PRIMARY CARE
of Cape Cod

***Daniel Arnold, MD; Anne Marie Kelly, MD; Andrea Lyonnais, PA-C;***
***Heather Malcomson, ANP-BC; Kelley Murphy, ANP-BC; Rebecca Saunders, FNP-BC***
**89 Lewis Bay Road, Suite 4, Hyannis, MA 02601**
**Phone: 508-418-6600 Fax: 508-796-2177**
***primarycareofcapecod.com***

## NEW PATIENT FORMS

Dr. Anne Marie Kelly is temporarily accepting new patients. Please contact your insurance company to ensure Dr. Kelly is contracted to become your primary care provider. Dr. Kelly's NPI is 1225192552. Please request a reference number from your insurance company for changing to Dr. Kelly's panel.

**Please note that we will not be writing prescriptions for chronic narcotics (ie oxycodone/hydrocodone) or benzodiazepines (ie lorazepam, diazepam).**

**Please also note that our brilliant Nurses, Nurse Practitioners and Physician Assistant will likely run your intake visit, and will all be a major part of your care in this practice.**

*--PLEASE FILL OUT AND SIGN ALL PAGES WHERE APPROPRIATE*

*--MAIL HARD COPIES TO THE OFFICE*

*--PLEASE ALSO INCLUDE A COPY OF ANY HEALTH INSURANCE CARDS (FRONT AND BACK) AND A COPY OF YOUR DRIVER'S LICENSE OR STATE ID*

*--ONCE WE RECEIVE ALL OF THESE DOCUMENTS WE WILL CALL YOU TO SCHEDULE A NEW TO ESTABLISH INTAKE VISIT*

*--WE WILL REVIEW WHAT OLD RECORDS TO REQUEST AT YOUR INTAKE VISIT*

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# ***PATIENT DEMOGRAPHICS***

***PLEASE ANSWER COMPLETELY***

**Who is your current PCP?**

**What is your reason for changing?**

**Reference # from insurance company for changing to Dr. Kelly:**

| | |
|---|---|
| **Patient name (Last, First, MI):** | |
| **Patient date of birth:** | |
| **Patient gender:** | |
| **Physical address (#, street, city, state, zip):** | |
| **Billing address (if different):** | |
| **Home phone:** | |
| **Mobile phone:** | |
| **Email:** | |
| **Emergency contact name and phone #:** | |
| **Any additional information? (ie do you go by a nickname?_** | |

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# ***PATIENT HEALTH INSURANCE INFORMATION***

**Please send copies of insurance cards (front and back) along with this paperwork. If unable to make copies please call the office at 508-418-6600. If you do not have insurance, please call the office to discuss our self-pay options.**

***PLEASE FILL OUT ALL APPLICABLE INFORMATION***

| | |
|---|---|
| **PRIMARY INSURANCE NAME:** | |
| **PRIMARY INSURANCE MEMBER ID#: (Include 2-digit suffix if applicable)** | |
| **PRIMARY INSURANCE GROUP #:** | |
| **PRIMARY INSURANCE OFFICE VISIT COPAY:** | |
| **----------** | **----------** |
| **SECONDARY INSURANCE NAME:** | |
| **SECONDARY INSURANCE MEMBER ID#: (Include 2-digit suffix if applicable)** | |
| **SECONDARY INSURANCE GROUP #:** | |
| **SECONDARY INSURANCE OFFICE VISIT COPAY:** | |
| **----------** | **----------** |
| **TERTIARY INSURANCE NAME:** | |
| **TERTIARY INSURANCE MEMBER ID#: (Include 2-digit suffix if applicable)** | |
| **TERTIARY INSURANCE GROUP #:** | |
| **TERTIARY INSURANCE OFFICE VISIT COPAY:** | |

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## Insurance and Payment Policy for Services Rendered

You are responsible for payment of your designated co-pay at each visit to the office BEFORE your appointment in addition to presenting updated insurance carrier information and new insurance cards upon checking in.

"I understand that my services are being billed directly to my insurance carrier for me for reimbursement. I understand that it is my responsibility to follow up with my insurance company and that any remaining balance is at all times my responsibility."

**If you do not have health insurance**: You are responsible for payment of your bill at the time of your visit. We accept personal checks, credit cards, and cash, a payment plan can be worked out at the time of the visit.

**Patient:** "I understand and agree that regardless of my insurance coverage, I am responsible for the balance on my account for any professional services rendered. I certify that the above information is true and correct to the best of my knowledge. I will notify the office of any changes in my insurance status. I also agree that if I am unable to pay my bill promptly, I will call the office to make timely payment arrangements."

**Responsible party**: "By consenting to care at Primary Care of Cape Cod, I am agreeing that I will take responsibility for the payment of the medical bills. I will provide the office with all necessary information and will communicate with the office regarding any changes in responsibility."

The above policies extend to any in-office services (such as visits with providers, nurses, lab services, injections, vaccines, procedures), as well as tele-health visits with a provider or nurse (including tele-video or tele-phonic visits).

**Name (Please Print):**_____ **DOB:** _____

**Signature:** _____

**Date:** _____

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# *"No-Show" and Late Cancellation Policy*

Everyone at Primary Care of Cape Cod strives to ensure timely access for all our patients. We make every effort to confirm appointments in advance. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Moreover, no-shows and late cancellations are not sustainable for our business. Therefore, Primary Care of Cape Cod, PC, reserves the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments which are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed directly to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" or late cancellations may result in termination from our practice. Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients. By signing this form, you acknowledge that you have received this notice and understand this policy.

# *Tele-Health Policy*

Due to the COVID-19 Crisis, Primary Care of Cape Cod is now utilizing tele-health (*either by video or telephone*) when clinically appropriate. We will bill for tele-health visits as is appropriate for the clinical situation, following guidelines from insurance payers. Please sign below to indicate your consent to participate in tele-health visits.

**Name (Please Print):**_____ **DOB:** _____

**Signature:** _____

**Date:** _____

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# Medical Information Release Form
# (HIPAA Release Form)

**Full Name Please Print:** _____

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

## Release of Information

[ ] I authorize the release of information including the diagnosis, records, examinations rendered to me and claims information. This information may be released to:

1. _____Relationship: _____Ph #: _____
2. _____Relationship: _____Ph #: _____
3. _____Relationship: _____Ph #: _____

[ ] My information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

The best way to reach me is: _____

[ ] You may leave a detailed message.
[ ] Please leave me a message asking to return your call.

**Signature**: _____ **Date**: _____

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**PATIENT NAME:** **PATIENT DATE OF BIRTH:**

**LOCAL PHARMACY:** **MAIL-AWAY PHARMACY:**

# CURRENT MEDICATIONS

***(use back of page if needed)***

| NAME OF MEDICATION | DOSE | FREQUENCY |
|---|---|---|
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