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.

Today's Date _____

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)

_____

Home Phone # Cell Phone # Alternate/Work Phone #

_____

Gender Preferred Language (**Please note: Grove Medical is not responsible to provide translators**)

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 so that we may improve our patient care. Please Circle Answers:

Race: African American American Indian/Alaska Native Asian Hispanic White Pacific Islander 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: _____

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. Initial _____
(Included in this New Patient Packet)

X_____

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:

X_____

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

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 _____

X_____

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.

X_____

Patient or Authorized Person's Signature Date

Patient Portal Agreement/Rules For Using the Patient Portal

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. ***By using the Patient Portal you agree to the following:***

- The Patient Portal is NOT FOR URGENT MATTERS OR REQUESTS. I will call Grove Medical Associates, P.C. directly at (508) 753-2060 with ANY URGENT MATTERS OR REQUESTS.
- NEVER 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.
- Patient Portal encounters will be completed within 48 business hours unless my provider is out of the office.
- If I do not receive a response to my Patient Portal request within 48 hours that I am to call Grove Medical Associates, P.C. directly at (508) 753-2060.
- Grove Medical Associates, P.C. will only assign new usernames and passwords to me directly. 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 am required to call and answer 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.

X_____

Patient or Authorized Person's Signature Date