



ELECTRONIC FORM DISCLAIMER: Compass Medical is deeply committed to protecting our patient's rights to privacy and safeguarding patient information. Please know we are working hard to bring our patients secure electronic messaging in the near future, however, at this time, we do not offer secure messaging. **Therefore, please do not attempt to fill out this form and send it back to Compass Medical electronically.** Please bring the completed form with you to your next visit. If you attempt to send this form back via fax, email, or any other means, you expressly assume all risk of any unauthorized disclosure of your information.

Welcome to Compass Medical!

We are honored you chose us as your healthcare provider! We are excited to begin our partnership with you and look forward to creating an exceptional experience for you and your family.

This **New Patient Information Packet** is designed to collect the information necessary to begin our partnership. It also contains important information for you as our patient. In an effort to streamline the registration process, please complete, sign and return the following items prior to your first appointment:

- ┆ **Patient Registration Form**
- ┆ **Payment Policy**
- ┆ **Family Health History**
- ┆ **Medication List and Preferred Pharmacy List of Current**
- ┆ **Specialists, Allergies and Surgical History**

In addition, please contact your previous Primary Care Provider to request your medical records be transferred to your new Compass Medical office. If your insurance company requires you to designate a primary care provider, please call your insurance company today to inform them of your new Compass Medical provider. Also, please remember to bring your insurance card and photo ID with you to your first appointment.

At Compass Medical, our goal is to provide exceptional medicine and compassionate care to each and every patient, every time. Our outstanding medical teams work together in Internal Medicine, Family Medicine, Urgent Care, Radiology, Cardiology, Diabetic Education, Nutrition, Podiatry, Physiatry and Behavioral Health to effectively coordinate our patients' care. Linked by our award winning, state-of-the-art electronic medical record system, Compass Medical makes it easy to visit an in-house specialist or Urgent Care provider. In addition, all Compass Medical patients have access to our in-house lab located in East Bridgewater. Compass Medical offers language assistance services, free of charge, for any patient that speaks any language other than English. Please contact your provider's office to arrange for an interpreter.

Compass Medical works diligently to ensure your clinical experience is exceptional every time. In an effort to measure your patient experience, we have teamed up with Press Ganey Associates to collect and evaluate patient feedback. After visiting with your PCP or one of our Urgent Care sites, you may receive a patient satisfaction survey in the mail or by email after your office visit. Completing these surveys provides Compass Medical with extremely important feedback and we look forward to hearing about your experience through these surveys.

Compass Medical also offers patients access to a secure and easy to use online patient portal. Compass Health Connection is a free patient portal gateway that makes it easy for you to securely access portions of your health record and allows you to navigate and make informed decisions about your health from anywhere, at any time. With Compass Health Connection, adult patients can view detailed information about your upcoming and past appointments, review your clinical visit summaries, view lab test results, view and download your Personal Health Record, request prescription refills and update personal demographic information. You can sign up for Compass Health Connection at your first appointment.

It is with the greatest pleasure that we welcome you to Compass Medical and look forward to exceeding your expectations at each and every visit. For any additional information, please visit our website at: www.CompassMedical.net.



Account #: _____
Date: ____/____/____
PCP: _____

PATIENT REGISTRATION FORM

PERSONAL INFORMATION

First Name _____ MI _____ Last Name _____ Suffix _____

Previous Name _____ Preferred Name _____ Birth Date _____ Sex Female Male

Address _____ City _____ State _____ Zip _____ Country _____

**While Compass Medical recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence.*

If a Child, Parent/Guardian's First Name _____ MI _____ Last Name _____

Please select a primary phone number by checking the appropriate box below

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Marital Status Married Single Divorced Legally Separated Partner Widow

Email Address _____

By giving Compass Medical, P.C. my email address, I understand I am giving them permission to send me health related information through my email with the confidence of knowing that I may safely unsubscribe at any time.

Preferred Method of Contact Letter Email

Employment Status Employed Retired On Active Military Duty Unemployed Other

Student Status Student Not a Student

EMERGENCY CONTACT

First Name _____ MI _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Relationship to Patient Parent Spouse Partner Child Sibling Grandparent Other _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Insurance Company _____ Phone Number (____) _____

Subscriber Name _____ Relationship to Patient _____ Birth Date _____

Policy # _____ Group # _____ Effective Date _____

SECONDARY INSURANCE:

Insurance Company _____ Phone Number (____) _____

Subscriber Name _____ Relationship to Patient _____ Birth Date _____

Policy # _____ Group # _____ Effective Date _____

PHARMACY

Preferred Pharmacy Name _____ Phone (____) _____

Address _____ City _____ State _____

HOW DID YOU HEAR ABOUT US? (Please check one.)

