreia Medeiros at 508-303-8553. All complaints will be investigated and you will not suffer retaliation for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC.

Affiliate institutions include:

- Marlborough Hospital
- UMass Memorial Medical Center
- Quest Lab
- eClinical Works

Each affiliate institution is individually responsible for abiding by the privacy practices and for resolving its own privacy complaints and violations.

Revised September 2013

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Office Policies

Welcome to Marlboro Internal Medicine. We are a primary care practice offering integrative healthcare. We want to work with you to address your health issues and offer guidance toward your best possible health. Please take a few minutes to read our policies. Your cooperation and proactive involvement will help us to assist you with your healthcare.

Appointments
We value our time with you and we want to make the most of it. Therefore, if you have been waiting more than 30 minutes for your appointment, let us know so we can accommodate you. For sick visits, please call early morning in order for us to get you in same day. For any changes to your appointment, a 24-hour advanced notice is necessary for our office to provide optimal service to all our patients. A $25.00 cancellation-no show fee will be assessed if an appointment is missed or cancelled without adequate notice. If you repeatedly miss appointments without calling, we may choose to not continue to see you. If you are 15 minutes or more, late for an appointment, we may ask you to reschedule.

Office Hours
Monday: 7:30 AM – 5:00 PM
Tuesday: 7:30 AM – 5:00 PM
Wednesday: 7:30 AM – 3:00 PM
Thursday: 7:30 AM – 5:30 PM
Friday: 7:30 AM – 3:30 PM

Phone Hours
Monday: 9:00AM - 4:00PM
Tuesday: 9:00AM - 4:00PM
Wednesday: 9:00AM - 2:30PM
Thursday: 9:00AM - 4:30PM
Friday: 9:00AM – 3:00PM

Closed for Lunch
Monday: 12:45PM – 1:45PM
Tuesday: 12:45PM – 1:45pm
Wednesday: 11:45AM – 12:45PM
Thursday: 12:45PM – 1:45PM
Friday: 12:45PM – 1:45PM

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Referrals
We are happy to refer you to a specialist if your problem is beyond our expertise. We may ask you to come in if we need more information. Emergency referrals will be made at the time of your need otherwise, please allow 3-5 business days for non-emergent requests. Please have the entire necessary information ready at the time of your request: your name, date of birth and insurance information, as well as the name of specialist, phone number and date of your visit.

Prescription Refills
Refills should be done at office visits- please bring your medicine bottles with you or bring a list of all your medications with number of refills remaining. Outside of appointments, we prefer requests be made by contacting your pharmacy directly so that they may fax your refill request to us electronically, or by using your patient portal. You must allow 2 business days for processing.

If we have not seen you in some time, we may give you a refill for 2-4 weeks only and request that you make a follow-up visit. No antibiotics will be given outside of an office visit. Narcotics will require patient to sign a contract with us and refilled according. (If necessary ask for copy of contract)

Telephone Calls
We try to return telephone calls as soon as possible between seeing scheduled patients. Emergent calls will be dealt with immediately and all Urgent calls will be returned within 2 hours. For non-urgent matters, please allow up to 24 hours for your call to be returned. Please be sure to give us the telephone numbers where we can contact you at various times. When leaving a message on our voice mail please include your first and last name, speak slowly and clearly, we also encourage you to leave your date of birth. Messages left after 3:30pm on voice mail may not be reviewed and returned until the following business day.

After Hour Calls
If you have symptoms that you think may be life threatening, including concerns about chest pain or stroke, please call 911 or go to the nearest emergency room. Otherwise, the answering service will page the doctor when the office is closed for urgent medical matters that cannot wait until the next business day. Please respect your providers off hour's time by calling only for urgent medical matters, not prescription refills, referrals, etc... If you page the doctor and do not receive a return call within 30 minutes, call the office and have the doctor paged again.

Email
Email is used only for non-urgent communication. Requests such as prescriptions, referrals, medical records can be sent to: info@marlborointernalmedicine.com

Patient Portal
Patient Portal is a great tool to communicate with your provider and submit requests. Your provider will also send you messages and or results of tests. Please be sure to notify office if you are unable to access your portal. This feature should **only be used for non-urgent matters**. Messages sent via the patient portal will be addressed and returned within 24 hours unless a request is sent after business hours on a Friday evening, in which case it will be responded to the following Monday. If you are not signed up please ask for more information on how to get started.

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Payment
All co-pays are due the day of your appointment. If you have a deductible or coinsurance we ask that you pay promptly upon receipt of invoice. If your insurance in NOT active, you will be responsible for your visit. We accept VISA, MC, checks and cash.
Please note; if your insurance denies your visit for ineligible at the time of service, you will be responsible, and this may include a plan in which we are not participating. It is your responsibility to verify if we are a participating provider within your plan before you are seen, by contacting your plan directly.

