

Northern Light  
Mercy Hospital

144 State Street, Portland, ME 04101

MERCY PRIMARY CARE  
REGISTRATION FORM

Page 1 of 2

Patient Identification

**PATIENT INFORMATION**

Legal Name: \_\_\_\_\_ Date: \_\_\_\_\_  
                    first                                    middle                                    last

Date of Birth: \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_ Secondary Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Religious Preference/Parish: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Status: FT PT

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Responsible Party if patient is a minor \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Primary Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
                                    first                                    last

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone #: \_\_\_\_\_ May we discuss your medical info with this person? Y N

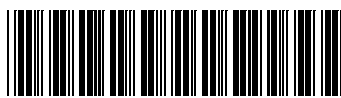
Secondary Person to Notify: \_\_\_\_\_ Relationship: \_\_\_\_\_  
                                    first                                    last

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone#: \_\_\_\_\_ May we discuss your medical info with this person? Y N

Primary Care Provider: \_\_\_\_\_ Do you have an advanced directive? Y N

Do you need an interpreter? Y N If yes, what language? \_\_\_\_\_



700070087

SCAN TO OTHER, ADMIN – NOT RELEASED

(03/17/20)

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Patient Identification

**FOR MEDICARE PATIENTS ONLY**

**MEDICARE NOTICE OF COINSURANCE RESPONSIBILITY**

1. As a hospital-based entity, this facility is required by Medicare to give you notice that you will have to pay a coinsurance fee for the facility services you receive here, in addition to the coinsurance fee you have to pay for the providers' services you receive. You would not have to pay this coinsurance fee if you were treated at a facility that was not a hospital-based entity.
2. The coinsurance fee for you provider services will decrease slightly.
3. We are required to give this notice to you before delivery of health care service to you, unless you seek treatment for an emergency medical condition, and we have not yet ruled out or stabilized the condition.
4. We expect that you will incur a facility coinsurance fee as estimated in the table below according to the specific visit level your provider indicates.
5. If your medical expenses are a hardship, please let our staff know. We will be happy to work with you to determine whether you may be eligible for financial assistance.

Outpatient Visit Code Fee	Description	New Coinsurance
99201	Level 1 – New	\$ 9.21
99202	Level 2 – New	\$ 15.36
99203	Level 3 – New	\$ 21.73
99204	Level 4 – New	\$ 32.78
99205	Level 5 – New	\$ 41.43
99211	Nurse visit – Established	\$ 4.62
99212	Level 2 – Established	\$ 9.10
99213	Level 3 – Established	\$ 14.95
99214	Level 4 – Established	\$ 21.90
99215	Level 5 – Established	\$ 29.29

**NOTE:** These estimates are based on typical or average charges for visits to this facility. The actual coinsurance will depend upon the actual services you get here.

**PLEASE SIGN AND DATE BELOW:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_



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(03/17/20)