Grove Medical Associates, PC

Primary Care Center of Excellence

John E. Kelly, MD
Dennis E. Murphy, MD
David E. Weinstock, DO

Elias V. Belezos, MD
Andrew F. Moring, PA-C
Michaela A. Richardson, FNP-C

Welcome to our Practice!

Thank you for choosing Grove Medical Associates, P.C. as your medical care provider. We look forward to developing an ongoing relationship with you. Our goal is to provide you with excellent medical care.

To expedite your first visit, we ask that you please accommodate us with the following:

1. Please bring your insurance card to every appointment. It is our office policy to require payment in full at the time of your first visit if you do not provide us with your insurance card. We accept cash, check, Visa and MasterCard for your convenience.
2. Please call your insurance company prior to your first appointment to ensure that your Primary Care Provider here at Grove Medical Associates, P.C. is appropriately listed on your insurance account.
3. Please bring your Driver's License or other authorized form of photo I.D.
4. Please bring the completed forms attached to this letter.
5. Please be prepared to pay any copayment, coinsurance or deductible that may be associated with your appointment.
6. Please bring in all of your medications, including all over the counter (OTC) medications that you take.
7. Please arrive at least 15 minutes prior to the start of your scheduled appointment time for patient registration. We do our best to stay on schedule to accommodate all of our patients. Please call the office if you are going to be late for any of your appointments, as you may be required to reschedule.

Our staff is available by phone Monday through Friday from 9:00AM to 12:30PM and from 1:30PM to 4:30PM. Please allow a reasonable amount of time for our staff to return your calls or obtain a response from your Primary Care Provider. Our staff is trained to respond to the majority of patient concerns and will act under the direction of the providers when administering advice. There is always a provider on-call for emergencies. You may reach our answering service after hours by calling our main telephone number at (508) 753-2060 and they will forward a message to the on-call provider.

Due to scheduling requirements, we require at least 24-hour notice for any cancelled or rescheduled appointments. A $25.00 service fee may be charged for a missed appointment or cancellation with less than 24-hour notice.

We offer our patients continuing and comprehensive care. We do encourage patients to assist us in the prevention of health problems and detection of diseases at the earliest stage. All health maintenance participation by our patients is expected to ensure we stay in compliance with health maintenance guidelines. Under appropriate circumstances, we will schedule these health maintenance appointments for you.

We offer a **Patient Portal**. This allows you access to your medical records online and a secure and convenient way to communicate with our staff. Please ask the front desk staff about our Patient Portal and see the additional information in our Patient Portal Agreement.

We look forward to getting to know you!

Sincerely,

The Providers and Staff at Grove Medical Associates, P.C.

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Patient Information

Legal First Name | Legal Last Name | Middle Initial | Suffix | Preferred First Name

Today's Visit

What is the reason for your visit today? _____

Have you been treated at Grove Medical Associates, P.C. before? ☐ Yes ☐ No

Patient Demographics

Permanent Address | Apt. # | City | State | Zip Code

Date of Birth | Social Security # | Email Address (we will never rent or sell your email address – we value your privacy)

Home Phone # | Cell Phone # | Alternate/Work Phone #

Gender | Preferred Language (**Please note: Grove Medical is not responsible to provide translators**) | Today's Date

We strive to ensure that all patients receive the highest quality of care. In order to do so, we ask that you share your racial/ethnic background and additional information so that we may review treatment of all of our patients.

Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic ☐ White ☐ Other ☐ Refuse to Report

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Refuse to Report

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner ☐ Refuse to Report

Student Status: ☐ Full Time Student ☐ Part Time Student ☐ Not a Student ☐ Refuse to Report

Educational Background: ☐ Did Not Finish High School ☐ H.S. Diploma ☐ GED/Certificate ☐ A.D. ☐ B.A/B.S. ☐ Master's Degree ☐ Doctorate Degree ☐ Some College Education ☐ Presently Enrolled in College ☐ Refuse to Report

Residence Type: ☐ Private Home ☐ Residential Home ☐ Skilled Nursing Home ☐ Assisted Living Facility ☐ Refuse to Report

Birth Order: ☐ First Child ☐ Second Child ☐ Third Child ☐ Fourth Child ☐ Fifth Child ☐ Sixth Child ☐ Refuse to Report

Responsible Party's Information (if someone other than the patient)

Legal Name of Responsible Party | Address | Apt # | City | State | Zip Code

Emergency Contact Information

Contact's Name | Contact's Phone # | Contact's Relationship to Patient

Name of Alternate Contact Not Residing at Your Address | Phone #

Who is your Primary Caregiver at Home? ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

