Dear New Patient,

We thank you for your interest in establishing medical care at Yarmouth Medical Center, LLC. At YMC, we offer primary care services in a medical home setting. As a patient here, we welcome you in an environment that is comforting and professional. You will enjoy personalized attention and will have access to medical services even when your normal provider is unavailable. In fact, we encourage you to get to know each of our providers. No matter who you see, you will find us to be a medical office that genuinely cares about your well-being. We are glad you are here with us.

Filling out the enclosed packet is the first step in the new patient process. The packet includes a basic demographic sheet, a health history form and HIPAA compliant release of information. The demographic sheet is obvious and self-explanatory. The health history form provides us with a couple things: Knowledge of your medical issues and medications so we know how to schedule your first appointment. It also lets us know ahead of time if our practice is the appropriate setting for your medical care. Finally, the release of information form (R.O.I) allows us to obtain your previous medical records before your first appointment. Having your medical records on hand is essential to providing you with comprehensive, meaningful medical care.

Once you have returned the new patient packet, we will get you entered into our electronic health record and contact you to schedule an initial appointment. Please be sure to indicate on the health history form if you feel you have an urgent need. We will do our best to expedite your application so you can be seen as soon as possible. Please note that, until you are seen here, we are not able to prescribe medications or process insurance referrals for you. Your previous provider is required to do this for at least thirty days. Also note that providers at Yarmouth Medical Center, LLC do not prescribe chronic pain medication(s).

We are very glad you have chosen Yarmouth Medical Center, LLC as your new medical home.

YMC Staff

Zouhdi A. Hajjaj M.D. **Thais Tibbetts NP-C**

YARMOUTH MEDICAL CENTER PATIENT REGISTRATION

21 Aaron's Way, Unit 2, W. Yarmouth, MA 02673

Today's Date:					
PATIENT INFORMATION					
Last name: First:			Middle:		Marital status:
Is this your legal name?	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex:
Address:					
Social Security:	Home phone:		Cell phone:		
Occupation:	Employer:				
Preferred Provider (note: Dr. Hajjaj is not accepting new patients):					
Other family members seen here:					
E-Mail Address:	Are you interested in being able to communicate with your medical team online? Yes No	May we leave messages on your voicemail regarding test results, prescriptions and appointments? Yes No			
Primary Language:		Race: Black or African American Asian White Hispanic American Indian Other			
Local Pharmacy:	Town:	Mail Order Pharmacy: Member #:	Phone: Fax:		
Please indicate primary insurance:					
Subscriber's name:	Relationship:	Birth date:	Group #:	Policy #:	Co-payment: $
Name of secondary insurance (if applicable):	Subscriber's name:	Policy #:	Group #:		
Patient's relationship to subscriber:					
IN CASE OF EMERGENCY					
Name of local friend or relative:	Relationship to patient:	Home phone:	Cell phone:		

I hereby give Yarmouth Medical Center and staff my consent for any necessary medical evaluation and treatment. I hereby assign all medical/surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance and other health plans to Yarmouth Medical Center. A photocopy of this assignment is to be considered as valid as original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize said assign to release all information necessary to secure payment.

Patient/Guardian signature **Date**

Assignment of Insurance Benefits

I, the undersigned certify I have insurance coverage with

Insurance Company Name

And assign directly to Yarmouth Medical Center, Zouhdi A. Hajjaj, M.D., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. I hereby authorize Zouhdi A. Hajjaj, M.D. to release all information necessary to secure payment of benefit. I authorize use of this signature on all insurance submissions.

Signature Date

21 Aaron's Way, Unit 2, W. Yarmouth, MA 02673

Personal Health History

NAME (please print):____ Date of Birth__________________

MEDICATIONS

Please list all medications you are currently taking:

List all medication and other allergies:

Name of previous primary care doctor:____

Have you been to the emergency room or an urgent care center recently:__________________

Please list any specialists you see:____

____

Please list any surgeries you have had:____

____

Do you see a dentist regularly? YES NO If yes, dentist's name:___________________________

Do you have regular eye exams? YES NO If yes, doctor's name:__________________________

Do you use tobacco? YES NO If yes, type of tobacco and frequency:______________________

Do you or have you used illegal drugs? YES NO Marijuana? YES NO

Do you drink alcoholic beverages? YES NO If yes, how many drinks per week:______________

Do you have a health care proxy? YES NO If yes, please provide us with a copy.

Do you have an advanced directive? YES NO If yes, please provide us with a copy.

