FamilyCare
Medical Group, PC

Dear Patient:

Welcome to FamilyCare Medical Group at The Synergy Center. We are honored that you have chosen us as your health care provider. FamilyCare Medical Group offers a wide variety of services from a state-of-the-art sleep center to co-located behavioral health services in some of our offices. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner, and we strive to provide our patients with same-day office visits with a member of their care team.

Please make sure that you bring your insurance card and a photo ID with you for each appointment. If you have any information changes or have seen any other doctors, please be sure to let our staff know so that we can update your information in the computer.

We ask that you allow plenty of time to get to the office for your appointment. Please plan on arriving at least 15 mins prior to your appointment.

To ensure that we provide you with quality care, we need certain information from you. Please fill out the enclosed forms completely and mail them back to our office to obtain an appointment. We will call you as soon as your paperwork is received. All co-pays and past due balances are expected at the time of service, unless a prior agreement has been made with our billing department. If you need information about insurance coverage, please let us know and we will assist you.

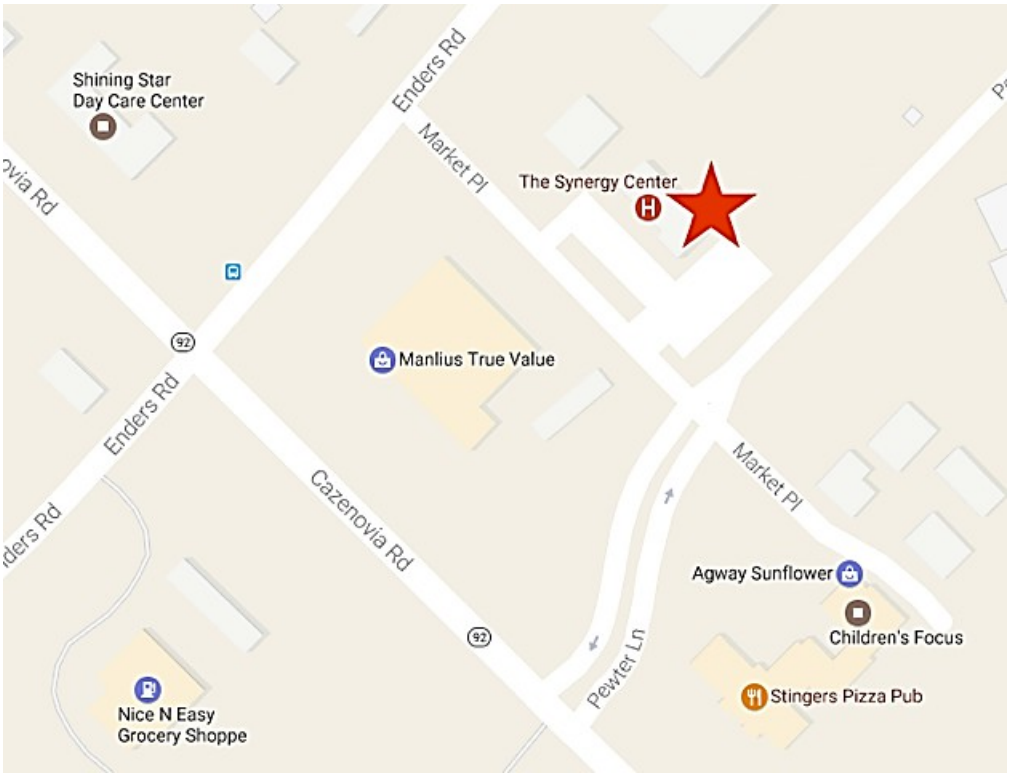
If you have an urgent after hours matter, you can call our answering service or visit our urgent care center Immediate Care West Monday-Friday 9am to 6pm and Saturday's and Sunday's from 8am to 4pm. Immediate Care West is also part of FamilyCare Medical Group and they have access to your patient records.

We look forward to working with you as your health care provider and we would like to thank you again for choosing FamilyCare Medical Group for all of your health care needs.

Sincerely,

Lori Anderson, MD and Christine Kirkman, CPNP

The Synergy Center
4500 Pewter Lane
Buildings 8-9
Manlius, NY 13104
(315) 692-2037



Located just off the intersection of route 92 and Enders Road. We are the large brown building behind the True Value Hardware.

From Syracuse/Dewitt:

From 481, take exit 3E for NY-92 E/NY-5 E toward Fayetteville. Take a slight right onto NY-5 E/NY-92 E towards Manlius. When road doubles, staying in right lane, turn left on to Route 173/92. Bear to the right onto Route 92 towards Cazenovia. Take left at Enders road and then immediate right on to Market Place. We are the large brown building on your left.

From the East:

From Route 5 heading into Fayetteville turn south on to Route 257/Fayetteville Manlius Road. When road doubles, stay in the right lane, turn left on to Route 173/92. Bear to the right onto Route 92 towards Cazenovia. Take left at Enders road and then immediate right on to Market Place. We are the large brown building on your left.