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Patient Employment Information

Employer Name Employer Phone #

☐ Full Time ☐ Part Time ☐ Unemployed ☐ Self-Employed ☐ Retired/Active Military

Medical Insurance Information

Insurance Company Name Policy Holder's Name Policy Holder's Relationship to Patient

Policy Holder's Address Apt # City State Zip Code

Policy Holder's Birthdate Policy Holder's Social Security # Policy Holder's Employer

Do you have a Secondary Insurance? (Please list company name, policy holder's name, and policy number)

Patient Consent for Treatment

1. I voluntarily consent to any and all healthcare treatment and diagnostic procedures provided by Grove Medical Associates, P.C. and its associated clinicians and other personnel.
2. I consent to the use and disclosure of my protected health information for purposes of treatment, healthcare operations, and obtaining payment for services rendered, consistent with Grove Medical Associates, P.C. Notice of Privacy Practices.
3. I authorize payment of medical benefits to Grove Medical Associates, P.C. or their designee for services rendered.
4. I give permission to Grove Medical Associates, P.C. to obtain my complete external medication/prescription history when processing prescriptions for my medical treatment.

I have received a copy of the Notice of Privacy Practices and Financial Policy and Disclosure. (Included in this New Patient Packet) ☐ Yes ☐ No Initial _____

Patient or Authorized Person's Signature Date

New Patient Medical Record Policy

If we have obtained paper copies of your past medical records and these have been entered into your permanent electronic health record. The information contained in these records will be available to the providers and staff of Grove Medical Associates, P.C. Your paper records will be available to be picked up at the time of your first appointment with our office. If you do not want these paper records, please notify us and we will destroy them according to our policy for the destruction of personal health information. Once destroyed, we cannot reproduce these medical records. If you require another copy, you must request them from your previous medical care provider. If you have not retrieved your paper records within thirty days of your first appointment, they will be destroyed in accordance with our policy. If you have provided us with your records on a disc or flash drive, and that device is unencrypted, Grove Medical Associates, P.C. takes no responsibility for loss of data or loss of the device once the device has been returned to you.

I have read and understand the New Patient Medical Record Policy as stated above:

Patient or Authorized Person's Signature Date

Worker's Compensation Information Policy

I hereby authorize Grove Medical Associates, P.C. to use and disclose my protected health information to my employer, insurance carrier or other professional involved in my care, with regards to a worker's compensation case.

Patient or Authorized Person's Signature Date

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Prescription Medication Policy

1. I understand that should I require a prescription refill, I will call my pharmacy and ask the pharmacist to send an electronic prescription refill request to Grove Medical Associates, P.C.
2. I understand that Grove Medical Associates, P.C. may require 48 business hours notice when filling any prescription refill requests.
3. I understand that with every prescription refill request, I must specify which pharmacy I would like the prescription to be sent to.

Preferred Local Pharmacy: _____
Preferred Local Pharmacy Address: _____
Preferred Local Pharmacy Phone Number: _____

Preferred Mail-Away Pharmacy: _____
Preferred Mail-Away Pharmacy Phone Number: _____

Patient or Authorized Person's Signature _____ Date _____

Controlled Medication Prescribing Policy

Grove Medical Associates, P.C., in compliance with the DEA and all government guidelines, requires all patients receiving controlled medications to review the practice's policy and sign a written acknowledgement prior to the prescribing of any controlled medications. In the event that I require treatment with a controlled medication, I will review and sign the Grove Medical Associates, P.C. Controlled Medication Agreement and abide by the terms within the contract.

Patient or Authorized Person's Signature _____ Date _____

Patient Portal Agreement

Grove Medical Associates, P.C. offers a Patient Portal which allows online access to your medical records and the ability to communicate with Grove Medical Associates, P.C. medical staff. Below are the rules for utilizing the Patient Portal:

- I understand that NO URGENT MATTERS OR REQUESTS should be addressed on the Patient Portal. I agree to call Grove Medical Associates, P.C. directly at (508) 753-2060 with ANY URGENT MATTERS OR REQUESTS.
- I understand that I am NEVER to send information or requests regarding another patient under my personal Patient Portal account. Non-adherence to this Patient Portal policy will result in the suspension of my Patient Portal account.
- I understand that Patient Portal encounters will be completed within 48 business hours unless my provider is out of the office.
- I understand that if I do not receive any response to my Patient Portal request within 48 hours that I am to call Grove Medical Associates, P.C. directly at (508) 753-2060.
- I understand that if I lose my username and password, Grove Medical Associates, P.C. will only reassign a new username and password to me directly. I understand that I can obtain my username and password by requesting them on Grove Medical Associates, P.C. website, www.grovedoc.com. If I cannot obtain them online, I will be required to call and answer a series of security questions to verify my identity. Under NO circumstances may anyone other than myself or an authorized legal representative obtain a new username or password on my behalf.