HEALTH ISSUES (circle any that apply)

AIDS/HIV	Fainting	Rheumatic Fever	Sinus Problems
Anxiety	Growths (skin)	Radiation Treatments	Stroke/TIA
Osteoarthritis	Hay Fever	Liver Disease	Thyroid Disease
Asthma/Emphysema	Heart Attack	Pacemaker	Tuberculosis
Artificial Joints	Heart Disease/Murmur	Ulcers	Tumors
Blood Disease	Hepatitis: Type:	Glaucoma	Vision Problems
Cancer; Type:	High Blood Pressure	Rheumatoid Arthritis	Chronic Pain
Depression	Insomnia	Stomach Issues	Alcoholism
Diabetes; Type:	Jaundice	Head Injury	STDs
Dizziness	Kidney Disease	Mental Health Issues	Headaches/Migraines
Seizures	Respiratory Problems	Other:	Other:

CONTROLLED SUBSTANCE DISCLOSURE: Yarmouth Medical Center does not prescribe chronic pain medication. We also do not prescribe Suboxone or Methadone.

By signing below you indicate that you understand this policy and attest to the truthfulness of the information provided above.

Signature:____ Date:_________________

Family Health History

NAME (please print):____ Date of Birth______________________

Please circle appropriate responses:

Were you adopted? YES NO If yes, any contact with biological family? YES NO

Father: ALIVE DECEASED If alive, overall health: EXCELLENT GOOD FAIR POOR

Mother: ALIVE DECEASED If alive, overall health: EXCELLENT GOOD FAIR POOR

Siblings: Number of Brothers:______ Number of Sisters:_____ Are all alive? YES NO If no, please indicate brother/sister, cause of death and age at time of death:_______________________________________

____

Please use the following legend to indicate any health issues members of your family have or have had.

Father=F Mother=M Brother=B Sister=S

FAMILY HEALTH ISSUES

Osteoarthritis	F	M	B	S	Heart Attack	F	M	B	S
Asthma/Emphysema	F	M	B	S	Heart Disease/Murmur	F	M	B	S
Blood Disease	F	M	B	S	Hepatitis; Type:	F	M	B	S
Cancer; Type:	F	M	B	S	High Blood Pressure	F	M	B	S
Cancer; Type:	F	M	B	S	Kidney Disease	F	M	B	S
Diabetes	F	M	B	S	Respiratory Problems	F	M	B	S
Seizures	F	M	B	S	Liver Disease	F	M	B	S
Fainting	F	M	B	S	Ulcers	F	M	B	S
Glaucoma	F	M	B	S	Rheumatoid Arthritis	F	M	B	S
Mental Health Issues	F	M	B	S	Stroke/TIA	F	M	B	S
Thyroid Disease	F	M	B	S	Tumors	F	M	B	S
Alcoholism	F	M	B	S	Headaches/Migraines	F	M	B	S
Other:	F	M	B	S	Other:	F	M	B	S

Signature:____ Date:__________________

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

YARMOUTH MEDICAL CENTER PATIENT REGISTRATION

21 Aaron's Way, Unit 2, W. Yarmouth, MA 02673

I hereby authorize the release of my medical record to Yarmouth Medical Center.

____

(Previous Doctor's Name, City/State, Phone Number)

Patient Information

Last Name	**M.I.**	**First Name**		**Date of Birth**
Street Address		**City**	**State**	**Zip**
Home Phone		**Cell Phone**		

Please mail or fax records pertaining to the patient identified to:

YARMOUTH MEDICAL CENTER
21 Aaron's Way, Unit 2, W. Yarmouth, MA 02673
PH: (508) 760-2054 FAX: (508) 760-1218

In accordance the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 2. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 2, I specifically authorize release of such information to the person indicated.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization
3. I have the right to revoke this authorization at any time by writing to Yarmouth Medical Center. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment at Yarmouth Medical Center, or eligibility benefits will not be conditioned upon my authorization of disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted in #2 above), and this redisclosure may no longer be protected by federal or state law.

Specific Information to be released:

If you only wish to release Medical Records within a certain date range, indicate here: from (insert date) __________ to (insert date) ___________

☐ **Medical Record dating back 2 years, including patient histories, office & consult notes, test results, radiology studies, films, labs, mammograms, pap smear results, bone density, colonoscopy, hospitalizations, CT's, MRI, EKG's & immunization history providers.**

____
____
____
____

Include: (**Indicate by Initialing**)

________ Alcohol/Drug Treatment

________ Mental Health Information

________ HIV-Related Information

This authorization will be in effect for one year from the date signed, unless you indicate a shorter period below:

Date or event on which this authorization will expire: ______________

All items on this form have been completed and my questions about this form have been answered. In addition, I have kept a copy of this form for my records.

____ ____

Signature of patient or representative authorized by law Date

21 Aaron's Way, Unit 2, W. Yarmouth, MA 02673

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION TO CERTAIN INDIVIDUALS

PATIENT NAME:___________________________________ DATE OF BIRTH:__________________
(PLEASE PRINT)

I hereby authorize Yarmouth Medical Center to disclose information contained in my medical record to the individual(s) listed below, if they request it. I understand that when information is disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and no longer considered protected health information (PHI). I understand that I can revoke this authorization, in writing, at any time.

