CapitalCare
Family Practice Guilderland
of Community Care Physicians

Carman Medical Arts
3757 Carman Road, Suite 100
Schenectady, NY 12303-5418
PH: (518) 355-7063
FX: (518) 357-0646
www.communitycare.com

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Dear Patient,

Please take a moment and fill out the attached forms so we can prepare for your **upcoming appointment which is on _____ at _____ with _____.**

Our providers have asked that you please fax them back or mail them to our office at ***least two weeks prior to your appointment***. This will ensure that we request any records that may be needed, update your chart with your demographic information, and gives the doctor time to review your personal health- both past and present.

Please note, that if we do not receive your packet by _____, it may result in your appointment being reschedule to a later date.

If you have any questions or concerns regarding the attached forms please feel free to contact us at **518-355-7063.**

Our office can be reached by phone Monday – Friday 7:00am-3:30pm.

Our return fax number is **518-640-1528**

Office Address is:
Capital Care Family Practice Guilderland
3757 Carman Road Ste. 100
Schenectady, NY 12303

Thank you very much for your time and we look forward to seeing you at your appointment!

Sincerely,

The Doctors and Staff at CapitalCare Family Practice Guilderland

CapitalCare

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Health History Questionnaire

Your answers on this form will help your health care provider better understand your medical concerns and conditions. All questions contained in this questionnaire are strictly confidential and will become part of your medical record. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you!**

Name: _____ Preferred First Name: _____

Date of Birth: _____

Address: _____

Home Phone: _____ Alternate Phone: _____

Previous Physician: _____

Have you requested copies of your records be sent to this office? ☐ Yes ☐ No

Occupation: _____ Employer: _____

What is your highest level of education? _____ Are you still in school? _____

What is your marital status? ☐ Single ☐ Partner/Married ☐ Divorced ☐ Widowed

What is your partner/spouse's name? _____

If you have children, please list their names and dates of birth: _____

Who lives at home with you? _____

Please list current and prior medical conditions, hospitalizations, surgeries, etc.

Have you ever had a transfusion of blood products? ☐ Yes ☐ No If yes, approximate year? _____

Date	Problem	Treating Physician/Specialist/Hospital

Please list current medications (prescription and non-prescription), and over the counter medications, herbal supplements, birth control pills, etc.

Medication	Dose (mg)	Frequency (Times per day)

Please list any allergies, including any allergic or adverse reactions to any medications. Please include the type of allergic or adverse reaction.

Social History:

Tobacco Use: ☐ Never ☐ Former ☐ Current
What year did you begin? _____
What year did you quit? _____
What is your current pack per day? _____
What was your maximum pack per day? _____
Do you use other forms of tobacco (as opposed to cigarettes)? ☐Yes ☐No
What kind(s) do you use? _____
Are you interested in help with quitting? ☐Yes ☐No

Alcohol Use: ☐ Never ☐ Former ☐Current
What type do you typically drink? ☐ Beer ☐Wine ☐ Liquor
How frequently would you say you drink (# per day, # per week)? _____
Is your alcohol use a concern for you and/or others? ☐ Yes ☐ No

Recreational Drug Use: ☐Never ☐Former ☐ Current
What do you use typically use? _____
Have you ever used needles to inject drugs? ☐ Yes ☐No

Sexual Activity:
Are you currently sexually active? ☐ Yes ☐ No Current sexual partner(s) is/are: ☐ Male ☐ Female
Is contraception/birth control being used? ☐ Yes ☐ No What type? _____
Have you ever had a sexually transmitted diseases (STD)? ☐ Yes ☐No
Do you want to be screened for sexually transmitted diseases? ☐Yes ☐No

Mental Health:

Is stress or anxiety a major problem for you? ☐ Yes ☐ No Do you feel depressed? ☐ Yes ☐ No
Have you ever been to a counselor? ☐ Yes ☐ No Are you currently seeing a counselor? ☐ Yes ☐ No
If yes, who? _____

Diet and Exercise:

Do you drink caffeinated drinks? ☐ Yes ☐ No What kind do you typically drink? _____
How many cups per day? _____
Are you satisfied with your weight? ☐ Yes ☐ No How would you rate your diet? ☐ Good ☐ Fair ☐ Poor
Do you follow a special diet (i.e. gluten free, vegan, etc.)? ☐ Yes ☐ No What kind? _____
Do you exercise regularly? ☐ Yes ☐ No What kind of exercise? _____
How many times per week? _____ How many minutes per session? _____

Safety:

Do you wear seatbelts consistently? ☐ Yes ☐ No
Is violence at home a concern for you? ☐ Yes ☐ No
Have you ever been abused? ☐ Yes ☐ No
Have you completed a Health Care Proxy or Living Will? ☐ Yes ☐ No

Health Screenings:

Cholesterol/Lipid - Date: _____ Was it abnormal? ☐ Yes ☐ No
Colonoscopy - Date: _____ Was it abnormal? ☐ Yes ☐ No
Where did you have it completed? _____ Who is your gastroenterologist? _____

WOMEN:

Mammogram - Date: _____ Was it abnormal? ☐ Yes ☐ No
Where did you have it completed? _____
PAP Smear - Date: _____ Was it abnormal? ☐ Yes ☐ No
Where did you have it completed? _____ Who is your OB/GYN? _____
Bone Density Scan - Date: _____ Was it abnormal? ☐ Yes ☐ No

MEN:

PSA (Prostate) - Date: _____ Was it abnormal? ☐ Yes ☐ No

Immunizations:

We kindly ask that you return a copy of your most recently updated immunizations with this packet.
This is especially important for new patient exams for children, as it will delay immunizations that may be needed for school.

Seasonal Influenza - Date: _____ Pneumovax (pneumonia) - Date: _____
Zoster (shingles) - Date: _____ Tdap (tetanus with pertussis) - Date: _____
Td (plain tetanus) - Date: _____ Other: _____ Date: _____

Pertinent family health history:

We kindly ask that you list chronic illnesses and significant health problems of listed family members, keeping in mind that we understand not all options may apply. Examples include, but are not limited to: cardiac disorders (high blood pressure, high cholesterol, heart attack, stroke, etc.), diabetes, autoimmune conditions, etc.

Family Member	Pertinent family history	Family Member	Pertinent family history
Father		**Children**	☐ M ☐ F
Mother			☐ M ☐ F
Sibling(s)	☐ M ☐ F		☐ M ☐ F
	☐ M ☐ F		☐ M ☐ F
	☐ M ☐ F	**Grandmother** *Maternal*	
	☐ M ☐ F	**Grandfather** *Maternal*	
	☐ M ☐ F	**Grandmother** *Paternal*	
	☐ M ☐ F	**Grandfather** *Paternal*	

Review of Symptoms:

Please check all symptoms that you have currently or have frequently.

Constitutional
- ☐ Recent fevers/sweats
- ☐ Unexplained weight loss/gain
- ☐ Fatigue/weakness

Eyes
- ☐ Change in vision
- ☐ Eye Pain
- ☐ Dry eyes

Ears/Nose/Throat/Mouth
- ☐ Difficulty hearing/ringing in ears
- ☐ Seasonal allergies/congestion
- ☐ Trouble swallowing

Cardiovascular
- ☐ Chest pain or discomfort
- ☐ Palpitations
- ☐ Edema (buildup of fluid in hands or feet)

Breast
- ☐ Breast lump
- ☐ Abnormal nipple discharge

Respiratory
- ☐ Cough/wheeze
- ☐ Coughing up blood
- ☐ Shortness of breath

Gastrointestinal
- ☐ Heartburn/reflux
- ☐ Diarrhea or constipation
- ☐ Nausea or vomiting
- ☐ Pain in abdomen

Genitourinary
- ☐ Painful or bloody urination
- ☐ Leaking urine
- ☐ Nighttime urination
- ☐ Discharge from penis or vagina
- ☐ Unusual vaginal bleeding
- ☐ Concern with sexual functions

Musculoskeletal
- ☐ Muscle/joint pain
- ☐ Recent back pain

Skin
- ☐ Rash
- ☐ New or changing mole

Neurological
- ☐ Headaches
- ☐ Memory loss
- ☐ Fainting

Psychiatric
- ☐ Anxiety/stress
- ☐ Depression
- ☐ Sleep problems

Hematologic
- ☐ Unexplained lumps
- ☐ Easy bruising/bleeding

Endocrine
- ☐ Cold/heat intolerance
- ☐ Increased thirst/appetite

Patient Signature: _____ Date: _____

Community Care Physicians Adult/Specialist Patient Registration Form

Date: _____ **Patient ID#:** _____
(for office use only)

PATIENT INFORMATION

Social Security Number _____/_____/_____ (Providing your SSN is optional. However, for patients with certain insurances this information may help us determine eligibility for certain health benefits).

LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____

Legal Name: _____ Preferred Name: _____

Street Address: _____
Mailing Address (if different, i.e. PO Box): _____

City: _____ State: _____ Zip: _____ Home Phone #: ( ) _____

Work #: ( ) _____ Cell #: ( ) _____ Preferred daytime phone: □ Home □Work □ Cell

Date of Birth: _____/_____/_____ Gender: □ Male □ Female □ Other _____

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

E-mail Address: _____ **Would you like to participate in the patient portal?**
□ Yes □ No

It is known that some medical conditions such as high blood pressure and osteoporosis, tend to have a higher incidence in certain ethnic groups. Therefore, we ask that you please provide us with information regarding your race and ethnicity so we can assess if you are at increased risk for the development of these conditions.

Race: Select one
□ American Indian/Alaska Native
□ Asian
□ Native Hawaiian or other Pacific Islander
□ Black/African American
□ White
□ Other

Ethnicity: Select One
□ Hispanic/Latino
□ Not Hispanic/Latino

Preferred Language: _____

Emergency Contact: _____ Emergency Contact DOB: _____/_____/_____

Emergency Phone: ( ) _____ Relationship to Patient: _____

Primary Care Physician: _____ Referring Physician: _____

In addition to telephone, which other methods of communication are acceptable? Please check all that apply

□ E-Mail (when available) □ Text □ Office may leave a message at home

Please Complete Page 2

Community Care Physicians Adult/Specialist Patient Registration Form

MEDICAL INSURANCE INFORMATION

(The subscriber is the same person as the policy holder)

Primary Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: ___/___/___Relationship to Subscriber: □ Self □ Spouse □ Child □Other _____

Co-pay: $_____ Policy ID # _____ Group #: _____

Secondary Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: ___/___/___Relationship to Subscriber: □ Self □ Spouse □ Child □Other _____

Co-pay: $ _____ Policy ID #: _____ Group #: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, when they accept assignment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize my Provider, to release any information necessary for my course of treatment.

_____ _____/_____/_____

Signature of Patient / Guardian Date

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. **OUR COMMITMENT TO YOUR PRIVACY**

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE CONTACT:

Michael O'Connor, Esq.
Privacy Officer, Operations Manager
711 Troy-Schenectady Road Suite 201
Latham, NY 12110 (518) 782-3767

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI. The uses are for Treatment, Payment, and Operations (TPO).

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

   Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you. We will not sell your data to an outside entity, nor will we permit an outside entity from accessing your information for purposes of informing you of health-related benefits or services.

7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you in some limited circumstances. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. **Disclosures Required By Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
   - Maintaining vital records, such as births and deaths
   - Reporting child abuse or neglect
   - Preventing or controlling disease, injury or disability
   - Notifying a person regarding potential exposure to a communicable disease
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - Reporting reactions to drugs or problems with products or devices
   - Notifying individuals if a product or device they may be using has been recalled
   - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - Concerning a death we believe has resulted from criminal conduct
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena or similar legal process
   - To identify/locate a suspect, material witness, fugitive or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. **Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an IRB or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to the individual's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

6. **Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

7. **Military.** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

8. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

9. **Inmates**. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

10. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

E. **YOUR RIGHTS REGARDING YOUR IIHI**

Although your health records are the physical property of the health care provider who completed it, you have the following rights with regard to the information contained therein and the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to your physician specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

   You also have the right to request a restriction in our use or disclosure of your IIHI to a health plan where the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full. In this circumstance, we are required to agree to your request, except where we are required by law to make a disclosure.