Insurance/Billing
We will bill your insurance as a service to you. Please have insurance cards available upon request at every office visit. Depending on the benefits of your plan you may be responsible for amounts not covered by your insurance company. Become familiar with the benefits of your plan what is covered and what is not. We are not responsible for any balance left to you from your insurance as we do not know every patients individual plan.

Feedback
We welcome your feedback, both positive and constructive. It helps us grow as a clinic and can be helpful to us personally as well. We wish to learn from our mistakes and to improve on the care we provide. If you feel uncomfortable discussing something with us in person, please send a letter. We appreciate the time you take to keep us informed.

Like us on **Facebook**!

Lalita Matta, MD

Estrela Chaves, NP

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BILLING AND INSURANCE

We kindly request that all patients bring a **current insurance card(s)** and **photo ID** to every visit. This will enable us to have up-to-date and accurate billing information in our system.

All payments are expected at the date of service. We are often able to work out special payment plans for patients with extenuating circumstances.

Please be aware that any labs done in the office are sent to Quest Diagnostics. Any Lab billing questions please contact Quest directly as we do not have access to their billing system.

At this time we DO NOT accept the following insurance plans *(last updated July 2018)*:

- Fallon Direct
- Fallon with Mass Health | health connector
- Celticare
- Harvard Pilgrim Focus
- Health Safety Net
- BMC
- AARP Medicare complete
- Tufts Health Direct/Together
- Tufts Health Spirit Plan
- Tufts Medicare Preferred HMO

For further assistance regarding insurance or billing please contact our office at **508-303-8553** between the hours of 9:00am and 3:00pm Monday, Tuesday, Thursday and Fridays. Existing patients who are web-enabled may also contact us regarding billing via their Patient Portal account.

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AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient: _____ **SS#:** _____ **DOB:** _____

I, hereby, authorize_____ to ☐ disclose my protected health information to and/or ☐ obtain my protected health information from:

Name: _____ Phone: _____
Address: _____

I understand that my health record may include *general* information related to my mental health, drug/ alcohol abuse, sexually transmitted diseases, abortion, or other information I may consider sensitive. I understand that this authorization pertains to information obtained on or before the date this authorization was signed. I authorize the release of the following information for dates of service from _____ through _____.

GENERAL RECORDS

__ Cardiac Studies- Heart
__ Consultations
__ Discharge Summaries
__ EEG/EMG/Sleep Studies
__ Emergency Service Records
__ Immunization Records
__ Laboratory Reports
__ Office/Clinic notes for Dr. _____
__ Operative/Procedure Reports
__ Pathology Reports
__ Patient Discharge Care Form
__ Problem List
__ Pulmonary Studies-Lung/Respiratory
__ Radiology Reports
__ Rehabilitation Notes- PT/OT/Speech
__ OTHER(specify)_____

STATUTORILY PROTECTED RECORDS

__ Abortion
__ Alcohol/Drug Abuse
__ Domestic Violence Counseling
__ Genetic Testing
__ HIV/AIDS Results/Treatment
__ Psychiatric Health-including Psychotherapy notes
__ Sexual Assault Counseling
__ Sexually Transmitted Diseases
__ OTHER(specify)_____

THE PURPOSE OF THE RELEASE OF THIS INFORMATION IS FOR:

__ Appointment with Specialist
__ Transferring Care to New Provider
__ Attorney/Legal Case
__ Disability/Insurance Application/Claim
__ Personal Use
__ Pre-employment
__ OTHER(specify)_____

I UNDERSTAND THAT:

- This authorization is voluntary. I do not have to sign to assure treatment unless the sole purpose of treatment is to provide information to a third party (example: employment physical).
- I may inspect or copy information to be disclosed as provided in the Notice of Information Practices.
- There may be a fee for photocopying my health information.
- Any disclosure carries the potential for unauthorized re-disclosure. I release Marlboro Internal Medicine from any legal liability that may arise from the disclosure or re-disclosure of this information.

EXPIRATION OF AUTHORIZATION: Unless otherwise revoked this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition, this authorization shall be valid for not more than ninety (90) days from the date of the signature below, except when Federal and/or State regulations specify otherwise. In such situations, the shorter time period shall apply.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AUTHORIZE THE DISCLOSURE OF THE INFORMATION REQUESTED ABOVE.

_____ _____ _____
Signature of Patient/Parent/Legal Representative* **Date** **Signer's Relationship to Patient**

_____ _____
Witness to Signature **Date**

***If signing as a legal representative, also provide appropriate paperwork to support representative status.**