FamilyCare Patient Portal Information

The online FamilyCare Patient Portal allows patients to access their health information and to communicate with their physician's office easily and safely. Patients can login to the password-protected, user-friendly patient portal to send secure messages to their provider's office 24 hours a day, 7 days a week, in order to:

- ✓ View, request and cancel appointments
- ✓ Review current medication list
- ✓ Review current list of allergies/medication allergies
- ✓ Request refills on medications prescribed by our office (please allow 48 hours for completion)
- ✓ View and update your primary pharmacies (local and mail order)
- ✓ View and update demographic information
- ✓ Access immunization records
- ✓ View laboratory and other testing results
- ✓ View portions of your personal health record

When you come in for your next appointment, ask the receptionist for your unique activation code for the patient portal.

****The patient portal is <u>not</u> intended to be used for emergency purposes. If you have a true medical emergency or are in need of immediate medical care or prescriptions, please all the office directly.****

FCMG AT THE SYNERGY CENTER
POLICY AGREEMENT

Please read and understand. If you have any questions we will be happy to explain.

Our staff will show you respect and courtesy at all times. The same is expected of our patients. Verbal abuse/rudeness toward any staff member is cause for dismissal from our practice.

1. We request every patient to arrive 15 minutes before their scheduled time. Any patient that arrives 10 minutes after their scheduled appointment time will be rescheduled.
2. When an appointment is no showed you will be charged a $50.00 fee. This fee will be billed directly to you, not your insurance company. A no show is 10 minutes late without any prior call.
3. After your third no show you will be dismissed.
4. In order to provide the best patient care, we need to be able to contact you. It is your responsibility to update our office with any phone number, address or insurance changes.
5. Insurance cards and photo ID must be brought to every appointment. If you are unable to present these upon request you might be asked to reschedule.
6. Patient co-pay is due at time of service. Payment on any overdue balance (minimum of $10.00) must be made upon check in. If we cannot validate your insurance, you may be asked to; pay the balance up front, sign a waiver, reschedule your appointment.
7. Please be aware that all insurances are different and some of your visit may not be covered. If you are unsure of what you insurance covers contact the number on your insurance card. We do not participate with No-Fault and Workers Comp.
8. All patients must check out at the end of appointment.
9. Non-compliance with scheduling appointments for your medical conditions will result in your dismissal from our practice.
10. We require 48 hours to complete all prescription refill requests.
11. Due to our high volume we require up to 10 business days to complete any paperwork and non-urgent referrals. Some paperwork/referrals may require an office visit with the doctor.
12. Urgent matters called in to the office will get a call back from a nurse within the same day. Non-urgent matters will get a call back from the nurse within 24 hours. If you are having an emergency, call 911.
13. Written abuse/rudeness toward any staff member or the practice is also cause for dismissal from our practice. This includes posting negative/abusive comments on all forms of social media!

Print:_____ Sign:_____Date:_____

Registration Form

(Please Print)

Date: _____

Name: _____ Sex: M___ F___ DOB: _____

Address: _____ City: _____ Zip: _____

Primary Phone: _____ Alt Phone: _____ Email: _____

Emergency Contact: _____ Phone #:_____

Marital Status: ( ) Single ( ) Married/Partnered ( ) Divorced/Separated ( ) Widow/Widower

Language Preference: _____ Race: _____

Ethnicity: ( ) Non-Hispanic/Spanish Origin ( ) Spanish/Hispanic Origin ( ) Patient declined/unknown

Spouse/Significant Others Name: _____ Phone #:_____

Spouse/Significant Others Employer:_____ Occupation:_____

Patients Employer: _____ Occupation: _____

Insurance Information

Primary Insurance: _____ ID #:_____

Subscriber Name: _____ DOB: _____

Secondary Insurance: _____ ID #:_____

Subscriber Name: _____ DOB: _____

Pharmacy Information

(list one even if you don't have active medications)

Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Mail Order Pharmacy

Name: _____ Phone: _____

Previous Provider/Group:_____

Personal History Form

Name: _____ Date of Birth: _____ Date: _____

Circle one: Single Married Divorced Separated Widowed Significant other

Who shares a home with you: _____

List any allergies to medications: _____

Any other allergies: _____

List all medications: (including the name, dose and frequency) _____

_____

_____

_____

_____

List any medical problems you have: _____

_____

Please list any surgeries: _____

Did you ever smoke? ____ How much per day? _____ How long did you smoke? _____ If you quit, when? ____

Do you drink alcohol? ____ How much per day? _____ How often? _____ If you quit, when? _____

Date of last tetanus shot: _____ Last physical: _____ Last pap smear: _____ Last mammo: _____

Family History:

	Living (how old)	Any Illnesses?	Age of Death	Cause of Death
Mother				
Father				
Siblings				

Have you ever had any blood transfusions, IV drug use or any other risk factors for HIV/AIDS? _____

Are you aware of all the health risk factors for HIV or AIDS? _____

Do you have a Health Care Proxy? _____Would you like information on one? _____

Thank you for providing this information. It helps us take better care of you!

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:

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: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
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.