By signing below, I understand and agree to the above policies.

Patient or Authorized Person's Signature _____ Date _____

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Financial Policy and Disclosure

This Financial Policy and Disclosure is to help us provide the most efficient and reasonable healthcare services. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment of services provided to patients.

Patients are responsible for the payment of all services provided by Grove Medical Associates, P.C.

Self-Pay Policy:

- If you are a self-pay patient, you will be required to pay for all services prior to the services being rendered.
- In addition, any outstanding balance on your account will be requested upon check-in of your next appointment.

Group Insurance Policy:

- If you are a patient who has insurance coverage, it is our policy to bill your insurance first as a courtesy to you, if we have your accurate and complete insurance information.
- If a service is provided that is not covered by your insurance company, you may be the responsible party for the entire balance of services rendered, and will be billed for the service accordingly.
- Copayments will be collected prior to the rendering of services and are the responsibility of the patient. Copayments that are not received at the time of service are subject to a $15.00 service fee. Deductibles and coinsurances will be billed in accordance with the processing of your insurance claims.
- In certain cases, we may require your assistance in contacting your insurance company for payment of services rendered.
- A $20.00 service fee will be charged for all returned checks.

Worker's Compensation Financial Policy:

- If you are a patient being evaluated under a Worker's Compensation case, it is our policy to bill your employer or the Worker's Compensation carrier for services rendered. Upon verification of the status of your Worker's Compensation claim, and completion of your insurance forms, Grove Medical Associates, P.C. can accept assignment of your claim. This information must be provided on the date of your first treatment.
- If you are covered under a Worker's Compensation case, we will accept payments from the Worker's Compensation carrier as per contracted rates based on the mandated Massachusetts state fee schedule.
- If payment is denied from your Worker's Compensation carrier, you may be the responsible party for the entire balance of services rendered, although we will make every effort to bill your medical insurance carrier.

Motor Vehicle Accident Financial Policy:

- If you have been involved in a motor vehicle accident, Grove Medical Associates, P.C. requires the insurance information of the vehicle in which you were riding. This information must be provided on the date of your first treatment.
- If payment is denied by the motor vehicle insurance, you may be the responsible party for the entire balance of services rendered, although we will make every effort to bill your medical insurance carrier.
- I hereby authorize any motor vehicle insurance payment directly to Grove Medical Associates, P.C. This authorization supersedes any and all other assignment of benefit claims including those of my Attorney.

Outstanding and Credit Balances Policy:

- All outstanding patient balances will be sent to a collection agency.
- All accounts sent to the collection agency will be charged a $15.00 collection fee in addition to the account balance.
- One of the following must be present for all patients with outstanding balances PRIOR to scheduling another appointment:
    1. A signed payment agreement and full compliance with monthly payment arrangements.
    2. Payment in full PRIOR to your next scheduled appointment.

Please note: If at any time your account is not in good standing, the practice reserves the right to cancel or reschedule your visits. If all attempts at collection fail, a patient may be discharged from the practice.

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Financial Policy and Disclosure cont.

Cancellation and No-Show Appointment Policy:

- The Grove Medical Associates, P.C. Cancellation and No-Show Policy states that a $25.00 service fee will be charged for all appointments not cancelled with a 24 hour notice to the practice or for all appointments not attended in which no attempt at cancellation is made. This Cancellation and No-Show Policy is posted in the office.
- Three No-Show appointments may result in the inability to schedule any further appointments with any provider at Grove Medical Associates, P.C. and may result in termination from the practice.

By signing below, I acknowledge that I have read and understand the terms of the Grove Medical Associates, P.C. Financial Policy and Disclosure and agree to abide by the policies as described:

Patient or Authorized Person's Signature _____ Date _____

Assignment of Benefits

I authorize Grove Medical Associates, P.C. to initiate a complaint to the insurance commissioner for any reason on my behalf.

I request that payment of authorized Medicare and/or other medical insurance company benefits be made on my behalf to Grove Medical Associates, P.C. for any services rendered to me. I authorize Grove Medical Associates, P.C. to release any information needed to determine these benefits or the benefits payable for related services to the Centers for Medicare & Medicaid Services (CMS) and/or other medical insurance company and their authorized agents.

