KRONOS HEALTH
360 Merrimack Street
Lawrence, MA 01843
Building 9 Entrance G
Phone: (978)-655-6652
Fax: (833) 963-2112

New Patient Demographics

Date: _____

Name_____ Date of Birth _____

Gender Identity ☐ Male ☐ Female ☐ Trangender Male ☐ Transgender Female ☐

☐ Additional category ☐ Decline to answer

Assigned Sex at Birth: ☐ Male ☐ Female

Preferred Pronouns: _____

Marital Status_____

Resident Address_____

Home Phone_____ Cell Phone_____

On which phone may we leave confidential messages? _____

Email_____

Billing Address (If different than residence)

Address_____

Primary Insurance	Secondary Insurance
Insurance Name:	Insurance Name (Secondary):
Subscriber #:	Subscriber #:

Who is financially responsible for this Bill? _____

Race (**circle one**): American Indian/Alaskan Native, Asian, Black/African American, Hispanic, Native Hawaiian, White, Other, prefer not to say

Ethnicity (**circle one**): Hispanic Non-Hispanic

Emergency Contact #1:_____

Relationship: _____Phone #_____

Emergency Contact #2: _____

Relationship: _____ Phone #_____

Whom should we contact to schedule an appointment? _____

Pharmacy (with phone): Local:_____

Mail Away: _____

I hereby authorize the release of medical information necessary to process medical benefits and I authorized
payment of medical benefits to Kronos Health, PPLC. For services rendered by this office:

_____ _____
Patient Signature Date

_____ _____
Signature of Power of Attorney Date
(or similar) if patient is unable to sign

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Consents

Patient Name: _____

HIPAA Notice of Patient Privacy Practices

I acknowledge that I have reviewed of the Kronos Health practice privacy notice. I may request a copy of the
privacy notice at any time; it is available at the office.

Signature: _____

Print Name: _____ Date: _____

Permission to communicate with other physicians, other community care providers and/ or mental health providers whom you have seen or will see to coordinate your care:

To ensure continuity of care and coordination of care is often necessary to communicate with other cliniciansand your insurance company. These communications may include information about your medical treatment,mental health, or substance-abuse treatment. This information is limited to that which is necessary to the determination of coverage or sharing of information critical to the clinicians who are sharing the informationand caring for you. Many insurance companies require us to document whether or not you will allow yourclinician to communicate with other clinicians involved in your care, which you can we have agreed to referyou, and your health insurance company: I authorize Kronos Health to release my healthcare information toclinicians as noted above, in order to provide continuity and coordination of my care.

Signature: _____

Print Name: _____ Date: _____

Consent for RXHub Inquiry

I consent for Kronos Health to obtain my RXhistory using the Sure-Scripts-RXhub network. I understand that this inquiry will provide my provider with an accounting of my medication history, reported by pharmacy benefit manager is a retail pharmacy. I also understand that the Sure-Scripts-RXhub has certified that any RX history capture follow strict security protocols to align with HIPAA requirements and respect patient privacy. All areas and responses are made automatically through security system to system communications.

Signature: _____

Print Name: _____ Date: _____

Authorization For Use or Disclosure of Medical Record Information

KRONOS HEALTH

Patient Information

Patient Full Name: _____ Date of Birth: _____

Any other Previous Names: _____

Patient Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Email: _____

Authorization to Release

I hereby authorize **Kronos Health** to (please choose one) ☐ Release my medical information to: ☐ Obtain 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? _____

Information to be Released

○ Please provide a 2 year abstract of my records

○ Other - please be specific, include dates and MD's under comments-

Comments

Authorization to Release Protected Information

STOP **IMPORTANT**- It is extremely important that you select "YES" or "NO" for each selection under the category of **Authorization to Release Protected Information**. Please do not skip any line items as it could impact our ability to fulfill your request and cause additional delays.

Yes ☐	☐ No	**Mental Health Information**
Yes ☐	☐ No	**Psychotherapy(from a Psychiatrist, Psychologist or Mental Health Clinical Nurse Specialist**
Yes ☐	☐ No	**HIV Tests & Related Information**
Yes ☐	☐ No	**Alcohol and/or Substance Abuse Treatment**
Yes ☐	☐ No	**Genetic Testing**
Yes ☐	☐ No	**Social Worker Communication**
Yes ☐	☐ No	**Sexual/Physical Abuse**
Yes ☐	☐ No	**Sexually Transmitted Disease (STD's)**
Yes ☐	☐ No	**Other**_____ *Other sensitive information?*

Sign Here

Patient's Signature **Date***

Parent/Legally Recognized Representative Signature** **Date****

Rev. 3/2020

*This Authorization is valid for 12 months unless you specify otherwise (enter expiration date)_____. You may revoke this Authorization at any time by providing a written statement, except to the extent that the provider has already completed action on it.

*The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem.

** If you are the legally recognized representative of the patient you must provide supporting documentation.

The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. The provider will not condition treatment on payment of the provision of this Authorization.

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Authorization for Use and/or Disclosure of Patient Health Information

I, the undersigned, authorized Kronos Health, PPLCto use and/or disclose certain protected health information (PHI) to the below designee about me.

Patient Information

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Designee

Designee Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Designee Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

The following individually identifiable health information about me may be disclosed (describe specifically the information to be used and/or disclosed such as: all information, date(s) of service, type of services, level of detail, origin of information, etc.)

Info Description: _____

The practice will ____/ will not ____ receive payment or other renumeration from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from KronosHealth, and have the right to refuse to sign thisauthorization. Information that isused and disclosed as directed above may be subject to disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice hasacted in reliance upon this authorization. Written revocation must be submitted to the Privacy Officer at Kronos Health, PLLC.

Signature _____ Date _____

Printed Name _____ Relationship to Patient _____