





# FamilyCare

## Medical Group, PC

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### **NO SHOW FEE AND LATE CANCELLATION FEE POLICY**

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences.

Due to high patient demand, and limited availability of appointments, we have instituted a fee up to \$50.00 for no show and a \$30.00 fee for late cancellations. As of January 1<sup>st</sup> 2009, you must give 24 hours advance notice to cancel/reschedule appointments.

By signing below, I acknowledge that I have read and understand this policy.

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**Patient Signature**

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**Date**

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**Patient Name (printed)**

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**Witness Signature**

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**Date**

# NEW PATIENT DATA SHEET

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Birthplace: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Are you a smoker?  Y  N  past? If yes, how many per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Do you drink Alcohol?  Never  Rarely  Daily  Socially Only Is it a problem?  Y  N

List Any Allergies:

\_\_\_\_\_

**List the medications you are currently taking:**

Name of Medication	Dosage	How Many Times Per Day

**Please list other healthcare providers & their specialty you see regularly:**

\_\_\_\_\_

**List any previous hospitalizations, excluding normal pregnancies:**

Operation, illness or procedure	Year	Doctor	Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### Personal Health History

Check off any conditions that you have, or have had in the past, if any:

- |                                       |  |   |   |
|---------------------------------------|--|---|---|
| <input type="checkbox"/> Stroke       | <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Blood Transfusions |
| <input type="checkbox"/> Seizures     | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Chicken Pox        |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Depression         |
| <input type="checkbox"/> Cataracts    | <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Ulcers               | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Glaucoma     | <input type="checkbox"/> Enlarged Heart      | <input type="checkbox"/> Diverticulitis       | <input type="checkbox"/> Diabetes           |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Kidney Stones        | <input type="checkbox"/> Migraines          |
| <input type="checkbox"/> Pneumonia    | <input type="checkbox"/> Breast Lump         | <input type="checkbox"/> Urinary Infection    | <input type="checkbox"/> Cancer             |
| <input type="checkbox"/> Emphysema    | <input type="checkbox"/> Prostate Problems   | <input type="checkbox"/> Anemia               | <input type="checkbox"/> Skin Cancer        |
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Blood Disorder      |   |   |

To the best of your knowledge have you ever been exposed to:

- Sexually Transmitted Diseases     Tuberculosis     Hepatitis B     HIV

## Family Health History

(Please check the conditions that are in your family)

	Mother	Father	Sister	Brother	Grandmother	Grandfather	other
Healthy							
Heart disease							
Diabetes							
High blood pressure							
COVID							
High cholesterol							
Stroke							
Colon cancer							
Breast cancer							
Prostate cancer							
Osteoporosis							
Other							

### For Women Only:

Total number of pregnancies: \_\_\_\_\_ Number of births: \_\_\_\_\_

Are you Currently Pregnant:  Yes  No Due Date: \_\_\_\_\_

Age of first period/menstruation: \_\_\_\_\_

Age of last period/menstruation (menopause/hysterectomy): \_\_\_\_\_

Do you have concerns about your periods or menopause you'd like to discuss?  No  Yes

If you are having periods, how often do they occur? Every \_\_\_\_\_ days. How long do they last? \_\_\_\_\_ days

### Do you have the following medical forms on file?

If not would you like information?  yes

- Advance Directive for Health Care (ADHC)
- Health Care Proxy
- Durable Power of Attorney (DPA) for healthcare decisions)
- Living Will
- MOLST (Medical Orders for Life Sustaining Therapy)



# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

OCA Official Form No.: 960

[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:	
<input type="checkbox"/> Medical Record from (insert date) _____ to (insert date) _____ <input type="checkbox"/> 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. <input type="checkbox"/> Other: _____	
Include: <i>(Indicate by Initialing)</i> _____ Alcohol/Drug Treatment _____ Mental Health Information _____ HIV-Related Information	
<b>Authorization to Discuss Health Information</b>	
(b) <input type="checkbox"/> By initialing here _____ I authorize _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span>Initials</span> <span>Name of individual health care provider</span> </div> to discuss my health information with my attorney, or a governmental agency, listed here: _____ <div style="text-align: center; font-size: x-small;">(Attorney/Firm Name or Governmental Agency Name)</div>	
10. Reason for release of information:	11. Date or event on which this authorization will expire:
<input type="checkbox"/> At request of individual <input type="checkbox"/> Other: _____	
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.

Signature of patient or representative authorized by law: \_\_\_\_\_ Date: \_\_\_\_\_

\* 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.