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

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 _____