Med-East Medical Walk-In Center
A Windham Hospital Partner

1703 West Main Street, Willimantic, CT 06226
Telephone (860) 456-1252 • Fax (860) 456-2278

200 Merrow Road, Tolland, CT 06084
Telephone (860) 871-5452 • Fax (860) 871-5712

Email: medeast@wcmh.org

Patient Name:_____

May we call you at work? ❑ yes ❑ no

May we call you at home? ❑ yes ❑ no

If no to both of the above, what number may we call? _____

May we leave messages (including lab results) on your answering machine?

❑ yes ❑ no

May we leave general messages on your answering machine?

❑ yes ❑ no

May we speak with your spouse or significant other regarding your treatment?

❑ yes ❑ no

May we send you a fax? ❑ yes ❑ no Fax number_____

May we contact you by email? ❑ yes ❑ no Address_____

_____ _____

Patient Signature *Date*

Or signature of person granting authorization on behalf of patient. Parent or guardian if patient is under 18 years of age

For restrictions to your protected health information other than noted above, please submit your request to the Compliance/Privacy Officer utilizing our "Restriction of Use of Disclosure of Protected Health Information" Form

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

_____ _____

Patient Signature *Date*

_____ _____

Printed Name *Date of Birth*

To be completed if unable to obtain written acknowledgement from patient

On _____ Med-East Medical Walk-In Center attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient. We were unable to obtain this acknowledgement because:

❑ Patient declined to sign this written acknowledgement

❑ Patient did not understand the request to sign the written acknowledgement

❑ Other (please specify)_____

_____ _____

Signature of employee *Date*

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Name:_____

Date of Birth: ___/___/_____ Social Security Number:_____

Address:_____

City:_____ State: _____ Zip:_____

Telephone: Home ( )_____ Office ( ) _____

Cell ( )_____

Email: _____

Employer:_____

Address:_____

_____

Primary Insurance:_____

ID#:_____ Insured:_____

Secondary Insurance:_____

ID#:_____ Insured:_____

Primary Doctor:_____

Telephone: ( )_____

In case of emergency, whom may we call?

Name:_____ Telephone: ( )_____

Relationship:_____

I understand and agree that (regardless of my insurance status) I am ultimately responsbile for any professional services rendered to me. I have read all the information on this sheet and have completed all of the above information. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the information progided.

_____ _____

Signature *Date*