

Spectrum Family Health

Manoj K. Garg, D.O.

Linda Berman, M.D.

Primary Care For All Ages

541 Newport Avenue

Pawtucket, RI 02861

(401) 475-4588

Fax: (401) 475-4589

www.SpectrumFamilyHealth.com

Welcome to Spectrum Family Health!

We are glad that you have chosen us to be your health care provider.

We ask you to please

- 1) Call your insurance company before your appointment and switch your primary care provider to either Dr. Garg or Dr. Berman. If this is not done before the appointment, we will need to try and do it for you at the time of your appointment. This can cause a 15-30 minute delay in seeing the doctor and sometimes your insurance company will not allow us to do this on the day of service so you may need to reschedule your appointment.
- 2) Complete and bring the enclosed registration paperwork to your appointment. This will decrease your waiting time on the day of your appointment. Included in the paperwork is a form for release of information from your prior primary care provider. If you see more than one doctor (i.e. any specialists), please photocopy and complete the record release form for each doctor. Although not necessary, it would be quite helpful if you can get hard copies of these records sent to our office before your visit.
- 3) Bring a list of your medicines with doses (or the actual medicine bottles).
- 4) Bring your insurance card.
- 5) Arrive 15 minutes early to your appointment so we can complete the new patient registration process.
- 6) Bring a copy of your living will, if you have one.
- 7) Learn about your insurance benefits including co-payments and deductibles.

We have included some additional information about us and how our practice works.

There is also more information about us and the practice at

www.SpectrumFamilyHealth.com

Please feel free to call us with any questions.

We look forward to meeting you.

Manoj Garg, D.O.

Linda Berman, M.D.

Who are the physicians?

Dr. Manoj Garg started Spectrum Family Health in 2002. Dr. Linda Berman joined the practice in January 2006. We both provide full spectrum family care excluding obstetrics. We see newborns, children, adolescents, adults, and elderly patients. We provide preventive medicine and health screens such as well-child checks, complete physical exams, blood pressure checks, and Pap smears. We also care for chronic medical illnesses such as diabetes, high blood pressure, high cholesterol, and asthma.

What are the office hours?

Monday, Tuesday, and Friday 8-5

Wednesday 9-5

Thursday 9-6

We are closed for lunch daily from 12-1.

Are you available to see us for sick visits?

We have same day visits for urgent medical issues including coughs, colds, ear infections, stitches, treatment of abscesses, and many other needs. Please call in the morning for same day appointments.

What if I need to be admitted to the hospital?

Dr Garg and Dr. Berman admit patients to Memorial Hospital of Rhode Island in Pawtucket. If you are admitted to Memorial, the doctors will attend to you there on a daily basis. If you are admitted to another hospital, the doctors will discuss your case with the physician caring for you. Dr. Garg and Dr. Berman also admit newborns to Women and Infants Hospital in Providence.

What do I do if I need to talk to the doctor during regular office hours?

Please call the office. During regular office hours, the doctor will most likely be seeing other patients either in the office or in the hospital. In case of emergency, the doctor can be interrupted and will be available. For non-emergent issues, every attempt will be made by the doctor to return your call the same day. The doctors often return phone calls during the lunch hour or at the end of the day.

How do I contact the doctor outside of regular office hours?

If you get sick after hours during the week and need to get a hold of the doctor for urgent medical needs, call the office phone number. The answering machine will tell you how to contact the doctor on call. Our doctors share call with two other groups of physicians for weekends and holidays. The office answering machine will tell you how to contact the doctor on call for the weekend.

Do you have an electronic medical record?

Yes. Our records are 100% computerized. This allows us to access your records instantaneously when you call the office instead of having to search for a paper chart. We back our records up daily in case of computer failure so your records will not be lost. Also, our records are not accessible on the internet so your confidentiality is maintained.

What if I need to get my blood drawn?