This authorization applies to the indicated PHI (check all that apply):

____ All Personal Health Information (PHI)

____ PHI related to the following conditions or treatments:____________________________________

Our providers may discuss your PHI as authorized above. The individuals listed cannot receive copies of any information from your medical record without your written consent. If there is no one we can communicate with, please write 'no one' in each space provided.

AUTHORIZED INDIVIDUALS:

Name:___________________________ Phone:______________ Relationship:____________________

Name:___________________________ Phone:______________ Relationship:____________________

Name:___________________________ Phone:______________ Relationship:____________________

The following individuals are authorized to pick up prescriptions, letters, or forms for me at the office. If there is no one, please write 'no one' in each space provided. You may write 'same as above' in the first space provided if individuals are the same.

Name:___________________________ Phone:______________ Relationship:____________________

Name:___________________________ Phone:______________ Relationship:____________________

Name:___________________________ Phone:______________ Relationship:____________________

Patient Signature:___________________________________ Today's Date:_______________________

Yarmouth Medical center, LLC – Visit Types

Thank you for establishing care with Yarmouth Medical Center. To better serve you, we are providing a description of visit "types" to optimally accommodate your medical needs:

New Patient: This is a visit to establish care with your new provider. It is an opportunity to get to know each other, discuss your health history and set up a plan for future care. During this visit urgent medial needs may be addressed, but a follow up visit may be necessary for more comprehensive care.

Annual Physical Exam: This is a routine check-up that you should have every year. During this visit, your provider will assess your overall health and screen for any issues that need to be addressed. These visits are partially administrative in nature and focus on health maintenance. Please note that if you have a health concern we need to prioritize, your medical team may need to change your visit to an Office Visit to thoroughly address that need.

Follow-Up: These are visits to check on the progress of a health issue you have been treated for or are currently being treated for. Your provider will ask you questions, perform an exam and make any necessary adjustments to your treatment plan. Please note, these visits are required every 3 months for any patients who are being prescribed controlled substances.

Office Visits: These are for health issues that are not life threatening but still need to be addressed by a provider, ie: a rash or sinus infection. We do our very best to schedule these visits on the same day or closely thereafter. If you are experiencing respiratory (cough, congestion, fever) or gastrointestinal (nausea, vomiting, diarrhea) symptoms, a virtual visit **MAY** be necessary to ensure the safety of our patients and staff.

Medicare Annual Wellness: These visits are scheduled 6 months after an Annual Physical exam for those patients on Medicare, per CMS guidelines. During this visit, your provider will review your health history, perform a physical exam and create a personalized prevention plan to help you stay healthy. Please note, a dedicated portion of this visit is administrative and reserved for collection health data for screening.

Transition of Care: These visits are for patients who have been discharged from an Emergency Room, Hospital or Nursing Facility to the outpatient community. During this appointment, our provider will review your medical history and any recent test results to make sure they have a complete understanding of your inpatient experience. They will also discuss any ongoing treatments or medication to make sure there are no gaps in your care. These visits are important because they help ensure a smooth and seamless transition in your medical care.

Chronic Care Management: Per CMS guidelines, we are required to check in with Medicare patients who are experiencing chronic health issues such as Diabetes and Heart Disease. This is accomplished through monthly phone calls from our off-site colleagues who will inquire about your health status and ask if you have any questions or issues you would like forwarded to the provider. These calls are considered a visit and are billed to Medicare and your secondary insurance. If you do not wish to receive these calls please let our office staff know, however, many patients find them very helpful with managing their chronic issues.

Patient Code of Conduct

To provide a safe and healthy environment for staff, visitors, patients and their families, Yarmouth Medical Center expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

As a patient visiting our practice, please consider the following:

- If you have any questions about the care or our unhappy with the service received in our office, please contact our practice manager before you leave our office so that any clarifications about your care or the services you received can be addressed.
- Please communicate all issues that you wish to discuss with the doctor at the time your appointment is scheduled, so that an appropriate amount of time can be allotted. If you do not do this in advance, another visit may be necessary so that the doctor can give all patients the time and quality of care they deserve.
- Questions about your billing can be addressed to APS, see bill for contact information.
- Our practice follows a zero-tolerance policy for aggressive behavior directed by patients against our staff.
- Please be courteous with the use of your cell phone and other electronic devices. When interacting with any of our staff, please put your devices away. Set the ringer to vibrate before storing away.
- Adults are expected to supervise their children.

The following behaviors are prohibited:

• Possessing firearms or any weapon

• Intimidating or harassing staff or other patients

• Making threats of violence through phone calls, letters, voicemail, email or other forms of written, verbal or electronic communication

• Physically assaulting or threatening to inflict bodily harm

• Making verbal threats to harm another individual or destroy property

• Damaging business equipment or property

• Making menacing or derogatory gestures

• Making racial or cultural slurs or other derogatory remarks

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.

Patient Name:____________________________________Date:_________________________

Patient Signature:____

Staff Initials:__________