Patient Identification

Northern Light Mercy Hospital

144 State Street, Portland, ME 04101

MERCY PRIMARY CARE REGISTRATION FORM

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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Mercy Hospital
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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	Description	New Coinsurance Fee
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: _____