   In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to your physician. Your request must describe in a clear and concise fashion:

   (a) the information you wish restricted;
   (b) whether you are requesting to limit our practice's use, disclosure or both; and
   (c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to your physician in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to your physician. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non- treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to your physician. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Michael O'Connor, Esq. at (518) 782-3767.**

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Michael O'Connor, Esq. at (518) 782-3767.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Types of uses and disclosures requiring authorization include use or disclosure of psychotherapy notes (with limited exceptions to include certain treatment, payment, or healthcare operations); use or disclosure of IIHI for marketing purposes; and disclosures that constitute a sale of IIHI.

   Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

9. **Right to be Notified of a Breach.** You have the right to be notified in the event that we (or a Business Associate) discover a breach of your unsecured IIHI.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Michael O'Connor, Esq. (518) 782-3767.**

Effective Date of Notice: April 14, 2003
Revised: June 1, 2013

COMMUNITY CARE PHYSICIANS

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

COMMUNITY CARE PHYSICIANS

Financial Policy

This financial policy contains important information about billing and payment for our professional services. It is intended to help ensure the best possible medical care for our patients, while also controlling administrative costs. It outlines our responsibilities, and those of our patients, with regard to billing and payment for our services.

- Our practice participates with many health insurance companies and managed care programs. Our business office will submit a claim for any services rendered to a patient who is a member of one of these plans. Patients must provide all necessary insurance information and complete any required forms before leaving the office.

- If a patient is a member of an insurance plan with which we do not participate, our office will also file the claim on the patient's behalf; however, the patient is expected to make payment in full at the time of service.

- It is the patient's responsibility to make payment at the time of service for any co-payment or co-insurance due. Any services not covered by a patient's insurance plan are the patient's responsibility and payment in full is expected at the time of service. Failure to make a co-payment on the day of service will result in an administrative charge of $15 in addition to the co-payment.

- Payment for professional services can be made by cash, check, credit card or debit card. We accept VISA®, MasterCard®, American Express® and Discover® Card. You may also pay online at www.communitycare.com --just click the link that says Pay Your Bill on the homepage.

- Community Care Physicians, P.C. charges a fee of $35 for each check returned for insufficient funds.

- It is the patient's responsibility to ensure that any required authorization or referral for treatment is provided prior to the visit. In the absence of a required authorization or referral, the patient's visit may be rescheduled or the patient may be personally responsible for payment for the services rendered by Community Care Physicians.

- It is the patient's responsibility to provide us with current insurance information and to present an active insurance card at each visit.

- Our staff is happy to help with insurance questions relating to a claim that has been filed, or to provide additional information required by the insurance carrier to process the claim. However, patients should direct questions about coverage for specific procedures to a representative of their insurance company's member services department. The phone number for member services is usually on the insurance card.

- An adult accompanying a child under 18, and/or the parent or guardian of the child, is responsible for payment according to the terms described above. Non-emergency treatment for children unaccompanied by an adult may be rescheduled by Community Care Physicians unless charges have been pre-authorized, or payment by credit card, debit card, cash or check at time of service has been arranged.

- If a patient requires the completion of medical forms at a time other than an office visit, each form will be subject to an administrative fee of $25.

- Please understand that when a patient does not cancel an appointment he or she is unable to keep, it may prevent other patients from receiving care they need. Therefore, Community Care Physicians charges a fee of $50 for appointments not cancelled with at least 24 hours' notice for a primary care appointment and a fee of $200 for a specialty care appointment not cancelled with at least 24 hours' notice. This fee is subject to change. A patient who fails to keep three or more appointments in a twelve-month period—without prior notice of cancellation—may be discharged from Community Care Physicians at the discretion of the patient's physician.

In the event of personal financial hardship, Community Care Physicians is able to offer special financial arrangements, including payment plans.

We firmly believe that effective communication is the key to a successful physician-patient relationship, and we are eager to help in any way we can.

Please direct all questions about payment for services to our Billing Department at (518) 782-3700.

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**.**

CapitalCare, Family Practice Guilderland
No Show Policy
Effective 1/1/2008
(Revised 10/1/2011)

We appreciate the trust you have placed by choosing our office for your health care needs. When you make an appointment at our office a specific amount of time is reserved for your care. We ask that you please schedule appointments at a time that is most convenient for you. We have a variety of times available and there should be a time that will suit your needs.