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Insurance Company | <input type="checkbox"/> Non-Compass Provider Referral | <input type="checkbox"/> Online Ad |
| <input type="checkbox"/> Compass Medical Website | <input type="checkbox"/> General Internet Search | <input type="checkbox"/> Other: _____ |

PATIENT DEMOGRAPHICS

Studies have shown there are health differences among different racial and ethnic groups. Your answers will help us make informed clinical decisions for improved delivery of your health care. Providing this information is voluntary and will be kept confidential and will only be used to meet the needs of the patients we serve.

1. Which of the following best describes your Race?

- checkbox American Indian or Alaska Native checkbox Asian checkbox Black or African American checkbox Declined to Specify checkbox Native Hawaiian or other Pacific Islander checkbox White/Caucasian checkbox Other: _____

2. Preferred Language?

- checkbox English checkbox Portuguese checkbox Creole: _____ checkbox Sign Language: _____ checkbox Declined to Specify checkbox Spanish/Castilian checkbox Chinese checkbox Urdu checkbox Other: _____

3. Which of the following best describes your Ethnicity?

- checkbox Not Hispanic or Latino/a checkbox Hispanic or Latino/a checkbox Other: _____ checkbox Declined to Specify

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT

(For Medicare Patient Use Only)

Name of Beneficiary (Patient) _____ HICN # (Medicare #) _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in Compass Medical, P.C. including physician services. I authorize any holder of medical or other information about me be released to the Centers for Medicare and Medicaid and its agents any information needed to determine these benefits or benefits for related services.

Signature of Patient: _____ Date: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Compass Medical, PC Notice of Privacy Practices (included in the back of this packet) and I understand that I may request a copy of this notice at any time.

By signing my name below, I agree to the above information.

Signature of Patient or Responsible Party: _____ Date: _____

PRESCRIPTION HISTORY CONSENT

I authorize Compass Medical to obtain a history of my prescriptions during the course of medical care by Compass Medical Physicians and Providers.

By signing my name below, I agree to the above information.

Signature of Patient or Responsible Party: _____ Date: _____



PAYMENT POLICY

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be forwarded to you upon request.

- 1. INSURANCE:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage or prior to scheduling a physical or screening test to verify coverage for these services. It is your responsibility to verify that the physician and/or facility in which you are seeking treatment is an authorized provider under your insurance plan. A current provider listing should be made available to you by your employer, insurance company or insurance company's web-site.
- 2. CO-PAYMENTS AND DEDUCTIBLES:** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients may be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
- 3. NON-COVERED SERVICES:** Please be aware that some-and perhaps all- of the services you receive may be non-covered or not considered reasonable or necessary by your insurance carrier. This may include physicals and screening tests. Please be aware that in the event of a scheduled annual physical, if the physician finds a new problem or an unstable chronic medical condition that requires further evaluation, an office visit may be billed in addition to the physical charge. However, some insurance carriers will not cover both services on the same day. Therefore, you may be billed for the portion not covered by the insurance carrier.
- 4. UNINSURED:** Patients with no insurance are expected to pay for their office visit at the time of service. Any additional charges for ancillary services will be billed to the patient.
- 5. PROOF OF INSURANCE:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license or other form of valid photo identification and your current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for any charges. Your insurance card must be presented at each visit.
- 6. CLAIMS SUBMISSION:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim may be your responsibility if your insurance company does not pay your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.
- 7. COVERAGE CHANGES:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. We will not be responsible for any denied claims due to filing deadlines if new insurance information was not given at the time of service.
- 8. WORKERS' COMPENSATION AND AUTOMOBILE ACCIDENTS:** In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you may be asked to either reschedule your appointment or pay for your visit at the time of service.
- 9. REFERRALS:** If you have an HMO plan with which we are contracted, you need to obtain a referral from your primary care physician prior to your appointment. If we have not received a referral prior to your arrival at the office, you will be rescheduled or asked to sign a waiver assuming all financial liability for the visit.
- 10. NONPAYMENT:** Your communication and involvement to ensure your balance is paid timely is important to us. It is imperative that you maintain communications and fulfill your financial agreement and arrangements to keep your account active and in good standing. Compass Medical reserves the right to deny future non-emergency treatment for any and all debtor-related unpaid account balances until the balance is paid in full. In addition, providers may no longer be able to continue providing you with care because of nonpayment. If your account balance becomes 90 days past due, further steps to collect this debt may be taken, including reporting the account to a collection agency. If the provider is unable to continue providing care because of nonpayment, you will be notified by mail that you have 30 days to pay the balance in full or find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis or until you are no longer in an acute phase of treatment or in the process of medical workup for diagnosis.
- 11. MISSED APPOINTMENTS:** Please be aware that your office *may* charge a fee for any appointments not canceled within 24 hours. For more information on your site's specific policy, please contact your site directly. Any fees incurred due to missed appointments without prior cancelation will be your responsibility and billed directly to you.
- 12. PAYMENT OPTIONS:** We accept MasterCard, Visa and Discover, cash, checks or debit cards. We also can set up a budget payment plan if your entire balance cannot be paid in full within 30 days. Please contact our Billing Department at (508) 350-2450 to set up a budget plan.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES.