We have a Memorial Hospital of Rhode Island laboratory in our office. They are open Monday-Friday except Wednesday and have the same hours as the office. No appointment is needed. Some insurance companies require their patients to use other laboratories. If you use another facility, the test results will still be sent to our office for our review.

What do I do if I need my prescription refilled?

We ask for a phone call 24 hours before you will need your prescriptions refilled. We will write the prescription and mail it to you, call it in to your pharmacy, or call/fax to mail-order pharmacies.

If you have any additional questions or concerns, please do not hesitate to call our office at (401)-475-4588.

PATIENT INFORMATION

Patient Name: _____

How would you like to be addressed? _____

If child, name of parent(s)/guardian(s): _____

Social Security Number: _____ - _____ - _____ Date of Birth: _____

Address: _____

	Street	City	State	Zip	
Home #:	_____	Work #:	_____	Cell #:	_____

If we are unable to reach you, where can we leave a message?

Home: _____ Work: _____ Cell: _____ Do not leave a message: _____

Email: _____

Can we use your e-mail to send personal information such as lab results? Yes ___ No ___

Sex: Male _____ Female _____

Marital Status:

Single ___ Married ___ Widowed ___ Separated ___ Divorced ___

Spouse's Name (if applicable): _____

Emergency Contact Name and Relationship: _____

Home #: _____ Work #: _____ Cell #: _____

Name of Insurance Company: _____

Policy ID/Member Name: _____

Policy Holder's Name: _____

Policy Holder's Birth Date: _____

Policy Holder's Social Security Number: _____ - _____ - _____

Relationship to Patient: _____

Name, Location, and Phone # of Pharmacy: _____

How did you hear about us? _____

Patient's Signature _____ Date: _____

(Parent/Guardian)

PATIENT CONSENT
(SIGNATURE REQUIRED)

I (or _____ acting on behalf of _____)
Name of Authorized Representative Name of Patient

Consent to receive such care, treatment and services which may include routine Diagnostic and therapeutic procedures (as laboratory tests or minor office surgical procedures) and outpatient treatment as Dr. Garg, Dr. Berman, and other Practitioners of ***Spectrum Family Health*** consider being necessary. This includes release of medical information to specialists as needed to help with my treatment.

Patient's or Authorized Representative's signature

ASSIGNMENT OF BENEFITS

(Signature Required)

I request that payment of authorized insurance benefits be made on my behalf to *Spectrum Family Health, Inc.* for services furnished to me by provider of services. I authorize any holder of medical information about me to release any needed information to determine these benefits or the benefits payable to related services. I further understand that if my medical insurance company does not pay the claims, then I am financially responsible for the total cost of services rendered.

Signature

Date

LIVING WILL/POWER OF ATTORNEY

Have you designated anyone to function as your legal guardian or decision maker (by completing a "living will" or "power of attorney") in the event that you are unable to make decision regarding your health care? YES NO

If "YES", please provide a copy and write the name, address, phone number, and relationship of that individual:

NAME: _____

ADDRESS: _____

RELATIONSHIP TO YOU: _____ PHONE # _____

If "NO", please ask your physician about this.

Consent for Medical Records

Patient Name: _____ **DOB:** _____

I hereby consent and authorize *Spectrum Family Health, Inc.* to obtain / release a copy of my medical record to:

NAME OF AGENCY, FACILITY OR PRACTITIONER

STREET

CITY

STATE

ZIP

Please check one:

- All of the information in such records is to be released, including **mental illness, alcoholism, substance abuse, and sexually transmitted infection and HIV testing, if any.**
- Only the following specific information described below and contained in such records to be released:

I understand that such information will not be given, sold, transferred or in any way relayed to any other person or party not specified above without my further written consent. I understand that this consent may be withdrawn at any time prior to the release of information here authorized.

I understand that such records are needed for, or will be used for continuing care.

Signed _____ Date _____
(Patient or authorized representative) (Month/Day/Year)

Name (Print) _____ Relationship _____

Witness Name _____ Witness Sign _____