North Country Family Health Center

Patient Registration Form

Patient Information

Patient Information:

First Name:	Last Name: M.I.:		First Name Used:
Street Address: Apt #	City:	State:	Zip:
Mailing Address: ☐ Same as Street Address			Employment Status: ☐ Student ☐ Employed ☐ Retired ☐ Unemployed
Social Security #:	Date of Birth:	Sex at Birth: ☐ Male ☐ Female	Occupation:
Home Phone: ☐ None	Cell Phone: ☐ Cell Phone is Home Phone		Work Phone:
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow ☐ Partner ☐ N/A (pediatrics)			
Patient/Guardian Email Address:		Preferred Pharmacy & Location:	
Emergency Contact Name:	Emergency Contact Phone #:		Relationship to Patient:

Pediatric Patients Only: Please select and document the name of each person who is authorized to make medical decisions for the child (legal documents may be requested).

☐ Mother/Guadian:	Phone:	Patient/Guardian Email Address:
☐ Father/Guardian:	Phone:	Patient/Guardian Email Address:
☐ Guardian or Foster Parent Name: ☐ N/A	Foster Parent Agency: ☐ N/A	
Mother's Maiden Name:		

Additional Patient Information

Additional Patient Information:

Preferred Language Patient Speaks:

☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Sign Language ☐ Other: _____

Translation Assistance Needed: ☐ Yes ☐ No

Race: ☐Asian Indian ☐Chinese ☐Filipino ☐Japanese ☐Korean ☐Vietnamese ☐Native Hawaiian ☐Other Pacific Islander ☐Guamanian or Chamorro ☐Samoan ☐Black or African American ☐American Indian/Alaskan Native ☐White	Ethnicity: ☐Mexican, Mexican American, Chicano/a ☐Puerto Rican ☐Cuban ☐ Another Hispanic, Latino/a, or Spanish ☐Non-Hispanic, Latino/a, or Spanish

Household Size & Income (For Children Enter Family Information):

Number of People in the Household: _____ Income $_____ ☐ Week ☐ Month ☐ Year

☐ Choose Not to Disclose

Housing Status of Patient (Location Patient Slept Last Night):

☐ At Home/Apartment ☐Group Home ☐ Shelter ☐ Car ☐ Street ☐ With a Friend/Relative

Migratory/Seasonal Agricultural Work Status of Patient/Dependent: ☐Seasonal or ☐Migratory Worker ☐ N/A/None/Neither

Patient Name: _____ Date of Birth: _____

Insurance Information

Responsible Person Information - Person Who Is Responsible for Payment of Patient's Account:		
First Name: ☐ Same as Patient	Middle:	Last Name:
Date of Birth:	Social Security #:	Phone: ☐ Cell ☐ Home
Address of Person Responsible: ☐ Same as Patient		
City/State/Zip:	Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian* ☐ Custodial Parent ☐ Foster Parent	

Primary Medical Insurance	**Dental Insurance**
☐ I ***Do Not*** Have ***Medical*** Insurance ☐ I Would Like to Apply for a ***Reduced Fee*** ☐ I ***Have Medical*** Insurance	☐ I ***Do Not*** Have ***Dental*** Insurance ☐ I Would Like to Apply for a ***Reduced Fee*** ☐ I ***Have Dental*** Insurance
Insurance Company Name:	Insurance Company Name:
Medical Policy #:	Dental Policy #:
Billing Address of Insurance Company:	Billing Address of Insurance Company:
Policy Holder's Name and Date of Birth:	Policy Holder's Name and Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
☐ **I Have Additional *Medical* Insurance**, Name of Insurance:	☐ **I Have Additional *Dental* Insurance,** Name of Insurance:
Medical Policy #:	Dental Policy #:
Policy Holder's Name and Date of Birth:	Policy Holder's Name and Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:

Patient Rights and Advance Directives

Patient Bill of Rights

Would you like a copy of the Patient Bill of Rights:

☐ Yes, and a copy has been provided to me.

☐ No, but I have been offered printed information and I have had the opportunity to ask questions.

Health Care Proxy

A Health Care Proxy gives someone else the power to make medical decisions for you when you cannot speak for yourself. Do you have a Health Care Proxy?

☐ Yes, and a copy has been provided to North Country Family Health Center.

☐ Yes, but a copy is not available at this time.

☐ No, but I have been offered printed information related to a Health Care Proxy and I have had the opportunity to ask questions.

Advance Directives

Advance Directives are written instructions relating to how healthcare is to be provided when and if an adult is unable to make their own decisions (examples of an Advance Directive: MOLST, DNR, Living Will, and/or Medical Power of Attorney).Do you have an Advance Directive?