Signature of Patient or Responsible Party: _____

Date: _____

For Office Use Only

Account #: _____



ELECTRONIC FORM DISCLAIMER: Compass Medical is deeply committed to protecting our patient's rights to privacy and safeguarding patient information. Please know we are working hard to bring our patients secure electronic messaging in the near future, however, at this time, we do not offer secure messaging. Therefore, please do not attempt to fill out this form and send it back to Compass Medical electronically. Please bring the completed form with you to your next visit. If you attempt to send this form back via fax, email, or any other means, you expressly assume all risk of any unauthorized disclosure of your information.

Patient Name: _____ Date of Birth: _____ Date: _____

MEDICATION HISTORY

Please list all prescriptions, over-the-counter medications, herbal supplements, etc. that you are currently taking. Please use the back of page if you need additional space.

	Medication Name	Dose <i>(ex: 25mg)</i>	How do you take this medication? <i>(ex: one tab twice per day)</i>	What do you take this for? <i>(ex: blood pressure)</i>
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

PREFERRED PHARMACY

Please list as #1 your **PREFERRED PHARMACY** for all maintenance medications.

List #2 a secondary pharmacy **ONLY** if you use a local pharmacy for same day prescriptions, not preferred MAILAWAY

	Pharmacy Name	Pharmacy Address (street/town)	Pharmacy Phone
1			
2			

For Office Use Only

Account #: _____



ELECTRONIC FORM DISCLAIMER: Compass Medical is deeply committed to protecting our patient's rights to privacy and safeguarding patient information. Please know we are working hard to bring our patients secure electronic messaging in the near future, however, at this time, we do not offer secure messaging. **Therefore, please do not attempt to fill out this form and send it back to Compass Medical electronically.** Please bring the completed form with you to your next visit. If you attempt to send this form back via fax, email, or any other means, you expressly assume all risk of any unauthorized disclosure of your information.

Patient Name: _____ Date of Birth: _____ Date: _____

ALLERGY HISTORY

Please list all/any allergies you have had in your lifetime. Allergies to medication, food, environmental, seasonal etc.

Type of Allergy	Reaction

SURGICAL HISTORY

Please list all surgical procedures you have had in your lifetime.

Type of Surgery	Surgeon	Date of Surgery



ELECTRONIC FORM DISCLAIMER: Compass Medical is deeply committed to protecting our patient's rights to privacy and safeguarding patient information. Please know we are working hard to bring our patients secure electronic messaging in the near future, however, at this time, we do not offer secure messaging. Therefore, please do not attempt to fill out this form and send it back to Compass Medical electronically. Please bring the completed form with you to your next visit. If you attempt to send this form back via fax, email, or any other means, you expressly assume all risk of any unauthorized disclosure of your information.

LIST OF CURRENT SPECIALISTS

Please list the following information for all the specialist that you are currently seeing.

