Upstate Family Health Center, Inc.

Main Office: 1001 Noyes Street, Utica NY 13502
(315) 624-9470 Phone | (315) 642-9480 Fax

New Patient Checklist

Required Documents (Please check each box once completed or provided):

- ☐ Picture ID (e.g. Driver's License, State ID, Passport etc)
- ☐ Insurance Card(s) (Provide copies of all active insurance cards)
- ☐ Patient Application Packet
    - Authorization for Verbal Disclosure of Information
    - Authorization for Access to Patient Information (RHIO Form - signed and completed)
    - Authorization for Release of Health Information Form (Signed and completed)
    - Patient Intake Form
    - Patient Expectations Information Sheet
    - Medication Refill Information and Acknowledgement/Controlled Medication Information Sheet
    - Patient Information Sheet: Form Completion Guidelines
    - Acknowledgment of Forms

Additional Instructions

- Please print clearly when filling out all forms
- Ensure that all sections of the packet are fully completed

We are here to help! Please ask any of our team members for assistance if needed!

Patient Name _____ Date of Birth _____ Today's Date _____ 9202024

Upstate Family Health Center, Inc.
1001 Noyes Street, Utica NY 13501 (P) 315-624-9470 (F) 315-624-9481
https://www.upstatefamilyhealth.org

PATIENT APPLICATION

Patient Information

Last Name	First Name (Legal)	Middle

Address	PO Box / Apt	City	State	Zip

Cell Phone Number		Social Security number

Home Phone Number	Email Address	Date of Birth

Emergency Contact Name	Emergency Contact Number	Relationship to Emergency Contact

	Veteran	Primary Spoken Language	Interpreter Needed?
	☐ Yes ☐ No		☐ Yes ☐ No

Patient Statistics

As a Federally Qualified Health Center (FQHC), we are able to offer services to all our patients, including the under-served, as a result of our Federal designation. As a FQHC, we are required to gather, on a yearly basis, statistics about the patients we serve. This information is confidential and will be used for statistics purposes only. We appreciate you taking the time to fully complete all questions in this section.

Marital Status
☐ Single
☐ Married
☐ Divorced
☐ Separated
☐ Other

Race
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Black or African American
☐ Chinese
☐ Declined to Specify
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Samoan
☐ Vietnamese
☐ White
☐ Other Asian

Ethnicity
☐ Chicano
☐ Cuban
☐ Declined to Specify
☐ Hispanic or Latino
☐ Mexican
☐ Mexican American
☐ Not Hispanic or Latino
☐ Puerto Rican

Sexual Orientation
☐ Straight ☐ Something Else
☐ Lesbian or Gay ☐ Don't know
☐ Bisexual ☐ Choose not to disclose

Gender Identity
☐ Male
☐ Female
☐ Transgender Male (Female to Male)
☐ Transgender Female (Male to Female)
☐ Other
☐ Choose not to disclose

Living Type (check if applies)
☐ Homeless ☐ Transitional Housing ☐ Migrant Worker ☐ Seasonal Worker

Household Size: (Number of people in household this income supports) Adults:_____ Children: _____

Annual Household Income
☐ <$10,000 ☐ $10-$20,999 ☐ $21-$30,999 ☐ $31-$40,999
☐ $41-$50,999 ☐ $51-$60,999 ☐ over $70,000

Custody arrangement in place?
☐ Yes ☐ No Name of Primary:

Responsible Party (if other than patient)

First Name	Middle	Last Name

Relationship to the Patient
☐ Spouse ☐ Partner ☐ Parent ☐ Child ☐ Other _____

	Date of Birth

Address	City	State	Zip

Email Address	Preferred Phone Number	Alternate Phone Number

Primary Insurance Information

Subscriber Name (Name on Insurance Card)		Subscriber DOB

Plan Carrier (Insurance Company)	Subscriber ID #	Group #

Patient Name	Date of Birth	Today's Date

Secondary Insurance Information

Subscriber Name (Name on Insurance Card)		Subscriber DOB
Plan Carrier (Insurance Company)	Subscriber ID #	Group #