To assist Grove Medical Associates, P.C., I agree to:

1. Provide my current demographic information and insurance carrier information.
2. Provide a current photo identification card and insurance card when changes are made.
3. Make the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or the entire amount if I am a Self-Pay patient.

Patient or Authorized Person's Signature _____ Date _____

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Notice of Privacy Practices

This Notice of Privacy Practices describes how your medical information may be used and disclosed, and how you can obtain access to this information. Please review this document carefully.

Protected Health Information (PHI): Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal laws, your PHI is confidential. PHI includes information about your symptoms, test results, diagnoses, treatment, and related medical information. Your PHI also includes payment, billing and insurance information. We are committed to protecting the privacy of your PHI.

How we use your PHI: This Notice of Privacy Practices describes how we may use your PHI within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, to obtain payment of rendered services, to perform healthcare operations, for administrative purposes and for evaluation of quality of care. We may also share your PHI for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Under some circumstances described below, we may be required to use or disclose your PHI without your consent.

Treatment: We will use and disclose your PHI to provide medical treatment or services. We may also disclose your PHI to other healthcare providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are assisting in your care.

Payment: We will use and disclose your PHI for payment purposes. For example, we may need to obtain authorization from your insurance carrier before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. PHI may be shared with the following: billing companies, insurance carriers/health plans, government agencies or collection agencies.

Healthcare Operation and Administration: We will use and disclose your PHI to perform various routine functions of a medical office. For example, PHI may be used in quality evaluations, records analysis, student and employee training, and to assist in resolving problems or complaints within the practice. We may use your PHI to contact you to provide information about referrals, for follow-up with lab results, to inquire about your health or for other reasons. We may share your PHI with Business Associates who assist in performing routine operational functions. These Business Associates adhere to the same safeguards as our office.

We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we may better care for you. Despite safeguards, it is always possible in a healthcare setting that you may learn information regarding other patients or that other patients may learn information about you. In all cases, we expect and request that our patients maintain strict confidentiality of PHI.

Special Situations that DO NOT Require Your Permission: We may be required by law to report gunshot wounds, suspected abuse or neglect, vital statistics, diseases and similar information to public health authorities. We may be required by law to disclose information for audits and similar activities in response to a subpoena or court order, or as required by law enforcement officials. We may release your PHI to worker's compensation carriers, government programs, approved medical research, or to certain entities in the case of death. Your PHI may also be shared if you are an inmate or under custody of the law which is necessary for your health or the health and safety of other individuals. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces Personnel for activities deemed necessary by the appropriate military authorities. We may disclose affairs of your eligibility for benefits to domestic or foreign military authorities if you are a member of those military affiliations. In some situations, we may ask for your written authorization before using or disclosing your PHI. If you sign an authorization, you may later revoke it in writing.

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Notice of Privacy Practices cont.

Individual Rights: You have certain rights with regards to your PHI. For example, you may identify individuals such as family members or friends with whom we may share your PHI. If you are not present or available to agree/object, the healthcare provider will use professional judgement to determine if it is appropriate and in your best interest to share the information with these individuals. We may use or disclose your PHI to notify these identified individuals of your location, general condition or death.

You may request restrictions on certain uses and disclosures of your PHI. We are not required to accept all restrictions. If you pay in full for a treatment or service at the time it is rendered, you can request that we not share this information with your medical insurance carrier or our Business Associates. We will make every effort to accommodate this request and if we cannot, we will inform you prior to rendering the service.

You may ask us to communicate with you confidentially, for example via sending notices to a special address.

In most cases, you have the right to get a copy of your PHI. There will be a charge for distributing these records. You will be informed of the amount of this charge and required to make payment in full prior to obtaining these records.

If you believe that information in your record is incorrect, or important information is missing, you have the right to submit a written request that we amend the existing information. You may request a list of instances in which we have disclosed your PHI for reasons other than treatment, payment and operations. The first request in a 12-month period is free of charge. Any additional requests may be subject to a service fee.

You have the right to obtain a paper copy of this Notice of Privacy Practices from us, upon request. We will provide you a copy of this Notice on the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible. You have the right to receive notification of any breach of your protected health information.

Our Legal Duty: We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area of our office and on our website at www.grovedoc.com.

