

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

Please Complete Page 2

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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

Adult Patient History Form

Name: _____ DOB: _____ Date Completed: _____

ALLERGIES: Do you have any allergies? Yes ___ Explain Below. No ___
Allergic to: _____ Specific reaction: _____
Allergic to: _____ Specific reaction: _____
Allergic to: _____ Specific reaction: _____

CURRENT MEDICATIONS: _____ OTHER PHYSICIANS YOU ARE SEEING/REASON: _____

SOCIAL HISTORY:

Marital Status: Married? ___ Single? ___ Divorced? ___ Widowed? ___ Children? _____

Do you use alcohol? Never ___ Rarely ___ Daily ___ How Many? ___ Socially _____

Do you smoke or use other tobacco products (include chewing tobacco)? No ___ Yes ___ How Much? _____

If you used to smoke, when did you quit? _____

Do you use drugs? Never ___ Rarely ___ Daily ___ How Much? _____

Do you drink coffee or caffeinated drinks? No ___ Yes ___ How Much? _____

Do you exercise regularly? No ___ Yes ___ If yes, what type of exercise and how frequently? _____

Are you on a special diet? No ___ Yes ___ If yes, please describe: _____

Are you under a lot of stress? No ___ Yes ___ If yes, please describe: _____

Are you sexually active? No ___ Yes ___

If yes, do you: Have Multiple Partners ___ Use Contraception ___ Method _____

Practice Safe Sex (use condoms, etc.) ___ Do you have any questions? _____

Do you wear seat belts? No ___ Yes ___ Helmets for biking, skating? No ___ Yes ___

PREVIOUS HOSPITALIZATIONS: (NOT INCLUDING NORMAL PREGNANCIES)

Operation or Illness	Year	Hospital and Doctor
_____	_____	_____
_____	_____	_____
_____	_____	_____

ADULT IMMUNIZATION HISTORY:

Immunization	Year	Immunization	Year	Immunization	Year
Td/Tetanus	_____	Flu Vaccine	_____	PPD or Tine	_____
Polio Vaccine	_____	Rubella Titer Done?	_____	Hepatitis B Series	_____
MMR	_____	Pneumococcal Vaccine	_____	Other:	_____

(OVER)

PERSONAL HISTORY: Please check if you have or have ever had any of the following conditions:

	Y	N		Y	N
Alcoholism.....	___	___	HIV/AIDS.....	___	___
Anemia.....	___	___	Heart Attack.....	___	___
Asthma.....	___	___	Heart Murmur.....	___	___
Bleeding Disorder.....	___	___	High Blood Pressure.....	___	___
Blood Transfusion.....	___	___	Jaundice.....	___	___
Breast Lump.....	___	___	Kidney Stone.....	___	___
Broken Bone.....	___	___	Measles.....	___	___
Cancer.....	___	___	Mental Illness.....	___	___
Cataracts.....	___	___	Mumps.....	___	___
Diabetes.....	___	___	Pneumonia.....	___	___
Diverticulitis.....	___	___	Rheumatic Fever.....	___	___
Drug Abuse.....	___	___	Seizures.....	___	___
Elevated Cholesterol.....	___	___	Skin Cancer.....	___	___
Emphysema.....	___	___	Stroke.....	___	___
Enlarged Heart.....	___	___	Thyroid Disease.....	___	___
Eye Trouble.....	___	___	Ulcer.....	___	___
Exposure to TB.....	___	___	Urine Infection.....	___	___
Gall Bladder Disease.....	___	___	German Measles.....	___	___
Glaucoma.....	___	___	Other.....	___	___
Gout.....	___	___		___	___

FAMILY HISTORY; Please Check if a family member had had any of these conditions:

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN	OTHER
State of Health if Living.....	___	___	___	___	___	___	___
Arthritis.....	___	___	___	___	___	___	___
Asthma.....	___	___	___	___	___	___	___
Cancer.....	___	___	___	___	___	___	___
Colitis.....	___	___	___	___	___	___	___
Diabetes.....	___	___	___	___	___	___	___
Gout.....	___	___	___	___	___	___	___
Heart Disease.....	___	___	___	___	___	___	___
High Blood Pressure.....	___	___	___	___	___	___	___
Kidney Disease.....	___	___	___	___	___	___	___
Stroke.....	___	___	___	___	___	___	___
Ulcer.....	___	___	___	___	___	___	___
Cause of Death.....	___	___	___	___	___	___	___