Specialist Name	Specialty	Reason/Diagnosis	For How Long

Patient Name: _____ DOB: _____ DATE: _____

FAMILY HISTORY

Please list your biological family members who are/were affected by the following conditions

FAMILY MEMBER	YOB	AGE	DIAGNOSIS (Mark all that apply with the year of diagnosis)			OTHER CONDITION
Mother ┆ Living ┆ Deceased			____ Diabetes ____ Hypertension ____ Heart Disease	____ Breast Cancer ____ Colon Cancer ____ Ovarian Cancer	____ Mental Illness ____ Drug/Alcohol Abuse	
Father ┆ Living ┆ Deceased			____ Diabetes ____ Hypertension ____ Heart Disease	____ Breast Cancer ____ Colon Cancer ____ Ovarian Cancer	____ Mental Illness ____ Drug/Alcohol Abuse	
Sister 1 ┆ Living ┆ Deceased			____ Diabetes ____ Hypertension ____ Heart Disease	____ Breast Cancer ____ Colon Cancer ____ Ovarian Cancer	____ Mental Illness ____ Drug/Alcohol Abuse	
Brother 1 ┆ Living ┆ Deceased			____ Diabetes ____ Hypertension ____ Heart Disease	____ Breast Cancer ____ Colon Cancer ____ Ovarian Cancer	____ Mental Illness ____ Drug/Alcohol Abuse	
Sister 2 ┆ Living ┆ Deceased			____ Diabetes ____ Hypertension ____ Heart Disease	____ Breast Cancer ____ Colon Cancer ____ Ovarian Cancer	____ Mental Illness ____ Drug/Alcohol Abuse	
Brother 2 ┆ Living ┆ Deceased			____ Diabetes ____ Hypertension ____ Heart Disease	____ Breast Cancer ____ Colon Cancer ____ Ovarian Cancer	____ Mental Illness ____ Drug/Alcohol Abuse	
Sister 3 ┆ Living ┆ Deceased			____ Diabetes ____ Hypertension ____ Heart Disease	____ Breast Cancer ____ Colon Cancer ____ Ovarian Cancer	____ Mental Illness ____ Drug/Alcohol Abuse	
Brother 3 ┆ Living ┆ Deceased			____ Diabetes ____ Hypertension ____ Heart Disease	____ Breast Cancer ____ Colon Cancer ____ Ovarian Cancer	____ Mental Illness ____ Drug/Alcohol Abuse	
Maternal Grandmother ┆ Living ┆ Deceased			____ Diabetes ____ Hypertension ____ Heart Disease	____ Breast Cancer ____ Colon Cancer ____ Ovarian Cancer	____ Mental Illness ____ Drug/Alcohol Abuse	
Maternal Grandfather ┆ Living ┆ Deceased			____ Diabetes ____ Hypertension ____ Heart Disease	____ Breast Cancer ____ Colon Cancer ____ Ovarian Cancer	____ Mental Illness ____ Drug/Alcohol Abuse	
Maternal Aunt ┆ Living ┆ Deceased			____ Diabetes ____ Hypertension ____ Heart Disease	____ Breast Cancer ____ Colon Cancer ____ Ovarian Cancer	____ Mental Illness ____ Drug/Alcohol Abuse	
Maternal Uncle ┆ Living ┆ Deceased			____ Diabetes ____ Hypertension ____ Heart Disease	____ Breast Cancer ____ Colon Cancer ____ Ovarian Cancer	____ Mental Illness ____ Drug/Alcohol Abuse	
Paternal Grandmother ┆ Living ┆ Deceased			____ Diabetes ____ Hypertension ____ Heart Disease	____ Breast Cancer ____ Colon Cancer ____ Ovarian Cancer	____ Mental Illness ____ Drug/Alcohol Abuse	
Paternal Grandfather ┆ Living ┆ Deceased			____ Diabetes ____ Hypertension ____ Heart Disease	____ Breast Cancer ____ Colon Cancer ____ Ovarian Cancer	____ Mental Illness ____ Drug/Alcohol Abuse	
Paternal Aunt ┆ Living ┆ Deceased			____ Diabetes ____ Hypertension ____ Heart Disease	____ Breast Cancer ____ Colon Cancer ____ Ovarian Cancer	____ Mental Illness ____ Drug/Alcohol Abuse	
Paternal Uncle ┆ Living ┆ Deceased			____ Diabetes ____ Hypertension ____ Heart Disease	____ Breast Cancer ____ Colon Cancer ____ Ovarian Cancer	____ Mental Illness ____ Drug/Alcohol Abuse	
Daughter ┆ Living ┆ Deceased			____ Diabetes ____ Hypertension ____ Heart Disease	____ Breast Cancer ____ Colon Cancer ____ Ovarian Cancer	____ Mental Illness ____ Drug/Alcohol Abuse	
Son ┆ Living ┆ Deceased			____ Diabetes ____ Hypertension ____ Heart Disease	____ Breast Cancer ____ Colon Cancer ____ Ovarian Cancer	____ Mental Illness ____ Drug/Alcohol Abuse	