If you are concerned about your privacy rights, or if you disagree with a decision that has been made about your PHI, you may contact our Privacy Officer at 508-753-2060. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

My signature below acknowledges that I have been provided a copy of the Gove Medical Associates, P.C. Notice of Privacy Practices and I understand and agree to the terms as described within the Notice of Privacy Practices.

Patient or Authorized Person's Signature _____ Date _____

Legal Authorization:

I hereby authorize the release of my medical records to any subpoenas that may be received by Grove Medical Associates, P.C. due to litigation:

Patient or Authorized Person's Signature _____ Date _____

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Patient Contact Consent Form

First Name _____ Last Name _____ Middle Initial _____ Date of Birth _____ Today's Date _____

I consent and agree that Grove Medical Associates, P.C. may contact me in regards to laboratory results, outside testing results, financial information and appointment information at the following telephone numbers:

Home Phone Number: _____
☐ OK to leave a message with detailed information

Cell Phone Number: _____
☐ OK to leave a message with detailed information

Work/Alternate Phone Number: _____
☐ OK to leave a message with detailed information

My Preferred Phone Number: ☐ Home ☐ Cell ☐ Work/Alternate

Current Mailing Address: _____

I consent that Grove Medical Associates, P.C. may contact and leave a message with the following person in regards to laboratory tests, outside testing results, financial information and appointment information.

First Name _____ Last Name _____ Relationship to Patient _____ Phone # _____

I understand and agree to the terms above and acknowledge that the information provided is accurate and complete.

Patient or Authorized Person's Signature _____ Date _____

Electronic Health Maintenance Communication Policy

Grove Medical Associates, P.C. will periodically send electronic communications regarding health maintenance reminders. Please indicate your preferences below:

My Preferred Communication Method: ☐ Phone call ☐ SMS Text Message (will use cell phone) ☐ Patient Portal Message

My Preferred Phone Number: ☐ Home ☐ Cell ☐ Work/Alternate

My Current Email Address: _____

My Preferred Time of Day for Contact: ☐ Morning ☐ Afternoon ☐ Evening

By signing below, I understand the Grove Medical Associates, P.C. Electronic Health Communication Policy and agree to receive periodic health maintenance communications from Grove Medical Associates, P.C.

Patient or Authorized Person's Signature _____ Date _____

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Patient Medical History

Patient Name:_____ Date of Birth:_____ Today's Date:_____

Allergies

1. Medication:_____ Reaction:_____
2. Medication:_____ Reaction:_____
3. Medication:_____ Reaction:_____
4. Medication:_____ Reaction:_____
5. Other:_____ Reaction:_____

If you have no known allergies, please check the box at the right. ☐ No known allergies to report

Past Medical History

Do you now or have you ever had any of the following (please check all that apply):

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hypothyroidism
- ☐ Goiter
- ☐ Cancer (Type) _____
- ☐ Leukemia
- ☐ Psoriasis
- ☐ Angina
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke
- ☐ Epilepsy (seizures)
- ☐ Cataracts
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Anemia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Stomach/peptic ulcer
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ HIV/AIDS

Other Medical Conditions (please list):

_____

_____

_____

Surgical History

Please list all major surgeries with estimated dates:

_____

_____

_____

If you have never had any major surgeries, please check the box at the right. ☐ No surgeries to report

Family Medical History

Mother:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify)_____	N/A
Father:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify)_____	N/A
Brother:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify)_____	N/A
Sister:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify)_____	N/A
Grandmother (M):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify)_____	N/A
Grandmother (P):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify)_____	N/A
Grandfather (M):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify)_____	N/A
Grandfather (P):	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify)_____	N/A

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Social History

Alcohol Consumption: ☐ Current ☐ In the past ☐ Never How much and how often?_____
Tobacco Use: ☐ Current ☐ In the past ☐ Never How much? Which product?_____
Recreational Drug Use: ☐ Current ☐ In the past ☐ Never Which substance?_____

Current Medications and Dosage

Please list all current medications and their dosages: ☐ No medications to report

_____
_____
_____
_____

Additional Medical Information

Date of Last Tetanus Vaccine:_____ Date of Last Shingles Vaccine (Zostavax): _____
Date of Last Pneumonia Vaccine:_____ Date of Last Prevnar Vaccine:_____
Date of Last Influenza Vaccine:_____

Date of Last Menstrual Period:_____ ☐ N/A
Are You Currently Pregnant? ☐ Yes ☐ No
Are You Currently Breastfeeding? ☐ Yes ☐ No

Patient Acknowledgement

To the best of my knowledge, the information provided above is accurate and complete.

_____
Patient or Authorized Person's Signature Date