Additional Parent/Guardians (if applicable) (**If Patient is under 18 years old**)

First Name	Last Name	Date of Birth
Relationship to the Patient ☐ Parent ☐ Guardian ☐ Other _____	Guardian Phone Number _____	
First Name	Last Name	Date of Birth
Relationship to the Patient ☐ Parent ☐ Guardian ☐ Other _____	Guardian Phone Number _____ _____	

Mother's Maiden Name: _____

Pharmacy Information

Name of patient's primary pharmacy	Address/Location
Name of patient's mail order pharmacy	Address/Location

I UNDERSTAND THAT MY MEDICATION HISTORY MAY BE OBTAINED UTILIZING AN ELECTRONIC INFORMATION EXCHANGE AND THAT THIS PROTECTED HELATH INFORMATION MAY BE VALUABLE INFORMATION FOR MY HEALTH CARE PROVIDER.

I hereby authorize Upstate Family Health Center, Inc. to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

Signature of Patient, Parent and Guardian	

Appointment Reminders/Patient Portal Access

How would you like to receive appointment reminders and care notifications via? ☐Text ☐ Voicemail ☐ Email	Would you like to access our patient portal? ☐ Yes ☐ No (If yes, please provide your email address)

INSURANCE AUTHORIZATION AND ASSIGNMENT

ASSIGNMENT AND RELEASE: I hereby authorize any and all insurances on file for my account to be paid directly to the agency and acknowledge that I am financially responsible for any unpaid balance. I also authorized the Agency to release any information required by my insurance company including medical, surgical, drug, alcohol, and psychiatric information. Release of HIV/AIDS information may require further authorization. I understand that if I am pending Medicaid that I will be billed for the full amount for services until accepted by Medicaid.

CONSENT TO TREAT

I hereby give consent for treatment or therapeutic intervention, which may include evaluations, routine diagnostic procedures, and tests as the health care professionals at Upstate Family Health Center, Inc. consider necessary. I acknowledge that this consent form has been explained to me and I have had my questions answered, and the explanation that I received is sufficient for me to give consent for treatment.

_____ _____

Patient Signature/Legal Representative (Consent to treat and bill) **Date**

_____

Authorized individual and relationship to patient (Consent to treat and bill) **Date**

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

Upstate Family Health Center, Inc.

Authorization for Verbal Disclosure of Information

This will remain in effect until notified differently by patient. The patient is responsible to notify the provider if they wish to revoke this form or make a revision of any information contained within this form.

Patient Last Name	Patient First Name	Date of Birth

Upstate Family Health Center, Inc. may discuss your protected health information with the following people:

Name	Relationship/Phone #	Any Exclusive/Comments
	_____ ☐ Parent ☐ Guardian ☐ Other _____	
	_____ _____ ☐ Parent ☐ Guardian ☐ Other _____	
	_____ _____ ☐ Parent ☐ Guardian ☐ Other _____	

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

Note: This discussion form is not meant to replace or be used instead of SMH/HH 48 Authorization for Release of Medical Information Protected info discussion permission.

Upstate Family Health Center, Inc.

HealtheConnections®

Authorization for Access to Patient Information
New York State Department of Health
Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network.

HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit the HealtheConnections website at http://healtheconnections.org/ .

My choice in this form will NOT affect my ability to get medical care. My choice in this form does NOT allow health insurers to access my information to decide whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change my decision at any time by completing a new form.
☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).
☐ **2. I DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

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

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number

Patient Address

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
UPSTATE FAMILY HEALTH CENTER, INC 1001 NOYES ST UTICA NY 13502 PH: 315-624-9470 FX 315-624-9481

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☐ Other:	EXPIRES 1 YEAR FROM SIGNED DATE BELOW
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

Patient Intake Form

Name: _____ DOB: _____ Date:_____

Address: _____

Phone No: _____ Email: _____

1. Have you had any primary care before?
☐ Yes ☐ No

If yes, please provide the name and address of your previous primary care provider:
Name: _____
Address: _____

