Partners in Family Medicine

Rensselaer Technology Park • 101 Jordan Road, Suite 104 • Troy, NY 12180
Main: (518) 274-0024 • Fax: (518) 274-9487

COMMUNITY CARE PHYSICIANS, P.C.
www.communitycare.com

*** IMPORTANT INFORMATION – PLEASE READ ***

Thank you for choosing Partners in Family Medicine as your primary care office.

Prior to your appointment we ask that you

- Contact your insurance and notify them of your new PCP
- Complete the new patient paperwork. If you have any questions about the paperwork, feel free to call the office.

Just a few important policies that we would like to bring to your attention:

- **On the day of your appointment, you must arrive 30 minutes prior to your appointment time with your completed paperwork, insurance card, photo ID and medications. If you are unable to arrive 30 minutes early, you will be asked to reschedule.**
- You will be asked to bring your insurance card to every visit. We will be scanning your insurance card and photo ID once a year.
- Our providers do NOT usually do physicals at your new patient visit. If you need to have a physical, you will need to schedule a separate appointment.
- If you are unable to keep your appointments, please give us 24-hour notice. A no show (a cancellation with less that 24-hour notice) for your new patient appointment will result in you not being rescheduled with our office. For all future appointments, you will be discharged from the practice after 3 no shows.
- The provider that you see for your new patient appointment is your primary care provider. Once established, you cannot switch primary care providers within the practice. If there is an issue with your primary care provider, please notify the staff. We will take these requests on a case-by-case basis.

If you have any questions on these or any other policies, please call our office at 518-274-0024.

IF, ON THE DAY OF YOUR APPOINTMENT, ANY OF THE FOLLOWING ARE TRUE, PLEASE CALL THE OFFICE AS WE MAY NEED TO RESCHEDULE YOUR APPOINTMENT:

- **YOU OR ANYONE IN YOUR HOUSEHOLD HAS ANY SIGNS OF ANY ILLNESS**
- **YOU OR ANYONE IN YOUR HOUSEHOLD HAS TESTED POSITIVE FOR COVID IN THE PAST 14 DAYS**
- **YOU OR ANYONE IN YOUR HOUSEHOLD HAS BEEN EXPOSED TO A COVID + PERSON IN THE PAST 14 DAYS**
- ***IF YOU DO NOT NOTIFY OUR OFFICE OF ANY OF THE ABOVE IN ADVANCE, THAT MAY RESULT IN YOU BEING RESTRICTED FROM FUTURE APPOINTMENTS WITH OUR OFFICE.***

COMMUNITY CARE PHYSICIANS

Partners in Family Medicine
101 Jordan Rd, Suite 104 – Troy, NY 12180
(518) 274-0024

New Patient Registration

PLEASE PRINT CLEARLY

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Preferred Method of Contact: ☐ Home ☐ Work ☐ Cell

Email address: _____

Gender (must match insurance) ..... ☐ Male ☐ Female

Marital Status ..... ☐ Single ☐ Married ☐ Other _____

Ethnicity ..... ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Declined

Race ..... ☐ White ☐ Black/African American ☐ Asian
☐ Mixed Race ☐ Other _____

Primary Language ..... ☐ English ☐ Other _____

Emergency Contact Information

Name: _____ DOB: _____

Phone number: _____ Relationship to patient: _____

Insurance Information (you must present ALL insurance cards at check in)

Primary Insurance Company: _____

ID #: _____ Group #: _____

Policy Holder (if different from patient): _____

DOB: _____ Relationship to patient: _____

Secondary Insurance Company: _____

ID #: _____ Group #: _____

Policy Holder (if different from patient): _____

DOB: _____ Relationship to patient: _____

Do you have another insurance policy in addition to the one listed above? ☐ YES ☐ NO

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.
RECEIPT OF NOTICE OF PRIVACY PRACTICES I have received a copy of Community Care Physicians Notice of Privacy Practices

_____ _____
(Signature of Patient/Legal Guardian) (Appointment Date)

Name (if signed by Legal Guardian): _____

COMMUNITY CARE PHYSICIANS

Partners in Family Medicine - Troy
101 Jordan Rd, Ste 104 – Troy, NY 12180

Patient Health Questionnaire (PHQ-9)

PLEASE PRINT CLEARLY

Name:_____ Date of Birth:_____

Appointment Date: _____

During the past two weeks, <u>how often</u> have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep or sleeping too much	0	1	2	3
4. Poor appetite, weight loss, or overeating	0	1	2	3
5. Feeling tired or having little energy	0	1	2	3
6. Feeling bad about yourself – or feeling that you are a failure, or have let yourself of your family down	0	1	2	3
7. Trouble concentrating on things, like reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns _____ + _____ + _____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card)