Medical Record # _____
To be completed by Compass Medical Staff

ELECTRONIC FORM DISCLAIMER: Compass Medical is deeply committed to protecting our patient's rights to privacy and safeguarding patient information. Please know we are working hard to bring our patients secure electronic messaging in the near future, however, at this time, we do not offer secure messaging. Therefore, please do not attempt to fill out this form and send it back to Compass Medical electronically. Please bring the completed form with you to your next visit. If you attempt to send this form back via fax, email, or any other means, you expressly assume all risk of any unauthorized disclosure of your information.

**CONSENT TO DISCLOSE PROTECTIVE HEALTH INFORMATION
TO FAMILY, FRIENDS, AND/OR OTHER REPRESENTATIVES**

THIS FORM IS OPTIONAL

Patient Name: _____ Date of Birth: _____

By signing below, I hereby authorize Compass Medical, P.C. to disclose my protected health information (PHI) to the following family members, friends etc.

<i>Name</i>	<i>Relationship</i>	<i>Phone Number</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature: _____ Today's Date: _____

By signing below, I hereby authorize the Providers and staff at Compass Medical, P.C. to leave information on my answering machine.

Patient Signature: _____ Today's Date: _____

Note: This form will be in effect until a verbal or written request has been received to revoke and/or change.

**The U.S. Department of Health and Human Services (HHS) issued the Privacy Rule under the governance of the Office of Civil Rights. The Privacy rules defines and limits the circumstances in which an individual's protected health information (PHI) may be used or disclosed. By completing this form, you are authorizing Compass Medical Providers and Staff to communicate with the individuals you have identified above about your Protected Health Information (PHI).*



AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

Compass Medical will happily file your claim with your insurance company as a courtesy. Compass Medical bills your insurance in accordance with all federal, state and other contractual requirements. I authorize Compass Medical to release all necessary information to my insurance carrier, and I assign payment of my Medical Benefits to Compass Medical. If your insurance company sends payments directly to you, send or drop-off the payment to Compass Medical Billing and we will apply it to your account.

By signing my name below, I agree to the above information.

Signature of Patient or Responsible Party (see Patient Registration form for Documentation)

Compass Medical, P.C. Medical Record Information

Compass Medical has partnered with a Bactes, a leader in release of information solutions, to help orchestrate all Medical Record Requests. Please refer to the frequently asked questions below for information on how to obtain a copy of your medical record, the cost, and the process.

The cost for reproduction on medical record requests is quite extensive, therefore, in order to fulfill your request, Bactes must ask for an upfront fee according to Massachusetts Statute. This fee is geared to off-set the rising costs associated with copying, tracking and reporting processes surrounding your request. Please contact Bactes directly for any questions or concerns regarding this fee.

Frequently Asked Questions

How can I obtain a copy of my medical record?

Complete the CMPC "Authorization for use or disclosure of Medical Record Information". Please forward this completed request to the MD office of the records that you are requesting.

Is there a cost to obtain a copy of my medical record?

Yes, there may be a charge to obtain a copy of your medical record. The cost is based on the following:

- the information requested
- the number of pages reproduced
- postage

The copy fee is in accordance with the Massachusetts law (MGL Chapter 111: Section 70).

Alternatively, you may request an 'abstract' of your medical record, which contains immunizations, two (2) years of office visits and labs, and five (5) years of radiology and diagnostic reports. The maximum fee for the abstract is \$25.00 or the MA Statute whichever is less. The abstract is usually sufficient to meet the need of many requests. Additional options and pricing can be found on the medical record request form.

How can I submit my payment?

You will receive an invoice from our release of information vendor, Bactes, shortly after we receive your request. Please note that Bactes accepts MasterCard, Visa, American Express, Discover and check or money order for payment. Unfortunately, Flex Health spending cards cannot be used for payment.

How soon can I expect the release of my medical record to be completed?

Processing time varies depending on the type of request; routine requests are usually completed within seven business days, assuming payment has been received.

Can I get my records sent to me electronically?