☐ Yes, and a copy has been provided to North Country Family Health Center.

☐ Yes, but a copy is not available at this time.

☐ No, but I have been offered printed information related to Advance Directives and I have had the opportunity to ask questions.

Patient Name: _____ Date of Birth: _____

North Country Family Health Center Policies and Consents

Permission to Disclose to Family or Other Individuals:

Adult Consent (Age 18 and Older): You may authorize North Country Family Health Center (NCFHC) to disclose your protected health information to family members or other individuals in order to assist with the coordination of your care.

☐ **No**, I do not give NCFHC permission to disclose my protected health information to family members or other individuals in order to assist with the coordination of my care.

☐ **Yes**, I give NCFHC permission to disclose my protected health information to the family members or other individuals listed below in order to assist with my coordination of care. This permission is valid for one year from the date of signature unless revoked or changed in writing prior to the expiration. ***OR***

Pediatric Consent (Age 17 or Younger): Non-Parental Consent: For pediatric patients, age 17 and under, you may designate another person to attend visits and authorize treatment decisions. Parents/legal guardians do not need to be added.

☐ **No**, I do not give consent for another adult to attend, give consent, and make treatment decisions in my absence.

☐ **Yes**, if I am unable to attend my child's appointments, I give consent for the following adult(s) to attend and to give consent for medical/dental/behavioral healthcare and to make treatment decisions for my child in my absence. I understand that when I designate another person to authorize a treatment decision, NCFHC may disclose protected health information to the authorized person(s).

If you checked "**Yes**" above, please complete the following section:

Name of Individual(s):	Relationship to Patient:

Finance Policy/Release of Billing Information/Assignment of Benefits: NCFHC serves all patients whether they are covered by insurance or not. When you use our services, you are responsible for the cost of those services. If you have insurance, you are responsible for understanding the limitations of your insurance coverage and are responsible for any co-pays, cost shares, and deductibles or non-covered services at the time service is provided. As a courtesy, we will bill your insurance for you. If requested, payment plans are available. We offer a sliding fee scale, which offers a discount on our services, to patients based on household size and income. You may apply for this Program at the front desk. We can also assist you with obtaining insurance coverage. I authorize NCFHC and its representatives to release any information they obtain, including medical information, to my insurance company or their representatives to process claims for payment. As applicable, I authorize my insurance provider to pay NCFHC for services rendered. I understand medical bills paid by credit card are no longer considered medical debt. By paying with a credit card, I am forgoing federal and state protections around medical debt which may include prohibitions on wage garnishment and property liens; prohibitions against reporting medical debt to credit bureaus; and limitations on interest rates.

Consent for Treatment:

- I authorize NCFHC to conduct any diagnostic or routine examinations, tests, and procedures to obtain specimens and to provide any medications, treatment, or therapy as necessary now or at future visits.
- I understand that specimens may be sent to an outside facility for processing. There may be a separate charge for this service.

Privacy Notice:

- I have been given the opportunity to review or receive a copy of NCFHC's Notice of Privacy Practices which describes how NCFHC may use and disclose my protected health information following applicable state and federal law. I understand NCFHC can request and use my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.
- I understand that I have the right to receive a copy of my medical information or to request restrictions on the use of my protected health information.
- I understand that NCFHC may engage business associates to assist in my coordination of care including afterhours telephone and triage coverage and call reminder service. I understand these calls may be recorded to improve customer service and patient care.
- I understand NCFHC may use letters, reminder calls, text messages, or secure email correspondences to communicate with me regarding my care. I authorize NCFHC to communicate with me via these methods.
- I understand NCFHC may use computer assisted technologies guided by our internal policies and procedures to enhance my care, with all data processed securely and all clinical decisions made by a qualified healthcare provider.
- I understand my care team may include resident physicians, students, interns, or other trainees supervised by a NCFHC provider. I understand I have a right to refuse this arrangement at any time.
- I have been given the opportunity to review and receive a copy of NCFHC's Patient Responsibilities and understand that these responsibilities are posted in all NCFHC locations, online, and are physically available to me upon request. I understand that NCFHC maintains the right to discontinue treatment for any violation of these responsibilities. In such cases, the patient or parent/guardian agrees to accept full responsibility for pursuing alternate medical care.

