

Burnt Hills Internal Medicine & Pediatrics Community Care Physicians 18 Year Old Registration Form

Patient	Last Name:		First Name:		MI:	Suffix:	Preferred/Nick Name:		
	Physical Address:			Maiden Name:		<input type="radio"/> Male <input type="radio"/> Female		Date Of Birth:	
	City:		State:	Zip:		Marital Status:		Social Security#:	
	Primary Contact Phone:					<input type="radio"/> Home: <input type="radio"/> Cell: <input type="radio"/> Work: <input type="radio"/> Other:			
	Secondary Phone:					<input type="radio"/> Home: <input type="radio"/> Cell: <input type="radio"/> Work: <input type="radio"/> Other:			
	Email:				Primary Care Provider:				
	In Case of Emergency, Notify:		Relationship:		Contact Phone #:		Date of Birth:		

Primary	Insurance Name:			Identification #:		Group #:	
	Address:		City:		State:	Zip:	
	Policy Holder Name and Address:			Subscriber DOB:		Copoly Amount:	
	Policy Holder Employer Name:		Employer Address:			Employer Phone:	

Secondary	Insurance Name:			Identification #:		Group #:	
	Address:		City:		State:	Zip:	
	Policy Holder Name and Address:			Subscriber DOB:		Copoly Amount:	
	Policy Holder Employer Name:		Employer Address:			Employer Phone:	



www.communitycare.com

Community Care Physicians

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Community Care Physicians
Print Patient Name

Notice of Privacy Practices.

Signature of Patient or Guardian

Date of Birth

Date

Witness

Date

HIXNY ELECTRONIC DATA ACCESS CONSENT FORM

Community Care Physicians

In this Consent Form, you can choose whether to allow Community Care Physicians to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York, Inc., doing business as Hixny (“Hixny”), which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Community Care Physicians to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the “**I GIVE CONSENT**” box below, you are saying “Yes, Community Care Physicians’ staff involved in my care may see and get access to all of my medical records through Hixny.”

If you check the “**I DENY CONSENT**” box below, you are saying “No, Community Care Physicians may not be given access to my medical records through Hixny for any purpose.”

Hixny is a not-for-profit organization. It shares information about people’s health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about Hixny and ehealth in New York State, read the brochure, “Your Health Information – Always at Your Doctor’s Fingertips.” You can ask Community Care Physicians for it, or go to the website www.hixny.org.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices.

- **I GIVE CONSENT for Community Care Physicians to access ALL of** my electronic health information through Hixny in connection with providing me any health care services, including emergency care.
- **I DENY CONSENT for Community Care Physicians to access** my electronic health information through Hixny for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through Hixny.

Print Name of Patient

Date of Birth

Signature of Patient or Patient’s Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

Details about patient information in Hixny and the consent process:

1. How Your Information Will be Used. Your electronic health information will be used by Community Care Physicians only to:

- Provide you with medical treatment and related services
- Check whether you have health insurance and what it covers
- Evaluate and improve the quality of medical care provided to all patients.

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. What Types of Information about You Are Included. If you give consent, Community Care Physicians may access ALL of your electronic health information available through Hixny. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Alcohol or drug use problems
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

3. Where Health Information About You Comes From. Information about you comes from places that have provided you with medical care or health insurance (“Information Sources”). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Community Care Physicians . You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

4. Who May Access Information About You, If You Give Consent. Only these people may access information about you: doctors and other health care providers who serve on Community Care Physicians' medical staff who are involved in your medical care; health care providers who are covering or on call for Community Care Physicians' doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. Penalties for Improper Access to or Use of Your Information. There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Community Care Physicians at: (518) 452-1337; or call Hixny at (518) 783-0518; or call the NYS Department of Health at (877) 690-2211.

6. Re-disclosure of Information. Any electronic health information about you may be re-disclosed by Community Care Physicians to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Hixny and persons who access this information through the Hixny must comply with these requirements.

7. Effective Period. This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

8. Withdrawing Your Consent. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Community Care Physicians. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 783-0518. **Note: Organizations that access your health information through Hixny while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.**

9. Copy of Form. You are entitled to get a copy of this Consent Form after you sign it.

**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

Patient's Full Name

Patient's Date of Birth

By signing this authorization, I authorize Community Care Physicians to use and/or disclose certain protected health information (PHI) about me to:

1.

Please list other medical providers, family, friends, etc. who, with your permission, may receive your medical information.

 → **Person or Entity to Receive the Information**

2. Specific Information to be Released:

Option 1: Entire medical record from (insert date) _____ to (insert date) _____ (If not specified, all dates.)

PLEASE NOTE: This includes any and all HIV-related information, drug and alcohol treatment, and mental health information. If you do not wish to have this information disclosed, please indicate below:

Do NOT Include: Alcohol/Drug Treatment Mental Health Information HIV-Related Information

Option 2: Include only:

Prescriptions Office Notes Lab Results

Billing Other (Please be specific): _____

Do NOT Include: Alcohol/Drug Treatment Mental Health Information HIV-Related Information

3. Please Initial:

_____ I understand that this authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV- RELATED INFORMATION** unless I exclude this information above. In the event my health information includes any of these types of information, I specifically authorize release of such information to the person(s) indicated above.