Yes, Bactes will provide a copy of your medical records via CD or secure email at no additional cost. Please contact Bactes directly if this is the preferred method of receiving records.

How can I get a copy of my medical record from my former doctor to my new Compass Medical, P.C. doctor?

If you need medical records from a previous doctor mailed to us, we will be happy to assist you. Simply complete the CMPC, "Authorization for use or disclosure of Medical Record Information" form and send it to your previous doctor. If provided with the mailing address, we will be happy to mail it for you. It is recommended that you contact your previous provider to obtain their medical record processing details as fees may apply.

Patient Information

Patient Name (Please Print): _____ Date of Birth: _____
 Any other Previous Names: _____
 Patient Address: _____ Phone #'s: _____
 City: _____ State: _____ Zip: _____ EMAIL: _____
 Your Compass Medical Doctor's Name that you are requesting records from: _____

I hereby Authorize Compass Medical to:

Please choose one: Release my medical record information to Obtain medical information from

Name/Facility: _____ Attention: _____
 Address: _____ Phone #: _____
 City: _____ State: _____ Zip: _____ Fax #: _____

Purpose of Request: Personal Referral or 2nd Opinion Legal Insurance Other _____
 Transfer from Practice/Reason? _____

Specific Records/Report(s) to be released:

- Provide a 2 year abstract of my records.
- Provide a copy of my full electronic record.
- Other - be specific, include dates and MD's under comments.

*****Please do not prepay. You will be invoiced for your selection by our vendor.*****

*COPY FEE: For Patient record requests – Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record or more than the two-year abstract, the rate will increase proportionately based on the cost. For all other release of information requests, the Massachusetts Chapter 111, Section 70 guidance will be followed.

Restricted Authorization to Release Protected Information:



IMPORTANT - It is extremely important that you select either you "DO" or "DO NOT" for each item contained in this section Authorization to Release Protected Information. Please do not skip any line item as it could impact our ability to fulfill your request and cause additional delays.

Release Records? Check one

- I **DO** **DO NOT** want **Mental/Behavior Health or Disability Services Provider Documentation** * released.
- I **DO** **DO NOT** want **HIV/AIDS Screening Test Results** released
- I **DO** **DO NOT** want information about **Alcohol and/or Substance Abuse Treatment** *** released
- I **DO** **DO NOT** want **Genetic Testing/Test Results** ** released
- I **DO** **DO NOT** want **Confidential Communications with a Social Worker** released
- I **DO** **DO NOT** want information about **Rape/Sexual Assault Victim's Counseling** released
- I **DO** **DO NOT** want **Child/Elder Abuse or Neglect & Abuse of an Adult with a Disability** released
- I **DO** **DO NOT** want information about **Sexually Transmitted Disease (STD's)** released
- I **DO** **DO NOT** want information about **Domestic Violence Victim's Counseling** released

* This Authorization is not valid for use or disclosure of psychotherapy notes.

** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not test done to diagnose a current condition or problem. This includes information related to the testing of embryo's created during IVF.

*** Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment" (42 CFR Part 2). Does not include records created or maintained by a general medical facility.

Sign Here

Date Here

Signature of Patient's

Date

Signature of Personal Representative

Date

Relationship to patient or authority to act for patient

Term: This Authorization will remain in effect until Compass Medical fulfills this request.

Revocation: I understand that I may revoke this Authorization at any time by requesting it of Compass Medical in writing at the address listed below. The revocation will be effective immediately upon Compass Medical's receipt of my written notice. I understand that the revocation will not have any effect on any action taken by Compass Medical in reliance on this Authorization before it received my written notice of revocation.

Written Notice is to be mailed to: ADDRESS INSERTED HERE

Effect on Treatment: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment at Compass Medical

Potential for Redisclosure: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state Privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by Compass Medical.

Access: I understand that in certain circumstances Compass Medical has the right to deny me access to all or portions of my Protected Health Information and must notify me in writing of any such denials.



NOTICE OF PRIVACY RIGHTS & PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Compass Medical, P.C. (referred to collectively as “we” or “us” in this notice) creates records of the health care and services you receive from us. We are required by law to protect the privacy of any medical information that identifies you; to provide you with this notice describing our legal duties and privacy practices with respect to your medical information; and to follow the terms of the most current Compass privacy notice.

1. Who Will Follow This Notice

This notice describes the privacy practices of Compass Medical, PC (“Compass”) and applies to all providers, employees, students and volunteers.