Please be aware that we require 24 hours notice for any appointment cancellations. As your doctors, we expect a good faith effort on your part to show consideration for the needs of other patients by honoring the time set aside for your care.

In accordance with our financial policy we will charge a fee of $50 for appointments not cancelled with 24 hours notice.

****Please be advised that if you fail to keep your new patient appointment, or do not cancel within 24 hours of your scheduled appointment, it is our office policy that you will not be able to reschedule with our practice.**

CapitalCare Family Practice Guilderland
No Show Policy

Patient MR #_____

I, _____ acknowledge that I have reviewed the No Show Policy for CapitalCare, Family Practice Guilderland and am aware the 24 hours notice is required for appointment cancellations. In the event that I do not cancel my appointment within 24 hours of my scheduled time I will be charged a fee of $50.00 which cannot be submitted to my insurance company.

_____ _____

Patient Signature Date

COMMUNITY CARE PHYSICIANS

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*: _____

CapitalCare, Family Practice Guilderland
Prescription Refills & Renewal Guidelines

Medication refills are best addressed at the time of your visit with your provider. This allows the physician to plan any necessary changes to your medication or arrange necessary laboratory testing. We understand however, that sometimes this is not possible therefore, your cooperation with this procedure allows us to provide you with quality clinical care and services.

Phone Requests:

If your prescription bottle indicates you have refills left, you can call the Pharmacy directly requesting the refill.

If you do not have any refills left, please notify us three business days before your prescription runs out.

In order to provide the highest clinical service to you, we will review your medical records to determine if a follow up visit for medication adjustment is needed before refilling the prescription at the pharmacy of your choice.

Please have the following information available at the time of the refill request

- ***Your name and date of birth***
- ***The name and spelling of your medication***
- ***The dosage of your medication and how often it is taken***
- ***The name and phone number of the pharmacy you wish to use***
- ***Does your insurance plan require a 90 day supply***
- ***Best call back number where you can be reached with questions***

Prescriptions will be electronically sent to the pharmacy within 48 hours of the receipt of your call. If there are questions or there is a need for you to have a follow up appointment or laboratory testing, this may cause a delay.

Please call the office during normal business hours Monday – Friday for routine refill requests. Any requests received after normal business hours will be handled the following business day.

Emergency after hour refills for some medications may be indicated and, if determined by the on-call provider to be appropriate, only a limited number may be prescribed until access to patient's chart is available.

The policy for prescriptions is to send them electronically.

COMMUNITY CARE PHYSICIANS

MRN:

Patient Name: _____ DOB: _____

Insurance Eligibility Waiver

I understand that my eligibility for coverage with _____ (name of insurance carrier) cannot be confirmed at this time. I wish to receive medical service from Community Care Physicians, P.C. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

Signature of Patient/Legal Guardian: _____

Waiver reviewed with patient/Legal Guardian. He/she refused to sign:

_____

Date: _____

PCP Waiver

I understand that my Primary Care Physician (PCP) could not be verified by my insurance carrier; _____ at this time. My stated PCP is _____. I wish to receive medical service from Community Care Physicians, P.C. If it is determined that I am not listed with the above named provider as my PCP, I understand that I will be responsible for payment of all services provided to the above named provider. I agree to verify this information with the member services department of my insurance carrier (This can be done by contacting the number on my insurance card).

Print Patient Name: _____

Patient's Date of Birth: _____

Signature of Patient/Legal Guardian:

_____

Waiver reviewed with patient/Legal Guardian. He/she refused to Sign:

_____

Date: _____

COMMUNITY CARE PHYSICIANS

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

Person or Entity to Receive the Information:

Dr. _____
Family Practice Guilderland
3757 Carman Road, Suite 100
Guilderland, New York 12303

This authorization permits the entity above to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.):

_____

_____

The information will be used or disclosed for the following purpose:

_____

If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on: _____.
{Expiration Date or Defined Event}

Unless specified otherwise above, this authorization shall expire one year from the date below.

The Practice 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. 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.

Signed by: _____
Signature of Patient or Legal Guardian

_____
Print Name of Patient or Legal Guardian

Relationship to Patient: _____

Patient Date of Birth: _____

Date: _____