Patient Name: _____ Date of Birth: _____

Telehealth Consent:

NCFHC offers its patients telehealth services as a method to expand access to care. I understand I may be offered a telehealth appointment at NCFHC. I consent to receive services via NCFHC's telehealth equipment or via my personal device and understand and/or agree to the following:

- I understand I have the right to refuse to participate in services delivered via telehealth at any time by informing any NCFH C staff member.
- I may request at any time an in-person appointment with another NCFHC healthcare provider.
- I understand that by selecting another provider there could be a delay in service and the potential need to travel for a face-to-face visit.
- I understand there are potential drawbacks of participating in a telehealth visit versus a face-to-face visit.
- I understand the healthcare provider performing the service will not be physically in the same room as me and will be performing the service at a different location, therefore, if parts of my care and treatment require physical examination they may be conducted by other NCFHC providers and staff under the direction of my telehealth healthcare provider or I may need to be re-scheduled for a face-to-face visit which could result in a delay in service and the potential need to travel for the face-to-face visit.
- I understand my visit will be conducted via technology and NCFHC cannot guarantee technology will always work.
- I understand that if there is an equipment failure I may need to be rescheduled for a face-to-face visit.
- I understand NCFHC utilizes HIPAA compliant, encrypted software to conduct its telehealth services.
- I understand I should use an internet service that is private and secure when using my personal device.
- I understand during the visit I should be in a private place, so other people cannot hear me.
- I understand I have the right to ask any questions regarding the telehealth equipment, technology, etc. at any time.
- I understand I will be informed and made aware of the role of the telehealth provider, if applicable, the role of the qualified professional staff at the NCFHC location who are going to be responsible for follow-up or ongoing care; and the location of the distant site if the provider is not located at a NCFHC site.
- I understand if I am attending a telehealth appointment at a NCFHC site, I have the right to have appropriately trained staff immediately available to me while receiving telehealth services to attend to emergencies or other needs. I understand this is not possible if I am conducting a telehealth visit from my place of residence located within the state of New York or other temporary location within or outside the state of New York.
- I understand I have the right to be informed of all parties who will be present at each end of the telehealth transmission and consent to have NCFHC staff in the exam room to operate telehealth equipment, if applicable.

New York State Immunization Information System (NYSIIS) Consent:

- I authorize NCFHC to release my immunization(s) and identifying information to NYSIIS; participation in NYSIIS for people 19 years of age and older is voluntary.
- I understand the purpose of NYSIIS is to assist in my medical care and to record the immunizations that I have had or will receive in the future.
- I understand my immunization information may potentially be used by the Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes. Information used for quality improvement or any research purposes will have my personal identifying information removed.
- I understand the immunization information in NYSIIS may be released to the following: myself, my health insurance plan, the state and local health departments, the school that I am registered to attend, and authorized medical providers that deliver my medical care.

My Signature Means:

- I have reviewed and completed the Permission to Disclose to Family or Other Individuals section. I understand that when I designate another person to authorize a treatment decision, NCFHCmay disclose protected health information to the authorized person(s).
- I have reviewed NCFHC's Finance Policy/Release of Billing Information/Assignment of Benefits; Consent for Treatment; Privacy Notice; Telehealth Consent; and NYSIIS Consent.
- I have been given the opportunity to ask questions and all of my questions have been answered fully and satisfactorily.
- I understand that my consent will remain in effect for one year from the date of my signature unless I notify NCFHC in writing. I understand that I may revoke my consent at any time.

Printed Name of Patient/Legally Authorized Representative:	Relationship to Patient: ☐ Patient ☐ Relationship to Patient: _____
Signature of Patient or Legally Authorized Representative:	Date:
Witness to Signature if Legally Authorized Representative:	Date:

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS related Information

Patient Name	Date of Birth	Patient Identification 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. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. 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 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of **Provider** or Entity to Release this Information:
Provider Full Name/Office Name:

Provider Address:

Provider Phone:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:
North Country Family Health Center, 238 Arsenal Street Watertown, NY 13601 Phone: 315-782-9450 Fax: 833-305-0396

7. Purpose for Release of Information: **Continuity of Care**

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ until _____
Time frame for which you authorize to allow information to be obtained INSERT START DATE INSERT EXPIRATION DATE OR EVENT

- ☐ All Immunizations
- ☐ Past 1 year of Office Visit Notes; Medications; Problem List (or last visit if not seen in past year)
- ☐ Past 2 year of Lab Tests & Imaging, or other procedure Reports
- ☐ Most recent mammogram, colonoscopy, pap smear, EKG

For the following to be included, indicate the specific information to be disclosed and initial below.

	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS- related Information		

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

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

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ _____ _____
STAFF PERSON'S NAME AND TITLE SIGNATURE DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment related information or confidential HIV related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

North Country Family Health Center

HealtheConnections

New York State Department of Health

Authorization for Access to Patient Information 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 HealtheConnections website at http://healtheconnections.org/ .

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding 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)