2. How We Use and Disclose Your Medical Information Without Your Written Permission

While in certain situations (described in Section 3 of this document) we are required to obtain your written permission to use or disclose your medical information, by law we are permitted to use and disclose your medical information without your written permission for certain purposes related to your care. The following are situations in which we may use or disclose your medical information without your written permission:

- **Treatment:** We use and disclose your medical information to provide, coordinate or manage your medical treatment and related services. For example, a physician will use your test results to diagnose and treat your injury or illness. We may share medical information with providers outside Compass that are involved in your care, such as a referring physician or specialist who is treating you.
- **Payment:** We use and disclose your medical information so that we can obtain payment for the health care services that we provide to you. For example, we may provide information about your treatment to your insurer or other company or program that arranges or pays for your health care, including when we need to obtain prior approval and authorization for your treatment, or to our payer network.
- **Health Care Operations:** We use and disclose your medical information to support our efforts to improve the quality and/or cost of care and for our own management and planning. For example, we may use your medical information to measure the performance of our staff in how they care for you. We may also share your medical information with our business associates with whom we have contracted to provide services, such as a billing company or medical transcription service.
- **Other Health Care Providers:** We may also share medical information with your doctor and other health care providers who are not part of Compass when they need it to provide treatment to you, to obtain payment for the care they give to you, to perform certain health care operations such as reviewing the quality and skill of health care professionals, or to review their actions in following healthcare laws and regulations.
- **Disclosure to Family, Friends and Other Caregivers:** We may share your medical information with a family member, a close personal friend, or another person who you identify if we (1) first provide you with the chance to object to the disclosure and you do not object; (2) infer that you do not object to the disclosure; or (3) obtain your agreement to share your medical information with these individuals. The medical information we share will be limited to the information necessary for that person’s involvement with your care or payment for your health care. We may also use or share your medical information with an organization, such as the American Red Cross, assisting in a disaster relief effort, to notify (or assist in notifying) your family about your location and general condition. In the event you are deceased, and unless we know that you would object, we may share your medical information with a family member or a close personal friend that was involved with your care or payment for your health care. The medical information we share will be limited to the information necessary for that person’s involvement with your care or payment for your health care.

- **Public Health Activities:** We are required or are permitted by law to report medical information to certain government agencies and others. For example, we may disclose your medical information:
 - To report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability;
 - To report abuse and neglect to government authorities or social agencies that are legally permitted to receive the reports;
 - To report information about products and services to the U.S. Food and Drug Administration;
 - To alert a person who may have been exposed to a communicable disease or may otherwise be at risk of developing or spreading a disease or condition;
 - To report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance; and
 - To prevent or lessen a serious and imminent threat to a person for the public's health or safety, or to certain government agencies with special functions such as the State Department.
- **Health Oversight Activities:** We may disclose your medical information to local, state or federal authorities that are responsible for the oversight of health care related matters, such as agencies administering Medicare and Medicaid.
- **Judicial and Administrative Proceedings:** We may disclose your medical information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process, to the extent the disclosure is authorized by a court, tribunal, or, in certain circumstances, to a subpoena, discovery request or other lawful process.
- **Law Enforcement Purposes:** We may disclose your medical information to the police or other law enforcement officials as required or permitted by law as part of law enforcement activities and investigations.
- **Decedents:** We may disclose your medical information to a coroner or medical examiner as authorized by law, and we may disclose medical information to funeral directors so they may carry out their obligations.
- **Organ and Tissue Procurement:** We may disclose your medical information with organizations that facilitate organ, eye, or tissue procurement, banking, or transplantation.
- **Military and Veterans:** If you are in the U.S. or foreign armed services, or a veteran, we may disclose your medical information as required by the proper military authority so that they may carry out their lawful duties.
- **National Security:** We may disclose your medical information to the appropriate federal officials for the protection of the President, to other authorized persons, to conduct special investigations or for intelligence, counter-intelligence and other national security purposes.
- **Inmates:** If you are an inmate in a correctional facility or in the custody of a law enforcement official, we may disclose your medical information to the correctional facility or law enforcement officer so that they may carry out their lawful duties.
- **Research:** We may use or share your medical information if the group that oversees our research, the Institutional Review Board/ Privacy Board, approves a waiver of permission (authorization) for disclosure or for a researcher to begin the research process.
- **Workers' Compensation:** We may disclose your medical information as permitted by or required by state law relating to workers' compensation or other similar programs.
- **As Required by Law:** We may use and disclose your medical information when required to do so by federal, state or local law.

