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: _____/_____/_____ Sex Assigned at Birth: □ Male □ Female

Preferred Pronouns: □ She/Her □ He/Him □ They/Them □ Other (please list) _____

Gender Identity: : □ Male □ Female □ Transgender Male (FTM) □ Transgender Female (MTF)
□ Non-Binary/Genderqueer □ Other (please specify) _____
□ Don't know □ Choose not to disclose

Sexual Orientation: □ Gay/Lesbian/Homosexual □ Straight/Heterosexual □ Bisexual
□ Other (please describe) _____
□ Don't know □ Choose not to disclose

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
□ Other

Please Complete Page 2

Community Care Physicians Adult/Specialist Patient Registration Form

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

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 #: _____

If Medicare – please list your Medicare Beneficiary Identifier (11 Characters) _ _ _ _ _ _ _ _ _ _ _

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

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

HIXNY ELECTRONIC DATA ACCESS CONSENT FORM
Community Care Physicians

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

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

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

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

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

Please carefully read the information on the back of this form before making your decision.
Your Consent Choices. You can fill out this form now or in the future. You have two choices.

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

- **I DENY CONSENT for Community Care Physicians to access** my electronic health information through Hixny for any purpose, *even in a medical emergency*.

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

_____	_____
Print Name of Patient	Date of Birth
_____	_____
Signature of Patient or Patient's Legal Representative	Date
_____	_____
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about patient information in Hixny and the consent process:

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

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

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

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

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

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

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

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

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

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

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

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

PATIENT HIPAA AUTHORIZATION

TO SEND RECORDS TO COMMUNITY CARE

Patient's Full Name (Last, First)	**Patient's Date of Birth**

Step 1: Who Can Receive Your Information?

I, the undersigned, being the patient/parent/legal guardian/personal representative, authorize the above-named patient's health information to be **SENT TO** the following Community Care Physicians location:

Burnt Hills Pediatrics and Internal Medicine
1184 Rt 50
Ballston Lake, NY 12019
P: 518-384-1281 F: 518-384-0321

Step 2: Where is Your Information Coming From?

Name/Entity:_____Phone: _____

Address/City, State, Zip:_____Fax:_____

Step 3: What Can CCP Receive?

I authorize the release of the following health information:

☐ Entire Medical Record from (insert date) _____to:_____(If no dates are listed, then the entire chart may be released)

Or, instead of releasing all my health information, please release only the following information: (check the applicable boxes below)

☐ Billing Records ☐ Last Office Note ☐ Immunizations/Vaccinations ☐ Radiology Reports ☐ Laboratory Reports

☐ Medications ☐ Last Physical ☐ Other: _____

My Sensitive Information:

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 below. 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.

DO NOT INCLUDE MY:

☐ **Alcohol/Drug Treatment** ☐ **HIV-Related Information** ☐ **Mental Health Information**

Reason for Release:

☐ At request of patient ☐ Transferring Care to a CCP Provider ☐ Other:_____

Step 4: When Does this Authorization Expire?

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. 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***: _____

COMMUNITY CARE PHYSICIANS

GENERAL

PATIENT HIPAA AUTHORIZATION

THIS IS NOT A MEDICAL RECORDS REQUEST FORM. TO REQUEST A COPY OF YOUR RECORDS, PLEASE SEE THE FRONT DESK OR VISIT www.communitycare.com

Patient's Full Name (Last, First) **Patient's Date of Birth**

Step 1: Who Can Receive Your Information?

I, the undersigned, being the patient/parent/legal guardian/personal representative, authorize the above-named patient's health information to be **RELEASED or SHARED BY Community Care Physicians** to the following:

Name(s)/Entities (please include address and phone number):_____

_____

_____

Step 2: What Can We Share?

I authorize the release of the following health information:

☐ Entire Medical Record from (insert date) _____to:_____(If no dates are listed, then the entire chart may be released)

Or, instead of releasing all my health information, please release only the following information: (check the applicable boxes below)

☐ Billing Records ☐ Last Office Note ☐ Immunizations/Vaccinations ☐ Radiology Reports ☐ Laboratory Reports

☐ Medications ☐ Last Physical ☐ Other: _____

My Sensitive Information:

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 below. 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.

DO NOT INCLUDE MY:

☐ **Alcohol/Drug Treatment** ☐ **HIV-Related Information** ☐ **Mental Health Information**

Reason for Release:

☐ At request of patient ☐ Transferring Care out of CCP to a New Provider ☐ Legal Request ☐ Other:_____

Step 3: When Does this Authorization Expire?

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. This authorization may include disclosure of information relating to all Community Care Physicians' offices I have visited. 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***: _____

mycareDOT™ *(powered by FollowMyHealth)* is Community Care Physicians' patient portal that allows you to manage your personal health information and communicate with your doctor's office anytime, anywhere using a secure internet connection. This online tool is powered by FollowMyHealth®, a partner of Community Care Physicians.

This tool is a convenient, free service that provides an alternative to phone calls and office visits when you have non-urgent healthcare needs.

In order to connect with your providers here in our practice, you will need to receive an emailed invitation from us. Please be sure we have the most current email for you on file! The email will come from **FollowMyHealth.** Be sure to check your Spam Filter for this email!

With the patient portal you can:

- Request prescription refills
- Request an appointment, instead of calling the office
- View test and lab results as soon as they become available
- Message your doctor's office (for non-urgent matters)

Need a prescription?

Community Care Physicians encourages all of our patients to use the patient portal when needing a prescription or a prescription refill.

Using mycareDOT™, you can access information about your visit, as well as allergies, medications, treatments, procedures and more. You can access the portal through a desktop/laptop computer or with a mobile device using the FollowMyHealth app for iPhone or Android.

Community Care Physicians is here to help you connect the dots to good health.

Don't have a Portal Account?

You will be sent an invitation automatically after your visit if you have an email on file, or feel free to ask a staff member to assist.

For additional support, contact us by email at
mycaredot@communitycare.com
by phone at 518-213-6952
or go to communitycare.com/contact/patient-portal.

COMMUNITY CARE PHYSICIANS

Patient Name: _____ DOB: _____ Date: ___/___/_____

The Patient Health Questionnaire (PHQ-9)

Over the past 2 weeks, how often 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 asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as 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 in some way	0	1	2	3

Column Totals: _____ + _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those 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

Form completed by:
☐ Patient
☐ Provider
☐ Other Staff: _____
(Name)

Reviewed by: _____
(Provider Signature)

Revised 4.11.17

Name (Please Print) _____ DOB: _____ Date: _____

Alcohol screening questionnaire (AUDIT) + 1 Question Drug Use

We ask all patients about alcohol and drug use at least once a year. Both can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

One drink equals:

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

1. 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
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

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

For Office Use Only: Total Score: _____

PCP Initials: _____