PLEASE CALCULATE TOTAL _____

** If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Provider initials _____

COMMUNITY CARE PHYSICIANS	Partners in Family Medicine 101 Jordan Rd - Troy, NY 12180 Phone (518) 274-0024 Fax (518) 274-9487	**New Patient Questionnaire**

PLEASE PRINT CLEARLY

Name: _____ **Date of Birth:** _____

Appointment Date: _____

Allergies

Allergy to:	Reaction:

CURRENT MEDICATIONS (Please use a separate sheet of paper if you need more room)

Prescription Drugs		❑ *Check if none*
Medication Name	**Dose** (Strength)	**Frequency** (How Often)

Over-the-Counter Medications (such as Aspirin, herbals, etc)		❑ *Check if none*
Medication Name	**Dose** (Strength)	**Frequency** (How Often)

Pharmacy Information:

Local (name & location):
Mail Order:

OCCUPATION

What do you do now?	**How long have you done it?**
What have you done the longest?	**How long did you do it?**

PLEASE PRINT CLEARLY

Name: _____ **Date of Birth:** _____

Appointment Date: _____

MEDICAL PROBLEMS OR INJURIES THAT YOU HAD IN THE PAST

What Problem?	Approximately When?

SURGERIES (Operations)

Procedure	Date

FAMILY HISTORY

	List Health Problems		List Health Problems
Mother		Maternal Grandmother	
Father		Maternal Grandfather	
Sisters (How many?)		Paternal Grandmother	
Brothers (How many?)		Paternal Grandfather	
Children (How many?)			

SOCIAL HISTORY

Exercise? Y ❑ N ❑ What type? _____ How long? _____ How often? _____

Have you used any drugs not prescribed by a physician? Y ❑ N ❑ If yes, what type? _____

Who else lives in your household?

IMMUNIZATIONS

❑ Influenza Date _____	❑ Pneumovac Date _____	❑ Zostavax Date _____	❑ Tetanus Date _____
❑ Hepatitis A Date _____	❑ Hepatitis B Date _____	❑ MMR Date _____	❑ Gardasil Date _____
❑ Polio Date _____	❑ Meningococcus Date _____	❑ Hemophilus Date _____	❑ Prevnar Date _____

Partners in Family Medicine
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Adult Intake Form (New Patients and Physicals Age 18-65)

PLEASE PRINT CLEARLY

Name _____ DOB _____ Appointment Date _____

Smoking Status: ❍ Current smoker ___ pack(s) a day ❍ Former smoker ❍ Never a smoker

❍ Vaping ____ times a day

Do you use any other forms of nicotine products? **Y** **N** If yes, what? _____

Alcohol: One drink= 

12 oz. beer  5oz. wine  1.5 oz. liquor (one shot)

How often do you have a drink containing alcohol?

❍Never ❍Monthly or less ❍2-4 times a month ❍2-3 times a week ❍4 or more times a week

How many standard drinks containing alcohol do you have on a typical day when you drink?

❍1 or 2 ❍3 or 4 ❍5 or 6 ❍7 to 9 ❍10 or more

MEN: How many times in the past year have you had 5 or more drinks in a day?	❍None	❍1 or more
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	❍None	❍1 or more

Do you use marijuana?

❍ Never ❍ Monthly or less ❍ 2-4 times a month ❍ 2-3 times a week ❍ 4 or more times a week

How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?	❍None	❍1 or more

Medication Allergies: _____

Do you see any other doctors? **Y** **N** If yes, please list them below along with their specialty

_____ _____

_____ _____

PLEASE PRINT CLEARLY

Name _____ DOB _____ Appointment Date _____

Females Only:	Date	**Males Only:**	Date
Last PAP/GYN/Breast exam	_____	Last Colonoscopy	_____
Last Menstrual Cycle	_____	Last DEXA Scan	_____
Last Mammogram	_____		
Last DEXA / Bone Density	_____		
Last Colonoscopy	_____		

How often does your partner:	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
Hurt you physically?	❍	❍	❍	❍	❍
Insult you or talk down to you?	❍	❍	❍	❍	❍
Threaten you with harm?	❍	❍	❍	❍	❍
Scream or curse at you?	❍	❍	❍	❍	❍

Please list any concerns or topics you would like to discuss with your provider today:

_____

_____

EXISITING PATIENTS ONLY: Have there been any new health problems in your family since your last visit?

