Upstate Family Health Center, Inc.

Making each and every life better...

New Patient Checklist

(Please complete all required sections and provide necessary documents)

Required Documents

(Please check each box once completed or provided.)

☐ **Picture ID (e.g. Driver's License, State ID, Passport)**

☐ **Insurance Card(s) (Provide copies of all active insurance cards)**

☐ **Records Release Form (Signed and completed)**

☐ **RHIO Form (Signed and completed)**

☐ **Provider list (List of prior Primary Care and prior/current Specialty Care providers)**

Additional Instructions

- **Please print clearly when filling out all forms.**
- **Ensure that all sections of the packet are fully completed.**
- **If you have any questions, please ask the front desk for assistance.**

Main Office
1001 Noyes Street
Utica, NY 13502
Phone: 315-624-9470 Fax: 315-624-9481

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 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)

Upstate Family Health Center, Inc.

Acknowledgment of Forms

Patient Name	Date of Birth

I HAVE RECEIVED A COPY OR WAS OFFERED 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)

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.

Upstate Family Health Center, Inc.

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

Dear Patient,

Thank you for choosing Upstate Family Health Inc. for your primary care needs.

In order to provide you the best quality of care, it is important that we have a full understanding of your medical history; in that regard, we need to obtain your medical records from other practices (your previous primary care provider and other specialty practices you obtain care from).

Please list all of your providers below, as indicated:

Practice Name	Specialty	Address	Fax Number