4. The Reason for Release of Information: At request of individual Other: _____

5. Expiration Date: This authorization will expire on _____

{Expiration Date or Defined Event} If no date is given, this authorization shall expire one year from the date signed below.

I understand that Community Care Physicians will not receive payment or other remuneration 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 Community Care Physicians. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure 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 has acted in reliance upon this authorization. My written revocation must be submitted to my personal physician.

Print Name of Patient or Legal Guardian

Signature of Patient or Legal Guardian

Date: _____

Relationship to Patient: _____



To Enroll in the Patient Portal mycareDOT™, complete this form and give it to the front desk

Patient's Name: _____ Patient's Date of Birth: _____

Information for the individual receiving the invite:

Name (if other than the patient): _____

Relationship to Patient: _____

Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

If someone other than the patient will be receiving the invite and the patient is an adult, the patient must choose what access they would like the proxy to have (please check one): Full Access Read Only

(PLEASE NOTE: If choosing Read Only access the authorized individual will be authorized to access your FollowMyHealth health record ONLY and will NOT be able to communicate with or otherwise engage in transactions with your providers)

Signature of patient or legal guardian: _____

Name of legal guardian (if applicable): _____

By completing this form and submitting it to your doctor's office, you are agreeing to the terms and conditions and allowing the office to invite you to join the patient portal via email invitations. (Please ask the front desk if you would like a copy of the terms and conditions)
You may also receive health and company news and announcements from Community Care Physicians, PC through your portal account. If you do not understand or do not agree to comply with or do not consent to these policies or procedures, please do not complete this form to enroll in the patient portal.
A copy of this form will be scanned into your permanent medical records.

Patient Information Update

Patient Name: _____ **DOB:** _____

Today's Date: _____

Do you have any New Workers Compensation/ No Fault claims? Yes or No

If Yes, please Inform the Front Desk Staff and fill out a Information sheet for billing purposes.

Since your last visit to our office, were you admitted to the hospital? Yes or No

If Yes, please write where and when: _____

Since your last visit to our office, have you had any medical tests? Yes or No

If Yes, please circle all that apply: Mammogram (breast X-ray) PAP Smear (Women) Colonoscopy
DEXA (Bone loss/Osteoporosis) Blood Work X-rays ECG/EKG (heart) Vision MRI
CT ("Cat" Scan) Other: _____

List where and when you had the tests done: _____

Since your last visit to our office, have you started any new prescribed medications? Yes or No

If Yes, list _____

Do you currently have any Advanced Care Directives? Yes or No

If Yes, Please Circle and bring in a copy if needed: Health Care Proxy Living Will POA (Power of Attorney)
MOLST (Medical Order for Life Sustaining Treatment (Pink form) DNR **If No, are you interested in information on any of the above?** _____

Do you or have you seen any of the following Specialist? Yes or No

If yes, Please Write the name of the Provider(s).











- Allergist _____ Cardiologist _____
- Endocrinologist _____ ENT(Ear, Nose, Throat) _____
- Gastroenterologist _____ Nephrologist _____
- Neurologist _____ OB/GYN _____
- Oncologist _____ Ophthalmologist (EYE) _____
- Orthopedist _____ Podiatrist _____
- Pulmonologist _____ Rheumatologist _____
- Urologist _____ Other _____

Date:

Patient DOB:

Name: _____ Phone number: _____

Preferred Language: _____ Best time to call: _____

		YES / NO
	In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?	<input type="checkbox"/> Y <input type="checkbox"/> N
	In the last 12 months, has your utility company shut off your service for not paying your bills?	<input type="checkbox"/> Y <input type="checkbox"/> N
	Are you worried that in the next 2 months, you may not have stable housing ?	<input type="checkbox"/> Y <input type="checkbox"/> N
	Do problems getting child care make it difficult for you to work or study? <i>(leave blank if you do not have children)</i>	<input type="checkbox"/> Y <input type="checkbox"/> N
	In the last 12 months, have you needed to see a doctor, but could not because of cost ?	<input type="checkbox"/> Y <input type="checkbox"/> N
	In the last 12 months, have you ever had to go without health care because you didn't have a way to get there ?	<input type="checkbox"/> Y <input type="checkbox"/> N
	Do you ever need help reading hospital materials ?	<input type="checkbox"/> Y <input type="checkbox"/> N
	Are you afraid you might be hurt in your apartment building or house?	<input type="checkbox"/> Y <input type="checkbox"/> N
	If you checked YES to any boxes above, would you like to receive assistance with any of these needs?	<input type="checkbox"/> Y <input type="checkbox"/> N
	Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight	<input type="checkbox"/> Y <input type="checkbox"/> N

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