_____

_____

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Review of Symptoms (Please check the following for symptoms now present)

PLEASE PRINT CLEARLY

Patient Name _____ DOB _____

Appointment Date _____

General:
- ○ Fever or chills
- ○ Night sweats
- ○ Excessive fatigue
- ○ Unintentional weight gain
- ○ Unintentional weight loss

Eyes:
- ○ Blurry vision
- ○ Eye pain
- ○ Pain looking at bright lights

Ear / Nose / Throat:
- ○ Hearing problems
- ○ Nose bleeds
- ○ Mouth sores
- ○ Voice change

Cardiovascular:
- ○ Chest pain at rest
- ○ Chest pain with exertion/exercise
- ○ Heart fluttering
- ○ Swollen feet / ankles

Respiratory:
- ○ Chronic cough
- ○ Difficulty breathing
- ○ Pain with breathing
- ○ Coughing up blood
- ○ Wheezing

Neurologic:
- ○ Headaches
- ○ Dizziness
- ○ Numbness/Tingling
- ○ Loss of coordination
- ○ Fainting
- ○ Seizures
- ○ Tremor
- ○ Memory loss

Gastrointestinal:
- ○ Abdominal pain
- ○ Vomiting
- ○ Vomiting blood
- ○ Trouble swallowing
- ○ Constipation
- ○ Diarrhea
- ○ Blood in stool
- ○ Heartburn

Genitourinary:
- ○ Painful urination
- ○ Frequent urination
- ○ Blood in urine
- ○ Difficulty controlling urine
- ○ Difficulty with erections
- ○ Painful menses
- ○ Irregular menstrual cycle
- ○ Heavy menstrual bleeding
- ○ Vaginal discharge or dryness
- ○ Post-Menopausal vaginal bleeding
- ○ Pain during intercourse

Musculoskeletal:
- ○ New joint pains
- ○ Joint stiffness
- ○ Back pain
- ○ Muscle aches

Skin/Breast:
- ○ Rashes
- ○ Unusual moles
- ○ Breast changes

Blood / Lymphatic:
- ○ Easy bruising
- ○ Swelling at neck

Endocrine:
- ○ Hot flashes
- ○ Hair loss
- ○ Infertility
- ○ Always cold

Psychiatric:
- ○ Excessive sadness
- ○ Excessive stress/anxiety
- ○ Mood swings
- ○ Suicidal thoughts

Allergic / Immunologic:
- ○ Seasonal allergies
- ○ Hives

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SOCIAL NEEDS SCREENING

PLEASE PRINT CLEARLY

Appointment Date: _____

Patient Name: _____ **DOB:** _____

		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?	Y N
	In the last 12 months, has your **utility company shut off your service** for not paying your bills?	Y N
	Are you worried that in the next 2 months, you **may not have stable housing?**	Y N
	Do problems getting **child care make it difficult for you to work** or study? *(leave blank if you do not have children)*	Y N
	In the last 12 months, have you needed to see a doctor, **but could not because of cost?**	Y 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?**	Y N
	Do you ever need help **reading hospital materials?**	Y N
	Are you **afraid you might be hurt** in your apartment building or house?	Y N
	If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	Y N
	**Are any of your needs urgent?** For example: I don't have food tonight, I don't have a place to sleep tonight	Y N

COMMUNITY CARE PHYSICIANS

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

PLEASE PRINT CLEARLY

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): _____

Today's Date: _____

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, 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.

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, P.C. 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, P.C. 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, P.C.. 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*: _____

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	Appointment 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**.**

COMMUNITY CARE PHYSICIANS

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(For us to obtain records from your previous PCP)

PLEASE PRINT CLEARLY

By signing this authorization, I authorize:

Provider / Facility Name: _____ Phone: _____

Location: _____ Fax: _____

To use and/or disclose certain protected health information (PHI) about me to:

Dr. _____
Partners in Family Medicine
101 Jordan Rd, Ste 104 – Troy, NY 12180
Phone: (518) 274-0024 | Fax: (518) 274-9487

1. 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): Last yr of records; immunization record; last colonoscopy (additionally for women) last PAP; last mammo; last DEXA

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

2. 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.

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

4: 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, P.C. will not receive payment or other remuneration form 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, P.C. 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.

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

_____ _____
Signature of Patient or Legal Guardian Date

_____
Name of Legal Guardian (if applicable)

COMMUNITY CARE PHYSICIANS

PLEASE PRINT CLEARLY

Patient Name: _____

Date of Birth: _____

Appointment Date: _____

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: _____

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).

Signature of Patient/Legal Guardian:

_____

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

Physical Waiver

I understand that new patient appointments are office visits.
Physicals are done at the provider's discretion and are not routinely done at new patient appointments.

Signature of Patient/Legal Guardian: _____

Primary Care Provider Policy

I understand that the provider I am seeing today will be my primary care provider going forward. I will not request to change my primary care provider unless I experience an issue. In that instance, I understand that my request must be reviewed by the physicians of the practice.

Signature of Patient/Legal Guardian: _____

Health Care Proxy

(1) I, _____ (DOB / /)

hereby appoint _____

(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint _____

(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (*Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions):*

_____

_____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary):*

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line),* your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

_____

☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1

Date _____

Name *(print)* _____

Signature _____

Address _____

_____

Witness 2

Date _____

Name *(print)* _____

Signature _____

Address _____

_____

NEW YORK STATE | Department of Health

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