2. When was the last time you saw your primary care provider?
Date: _____

3. Do you work with a Case Manager?
☐ Yes ☐ No

If yes, please provide the name and phone number of your Case Manager:
Name: _____
Address: _____

4. Have you seen any specialists in the last 6 months?
☐ Yes ☐ No

If yes, please list the name and address of each specialist:
Name: _____
Specialty: _____
Address: _____

Name: _____
Specialty: _____
Address: _____

5. What is the reason you want to establish care with us?

_____

_____

6. Please list all medications you are currently taking (include dosage and frequency if known):

- _____
- _____
- _____

Patient Name: DOB: Date:

Upstate Family Health Center, Inc.

Patient Expectations Information Sheet

Dear Patient,

At Upstate Family Health Center, we are committed to providing high-quality care in a safe, respectful environment. To help us achieve this, we ask all patients to follow the expectations below:

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1. Respectful Communication

- Treat staff and other patients with courtesy at all times.
- Aggressive or abusive language or behavior is not acceptable.
- If you have concerns about your care, please share them respectfully and through the appropriate channels.

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2. Follow Your Treatment Plan

- Take your medications exactly as prescribed.
- Let your provider know right away if you have side effects or problems with your medications.
- Follow the treatment plan discussed with your healthcare provider.
- Be an active participant in your care.

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3. Appointment Attendance and Punctuality

- Arrive on time for your appointments. Not more than 15 mins before your appt
- If you can't make it, please give at least 24 hours' notice.
- Being late may require us to reschedule your visit.
- Missing three or more appointments without notice may result in dismissal from our practice. (We will consider special circumstances.)

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4. Respect Our Facility

- Please take care of our property and equipment.
- Damage may result in financial responsibility or removal from the practice.

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5. Respect Privacy

- Your medical records are private and confidential.

- Please also respect the privacy of other patients while in our care.

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6. Follow Office Policies

- Comply with our office guidelines related to appointments, payments, and privacy.

Important:
Not following these expectations may lead to a review of your care at our practice and could result in being discharged from Upstate Family Health Center.

Acknowledgment
By signing below, you confirm that you have read, understood, and agree to follow these expectations.

Patient Signature: _____
Print Name: _____ DOB: _____
Date: _____

Thank you for helping us maintain a positive and respectful care environment.

Sincerely,
Upstate Family Health Center

Upstate Family Health Center, Inc.

New Patient Medication Refill Information and Acknowledgment Form

We are glad you have decided to join Upstate Family Health Center as your healthcare provider. Our team is committed to delivering the high-quality care you deserve, with your safety as our top priority.

During your first visit, our providers will perform a comprehensive evaluation of your overall health and medications. Based on this evaluation, they may:

- Continue your current medications,
- Discontinue certain medications, or
- Adjust or switch you to alternative medications as clinically appropriate.

Important Information About Controlled Medications:

Please be aware of our **policy regarding controlled substances**:

- Our providers **do not prescribe or refill** any controlled medications related to **pain management or mental health conditions**.
- If you are currently taking such medications, we will refer you to an appropriate specialist to manage these needs.
- Establishing care with a specialist may take approximately **2–3 months**.
- You must arrange for your **current prescriber** to continue your controlled medications **until you are fully established** with the referred specialist.

A list of local **mental health care providers** is attached to help you begin this process.

Patient Acknowledgment

Please read and confirm the following statements by checking each box:

☐ I understand that Upstate Family Health Center does not refill controlled substances for pain or mental health conditions.
☐ I agree to follow up with the referred specialist for continued management of my controlled medications.
☐ I understand that it is my responsibility to ensure my current prescriber continues these medications until I am under the care of a specialist.

Patient Name (Print): _____
Date of Birth: _____

Patient Signature: _____ **Date:** _____

Provider/Witness Signature (optional): _____ **Date:** _____

Patient Name: DOB: Date:

Patient Information Sheet: Form Completion Guidelines

At UFHC, your care is our priority. In order to support you while maintaining high standards and compliance, please carefully review our guidelines for form completion.

