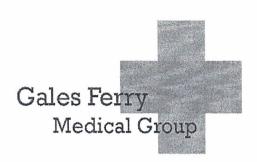
JOHN J, HENNESSEY, M.D. ☐ CATHERINE KRENICKY, A.P.R. ☐ SANFORD A, GREENHOUSE M.D. ☐ KATHLEEN O'CONNOR A.P.J. ☐ PATRICIA MURDOCH A.P.R.N			
PATIENT INFORMATION:			
Last Name: First Name:	Middle Initial: Date of Birth		
ailing Address: Social Security Number:			
City: State:			
Tome Phone: Cell Phone			
Email:			
Employer:	Work Phone:		
	d other):		
	Phone:		
Insurance Information: Primary	Insurance Information: Secondary		
Insurance Name:Copay:	Insurance Name:Copay:		
Contract Number:	Contract Number:		
Group Number:	Group Number:		
Policy Holder Information:	Policy Holder Information:		
Last Name: First Name: Middle initial	Last Name: First Name: Middle initial		
Social Security Number: Age:	Social Security Number: Age:		
Date of Birth:	Date of Birth:		
Relationship to Patient:	Relationship to Patient:		
Please remember that insurance is considered a methosubstitute for payment. Some companies fix allowances for coyour responsibility to pay any deductible amount, co-insurance	od of reimbursing the patient for fees paid to the doctor and is not a ertain procedures, and others pay a percentage of the charge. It is ce, or any other balance not paid by your insurance.		
IN ORDER TO CONTROL YOUR COST OF BILL! VISITS BE PAID AT THE CONCLUSION OF EACH VISIT	INGS, WE REQUEST THAT OUR CHARGES FOR OFFICE T.		
If this account is assigned to an attorney for collection fees and costs of collections. I authorize the release of any infreimbursement on any claim.	n and/or suit, the practice shall be entitled to reasonable attorney's formation necessary to determine liability for payment and to obtain		
entitled including Medicare, private insurance and other healt	nade on my behalf. I assign the benefits payable to which I am the plans to the practice named at the top of this form. This assignment copy of this assignment is to be considered as valid as an original. I hether or not paid by said insurance.		
I AGREE TO ASSIGNMENTS OR FINANCIAL RE	ESPONSIBILITIES SHOWN ABOVE		
CIONED (D	ent if under 18 years of age) Date		
Stored (ration or pare	ent if under 18 years of age) Date		



John J. Hennessey, M.D., Sanford Greenhouse, MD Catherine Krenicky, APRN, Kathleen O'Connor, APRN Patricia Murdoch, APRN P.O. Box 355, Gales Ferry, CT 06335 Phone – 860-464-7274 Fax – 860-464-7404 www.galesferrymedicalgroup.com

I authorize Gales Ferry Medical Group doctors and employees to release medical information (e.g. test results, appointments with specialists, appointments at this office, information about medication I have been prescribed) to:

Family Members. Please check all that apply:					
·	Spouse/ Partner				
	Children				
_	Parent				
	Other Family Member- Please Specify				
	Other- Please Specify				
_	No One				
Signed:	Date:				
I give permission for information to be left on my answering machine. Please check all that apply.					
_	Test Results				
_	Appointments for Tests				
	Appointments made with other doctors				
_	Information regarding prescriptions I am taking or changes in prescriptions				
_	Reminders about upcoming appointments in this office				
-	Nothing				
Signed:	Date:				

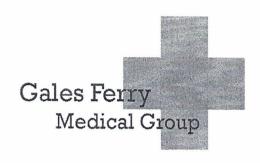


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ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of
Gales Ferry Medical Group's Notice of Privacy Practices. By signing below I am ONLY giving
acknowledgment that I have received or have had the opportunity to receive the Notice of Privacy
Practices.

Patient Name (print please)	Date
Signature	



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Patient Name: Race: American Indian Asian African American, Not of Hispanic origin Caucasian, not of Hispanic origin __ Hispanic/Latino Other Unknown English Language: French Spanish Other Unknown Sexual Orientation: Not Disclosed Heterosexual Homosexual Bisexual Other Please Circle one of the following in each category: Sex at Birth: Female / Male Current Gender Identity: Female / Male / Other **Preferred Pronouns:** she / her / hers he / him / his they / them Patient Portal: Please provider your email address so that we may invite you to our patient portal.



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CHRONIC CARE MANAGEMENT

Our practice is committed to providing our patients with the very best medical care. This new program through Medicare and some Commercial insurance plans is designed to assist practices in managing their patients who have chronic medical conditions more thoroughly.

The program consists of:

A designated Care Coordinator: Jennifer Witherspoon
Close monitoring of all medications prescribed by our office and specialty providers
24/7 availability for problems- phone calls during and after hours
Close monitoring of care provided by Specialty Physicians
Close monitoring of care provided by ancillary care providers
Care plans for chronic conditions
Preventative care arrangements and monitoring

This program began January 1, 2015. Medicare and some Commercial Insurances will be reimbursing us most of the cost, but there may be small co-pays for the patient depending on the supplement policies. We believe this will improve your medical care and therefore we urge you to take advantage of this new medical program.

Medicare requires that you sign this document in order for us to perform and be reimbursed for these services. Commercial insurances do not require a signature. Contract is for informational purposes only.

SIGNATURE	
PRINTED NAME	
DATE	
ACCOUNT NUMBER	