HEALTH MAINTENANCE: Please list last date of:

Complete Physical _____	Performed by _____	
Cholesterol _____	Performed by _____	
Stool Check for Occult Blood _____	Performed by _____	Results _____
(Women) Pap Test _____	Performed by _____	Results _____
Mammogram _____	Performed by _____	Results _____
(Men) Prostate Check _____	Performed by _____	Results _____
PSA test _____	Performed by _____	Results _____
Do you do self-testicular exam? _____		

REVIEWED BY: _____ DATE: _____

Today's Date: _____

Patient Name: _____ Date of Birth _____

Please circle your answer to the following questions.

1. What is your living situation today?

I have a steady place to live

I have a steady place to live but I **am worried** about losing it in the future

I do not have a steady place to live. (I am temporarily staying with other, in a hotel, in a shelter, living outside on the street, on a bench, in a car, abandoned building, bus or train station or in a park)

2. Think about the place you live. Do you have problems with any of the following?

(Choose all that apply)

Pests such as bugs, ants, or mice

Mold

Lead paint or pipes

Lack of heat

Oven or stove not working

Water Leaks

Smoke detectors missing or not working

None of the above

3. Within the past 12 months, were you worried that your food would run out before you got money to buy more?

Often True

Sometimes True

Never True

4. Within the past 12 months, has the food you bought not lasted and you didn't have money to buy more?

Often True

Sometimes True

Never True

5. In the past 12 months has the electric, gas, oil or water company threatened to shut off services in your home?

Yes

No

Already shut off

6. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

Yes

No

7. How often does anyone, including family and friends, physically hurt you?

Never

Rarely

Sometimes

Fairly Often

Frequently

8. How often does anyone, including family and friends, insult or talk down to you?

Never

Rarely

Sometimes

Fairly Often

Frequently

9. How often does anyone, including family and friends, threaten you harm?

Never

Rarely

Sometimes

Fairly Often

Frequently

10. How often does anyone, including family and friends, scream or curse at you?

Never

Rarely

Sometimes

Fairly Often

Frequently

11. Do you want help with school or training? For example, starting or completing job training, or getting a high school diploma, GED or equivalent?

Yes

No

Not applicable

12. Do you want help finding or keeping work or a job?

Yes, help finding work

Yes, help keeping work

I do not need or want help

Not applicable

PATIENT HIPAA AUTHORIZATION TO SEND RECORDS TO COMMUNITY CARE

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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:

Charlton Family Medicine
286 Stage Road
Charlton, NY 12019-2619
P: 518-399-2101 F: 518-399-2130

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: _____

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 (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.

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

You have two choices:

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

- I DENY CONSENT for Community Care Physicians to access** my medical records through Hixny for any purpose, *even in a medical emergency*. Unless you check this box, New York State law allows medical providers 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

Date

Signature of Patient or Patient's Legal Representative

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:

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

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.

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

***If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, such as medications and dosages, lab test results, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social support, and health insurance claims history.**

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 Hixny. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

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.

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) 783-3110; or call Hixny at (518) 640-0021; or call the NYS Department of Health at 518-474-4987.

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.

Effective Period

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

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) 640-0021.

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.

Copy of Form

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

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:

Mackensie Greene, Esq.

Privacy Officer

6 Wellness Way, Suite 201

Latham, NY 12110 (518) 782-3700

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 **Mackensie Greene, Esq. at (518) 782-3700.**

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 **Mackensie Greene, Esq. at (518) 782-3700.** 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 **Mackensie Greene, Esq. (518) 782-3700.**



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



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, P.C.
- 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, P.C. 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 \$15.
- 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, P.C. 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, P.C. at the discretion of the patient's physician.

In the event of personal financial hardship, Community Care Physicians, P.C. 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.

**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

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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: _____