Foley Family Practice
HEIDI J. FOLEY, MD

78 Brickyard Road
Suite 2
Athol, MA 01331
Tel: (978) 249-7300
Fax: (978) 249-5785

Patient Registration (pg 1)

Last Name: _____

First Name: _____

Middle Initial: _____

Suffix: _____

Sex: ☐ Male ☐ Female

Previous Last Name: _____

Date of Birth: ____/ ____/ _____

Social Security Number: _____ - ____ - _____

Address: _____

Address line 2: _____

Zip Code: _____

City: _____

State: _____

Home Phone: (_____) _____ - _____

Work Phone: (_____) _____ - _____

Mobile Phone: (_____) _____ - _____

Email: _____ No-email ☐

Contact Preference: Home ☐ Work ☐ Mobile ☐ Mail ☐ Portal ☐

***Continued on next page>>>>>

Patient Registration (pg. 2)

Language: ☐ English ☐ Other: _____

Race: ☐ White ☐ Other: _____

Ethnicity:
☐ Central American
☐ Cuban
☐ Dominican
☐ Hispanic or Latino/Spanish
☐ Latin American/Latin Latino
☐ Mexican
☐ Not Hispanic or Latino
☐ Puerto Rican
☐ South American
☐ Spaniard

Marital Status: _____

Are You Homebound? ☐ Yes ☐ No

How did you hear about us?
☐ Advertising
☐ Primary Care Physician
☐ Specialist Physician
☐ Word of Mouth
☐ Patient in Practice
☐ Hospital
☐ Insurance Company
☐ Other

Do you wish to register for the Patient Portal? ☐ Yes ☐ No

Guardian Last Name: _____
(if applicable)

Guardian First Name: _____
(if applicable)

Guardian Middle Initial: _____
(if applicable)

Guardian Suffix: _____
(if applicable)

Emergency Contact Name: _____

Emergency Contact Relation: _____

Emergency Contact Phone: (_____) _____ - _____

Emergency Contact Mobile Phone: (_____) _____ - _____

Next of Kin Name: _____

Next of Kin Relation: _____

Next of Kin Phone: (_____) _____ - _____

Employer Name: _____

Employer Phone: (_____) _____ - _____

Occupation: _____

Patient Registration (pg. 3)

Guarantor Information (name to whom statements are sent):

Relationship to Guarantor: _____
(skip remainder of page if "self")
Guarantor Last Name: _____

Guarantor First Name: _____

Guarantor Middle Initial: _____

Guarantor Suffix: _____

Guarantor Date of Birth: _____/ _____/ _____

Guarantor Address: _____

Guarantor Address line 2: _____

Guarantor Zip: _____

Guarantor City: _____

Guarantor State: _____

Guarantor Social Security Number: _____ - _____ - _____
(optional)
Guarantor Phone: (_____) _____ - _____

Guarantor Email: _____

Guarantor Employer: _____

Insurance Information:

Please complete the insurance information below completely to ensure billing accuracy.

1st Insurance Company		2nd Insurance Company	
Company Name		Company Name	
Relationship to Insured		Relationship to Insured	
Policy Number		Policy Number	
Group Number		Group Number	
Effective date		Effective date	
Co-Payment Amount		Co-Payment Amount	
Type of Insurance Plan		Type of Insurance Plan	

Patient Registration (pg. 4)

Policy Holder Information:

☐ Self

Last Name: _____

First Name: _____

Middle Initial: _____

Suffix: _____

Address: _____

Address line 2: _____

Zip Code: _____

City: _____

State: _____

Social Security Number: _____ - ____ - _____

Date of Birth: ____/ ____/ _____

Sex: ☐ Male ☐ Female

Employer Name: _____

****Please note:**

***Insurance Co-Payments are due at the time of Service.**

***New patients: Please contact your insurance company before your 1st appointment to ensure that Dr. Foley is listed as your Primary Care Provider (PCP).**

Patient Registration (pg. 5)

Patient Release of Billing Information and Assignment of Benefits

I hereby authorize the processing of the medical insurance either by electronic or by manual method by Foley Family Practice P.C. My signature below authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer (listed above on this form) to pay Foley Family Practice P.C. I further authorize assignee to release all medical and/or insurance claim information necessary to secure payment(s). I recognize my financial obligation of any co-insurance or deductible and any non-covered services that may be required. I realize that it is my responsibility to know what my insurance covers. This agreement will remain in effect until revoked by me in writing.

Patient Signature: _____ Date: ____/____/_____

I understand that it is my responsibility to notify and confirm with my insurance that I am changing my primary care provider to Dr. Heidi J Foley. By signing this form, I am stating that I will pay any fees not covered by insurance if the change of primary care provider has not gone through by the time of my first appointment.

Patient Signature: _____ Date: ____/____/_____

Medicare Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Foley Family Practice P.C. for any services furnished by me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financial Administration and its agents any information needed to determine these benefits payable to related services. I understand my signature below requests that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 or the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determined by the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered charges. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature: _____ Date: ____/____/_____

Permission to Release Medication History

I hereby give permission for Heidi J. Foley, M.D. and her staff to retrieve my medication history either electronically or verbally

Patient Signature: _____ Date: ____/____/_____

Permission to Discuss Medical Information

I hereby give permission for Heidi J. Foley, M.D. and her staff to discuss my medical record with:

_____ _____
_____ _____
_____ _____

Patient Signature:_____ Date: ____/____/_____

Patient Registration (pg. 6)

Reminder Call Questions

We are now using an automated reminder call and messaging system to notify you of upcoming appointments, lab results, test results, announcements and billing information. For your upcoming appointments you will be contacted two days in advance and given the opportunity to confirm or change your appointment. For lab and test results you will be directed to select to hear your results on the phone or view them on the patient portal. Because of this, we need you to answer a few questions so we can set up the call and messaging system to your preferences.

Do you want automated calls and messages to be placed regarding (Select all that apply):

Appointments:	☐	Email	☐	Home Phone	☐	Text Message
Lab and Test Results:	☐	Email	☐	Home Phone	☐	Text Message
Announcements:	☐	Email	☐	Home Phone	☐	Text Message
Billing:	☐	Email	☐	Home Phone	☐	Text Message

Please provide us with the following information for our automated messaging system:

Email Address:_____
Home Telephone:_____
Mobile Telephone:_____

We also need to know if there are any restrictions as to who is allowed to reschedule your appointments. Please note these below:

_____

_____

_____

_____

Thank you for taking the time to answer these questions. Please note that if you wish to change any of this information in the future you will have to notify us.