☑ What You Need to Know

1. What types of forms are covered?
Requests such as the following fall outside routine medical care and are not included in a standard visit. We will schedule a dedicated appointment.

- School or camp forms
- FMLA paperwork
- Long-term care or life insurance forms
- Veterans Affairs documents
- Disability forms
- Employment-related forms (e.g., return-to-work or work restrictions)

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2. Who is eligible for form completion?
To be eligible, you must:

- Be a UFHC patient for **at least one year**, or have had **six or more visits**, **AND**
- Have been seen **within the last 6 months**.

📌 *Note: Based on your condition, your provider may determine that a specialist should complete your form. We can provide a list of trusted referral providers for disability-related matters.*

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3. Disability and Work-Related Forms

UFHC providers **do not provide legal disability determination.**
If your form requests:

- A decision about your ability to work
- Functional assessments

➡️ You will be referred to an appropriate specialist (e.g., physiatry, occupational medicine, physical medicine).

🗓️ Form Completion Process

STEP 1: Schedule a dedicated office visit.
We do **not** accept walk-in or drop-off forms. This dedicated scheduled visit ensures your provider can review and discuss the form properly. If your provider has sufficient information and decides to complete the form, it will be done within 10 days of your visit."

STEP 2: Bring your form to the visit.

- Obtain the form from your employer, insurance, or agency.
- Complete the patient portion before your appointment.
- Please sign any required Release of Information allowing us to release medical information per HIPAA regulations.

STEP 3: Pay applicable charges.

If the service is **not covered by insurance**, you will be responsible for the charge directly. Standard visit charges and clinic policies apply.

🗂️ After Your Form Is Completed

- A copy will be kept in your permanent medical record.
- If you need another copy:
    - **Contact the Medical Records Department**
    - Or use the **Patient Portal** to access your records electronically.

📌 *Providers cannot release records directly. Please do not contact them for copies.*

❗ Important Reminders

- Providers are legally responsible for any information they sign. Forms will be filled out with care to avoid errors that may affect your case.

- Providers have full discretion to refuse to fill out or sign forms requested.
- Do not leave forms at the front desk or with your provider without an appointment. We cannot accept responsibility for lost or incomplete paperwork.

Patient Acknowledgment & Signature

I have read and understood the **UFHC Form Completion Guidelines**. I acknowledge that:

- I must schedule a dedicated visit for form completion.
- I am responsible for any charges not covered by insurance.
- I must complete my portion of the form prior to submission.
- Copies of forms can only be obtained through the Medical Records Department or the Patient Portal.

I agree to follow the process outlined above and understand that failure to do so may delay form completion.

Patient Name (Printed): _____
Date of Birth: _____
Signature: _____
Date: _____

Upstate Family Health Center, Inc.

Acknowledgment of Forms

Patient Name	Date of Birth

UPON REQUEST, YOU WILL RECEIVE A COPY OF THE FOLLOWING

1. Payment Policy
2. Patient Responsibilities & Code of Conduct
3. Patient Bill of Rights/ Grievance Process
4. Planning in Advance for your Medical Treatment (Advance Directive)

NOTE: if patient is a child, # 4-6 are not applicable

5. About Health Care Proxy-FAQ
6. NYS Healthcare Proxy (Blank Form)
7. Privacy Commitment Notice (HIPAA)
8. Sliding Fee Program Information
9. Release of Information to obtain records from prior PCP

Before signing…if you have any questions, please discuss them with staff…

1. The New York State Health Care Proxy has been explained to me and I: (applicable for adults only). Adult means any person 18 years or older, and (if under 18 years) you are a parent or married).

   - ☐ I have an advance directive. (**Please provide the office with a copy for our records**)
   - ☐ I choose not to execute my right to make an advance directive at this time.

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK YOUR HEALTHCARE PROVIDER

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