3. Uses and Disclosures Requiring Your Written Permission (Authorization)

We are required to obtain your written permission to use or disclose your medical information for the following reasons. You may revoke an authorization at any time, in writing, except to the extent that we have already acted in reliance on it.

- **Use or Disclosure with Your Permission (Authorization):** For any purpose other than the ones described in Section 2, we may only use or share your medical information when you grant us your written permission (Authorization).
- **Marketing and Sale of Your Medical Information:** We must also obtain your Authorization prior to using or disclosing your medical information to send you any marketing materials. In addition, we are prohibited from selling your medical information without your written authorization to do so. We may, however, communicate with you about products or services related to your treatment, case management or care coordination, or alternative treatments, therapies, health care providers, or care settings without your permission.

- **Uses and Disclosures of Your Highly Confidential Information:** Federal and state law may require special privacy protections for any portion of your medical information that is considered “highly confidential information”, including, to the extent applicable, records regarding: (1) psychotherapy notes; (2) mental health and developmental disabilities services; (3) alcohol and drug treatment; (4) HIV/AIDS testing; (5) sexually transmitted disease(s); (6) genetic testing; (7) child abuse and neglect; (8) abuse of an adult with a disability; (9) sexual assault; or (10) invitro fertilization (IVF). Before sharing your highly confidential information (as defined above) for a purpose other than as permitted by law, we must obtain your written permission.

4. How Long We Keep Your Medical Information

Compass maintains medical records for the period of time required by law. Copies of applicable record retention policies are available upon request.

5. Your Rights Regarding Your Medical Information

With respect to the medical information maintained by Compass, you have the right:

- To see and to obtain a copy of your medical information that is used to make decisions about your care and treatment, including your medical and billing records. Under certain circumstances, we may deny your request. If we do so, we will send you a written notice describing the basis of our denial. Requests must be made in writing. We may charge a reasonable fee for copying, mailing or other expenses associated with processing a request. If your medical information is maintained electronically, you may request a copy of the information in an electronic format.
- To request a change or amendment to your medical information. Requests for an amendment must be made in writing and provide the reason for which an amendment is being requested. We may deny your request under certain circumstances. If we deny your request, we will send you a written notice of denial. This notice will describe the reason for our denial and your right to submit a written statement disagreeing with the denial.
- To receive an accounting of our disclosures of your medical information. Requests for an accounting must be made in writing. An accounting will only include disclosures made during the time period indicated on the request, but may not exceed a period of six years.
- To request that we restrict or limit our use or disclosure of your medical information. Whether we are required to agree to your request or not depends on the nature of the request and applicable law. We must, however, agree to your request to restrict the disclosure of your medical information to a health plan if the medical information pertains solely to a health care item or service for which you or a person other than a health plan has paid for in full at time of service. Please note that in certain cases, we may not be legally permitted to agree to a requested restriction.
- To receive confidential communications at a phone number or address other than your home. We will accommodate your request if your request is reasonable and you specify an alternative means or location.
- To receive notice if we discover a breach of your unsecured medical information and notification is required by law.
- To receive a paper copy of this notice, upon request, even if you have agreed to receive it electronically.
- To revoke an authorization at any time, in writing, except to the extent that we have acted in reliance on the authorization.

6. Effective Date and Changes to this Notice

This notice takes effect April 1, 2022. We reserve the right to change this notice and our privacy practices, policies and procedures and to make the new notice, practices, policies and procedures effective for all medical information we already have as well as any we create or receive in the future. If we make any changes to the notice, we will publish the revised notice on the Compass website at www.compassmedical.net and post it in common areas in our physician practices and other patient care areas.

7. Questions and Complaints

Please contact the Compass Medical Compliance Office to request a copy of this notice, to obtain help understanding this notice or to obtain more information. You may also contact Compass Medical’s Privacy Officer if you are concerned that your privacy rights have been violated or if you disagree with a decision that was made about access to your medical information. A Privacy Officer can be reached by phone at (508) 350-5651, or in writing at: Privacy Officer, Compass Medical P.C., 362 North Bedford Street, East Bridgewater, MA 02333.

Written complaints may also be filed with the Office for Civil Rights, U.S. Department of Health and Human Services. Filing a complaint will not affect the treatment or services you receive from us.