FamilyCare

Medical Group, PC

Dear Patient:

Welcome to FamilyCare Medical Group. 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 a co-located behavioral health services in some of our offices. Our goal is to provide the highest quality of 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 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 minutes 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 and bring them with you to your appointment. 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-6pm and Saturday's and Sunday's from 8am-4pm. Immediate Care West is also part of FamilyCare Medical Group and they have access to you patient records.

We look forwards 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,

The staff at FamilyCare Medical Group

Cortland Health Center
1259 Fisher Avenue
Cortland, NY 13045

Ph. 607-756-4600
Fax. 607-753-6266

Dear _____,

We would like to thank you for choosing the Cortland Health Center for your health care needs. To benefit the Doctor and myself will all of your health care needs, we ask that you take a moment to complete the enclosed forms and bring them with you to your appointment. Thank you!

Your appointment has been scheduled:

WITH:_____

DATE:_____

TIME:_____

PLEASE BRING THE FOLLOWING WITH YOU AT THE TIME OF YOUR VISIT:

Enclosed Forms
Immunization Records
Insurance Card(s)
Medication List or Bottles (Include over the counter medications)

IF YOU HAVE FIDELIS INSURANCE, PLEASE CONTACT FIDELIS & CHANGE YOUR PCP TO THE DOCTOR NOTED ABOVE. OTHERWISE YOU WILL HAVE TO RESCHEDULE YOUR APPOINTMENT.

All of us here at the Cortland Health Center want to make your visit a pleasant one!

Sincerely,

Medical Secretary

****PLEASE CALL AT LEAST 24 HOURS IN ADVANCE IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT.**

HEALTH HISTORY

Name:_____DOB:_____Acct #_____

To help us meet all of your health care needs, please fill out this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's Date_____ When was your last physical exam?_____

Place of birth_____ Name of doctor & phone_____

Highest level in school_____ Occupation_____

Previous Occupations_____ Marital Status_____

Hobbies_____ Exercise_____

Please list all serious illnesses, surgeries, and other hospitalizations you have experienced and indicate year these occurred:

_____

_____

Please list all current medications, including non-prescriptions and supplements:

_____

_____

Describe all serious accidents, injuries, head injuries, fractures, or broken bones (include dates):

_____

_____

HABITS:

Smoker (type & amount per day)_____If former smoker, date quit_____

Alcohol (type & amount per week)_____

Caffeine (type & amount per day)_____

Street Drugs (type & amount per day)_____

Weight_____ Date of last Dental exam_____

Please list all allergies (food, drugs, environmental)

_____

_____

CHIEF COMPLAINTS

Please list, in order of importance, the present health concerns, symptoms, or problems you are experiencing:

_____

_____

PAST MEDICAL HISTORY

Have you ever had the following: Circle "YES" or "NO", leave blank if you are uncertain.

Measles YES or NO	Migraine Headaches Yes or NO	Hives or Eczema YES or NO
Mumps YES or NO	Tuberculosis YES or NO	AIDS or HIV YES or NO
Chickenpox YES or NO	Diabetes YES or NO	Infectious Mono YES or NO
Whooping Cough YES or NO	Cancer YES or NO	Bronchitis YES or NO
Scarlet Fever YES or NO	Polio YES or NO	Stroke YES or NO
Diphtheria YES or NO	Mitral Valve Prolapse YES or NO	Glaucoma YES or NO
Small Pox YES or NO	Hernia YES or NO	Hepatitis YES or NO
Pneumonia YES or NO	Ulcer YES or NO	Back Pain YES or NO
Kidney Disease YES or NO	Thyroid Disease YES or NO	Bleeding Tendency YES or NO
Arthritis YES or NO	Venereal Disease YES or NO	Hemorrhoids YES or NO
Anemia YES or NO	Bladder Infections YES or NO	Epilepsy YES or NO
Asthma YES or NO	High Blood Pressure YES or NO	Low Blood Pressure YES or NO

Any other Disease YES or NO _____

Date of last Chest X-Ray _____

FAMILY HISTORY (parents, siblings, and children only)

Has any blood relative had any of the following? (Check the condition, leave blank if unsure)

	Relationship		Relationship
Cancer ____	_____	Stroke____	_____
Tuberculosis ____	_____	Epilepsy____	_____
Diabetes____	_____	Allergies____	_____
Heart Disease____	_____	Anemia____	_____
Bleeding Tendency ____	_____	High Blood Pressure____	_____
Asthma____	_____	Lung Disease____	_____
Mental Illness____	_____	Leukemia____	_____
Obesity____	_____	Thyroid Disease____	_____
Ulcer____	_____	Depression____	_____
Kidney Disease____	_____	Glaucoma____	_____
Gout____	_____	High Cholesterol____	_____
Drug/Alcohol Dependency____	_____	Migraine Headaches____	_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING IN THE PAST YEAR? (Please use a check mark)

Weakness/Paralysis____	Bloody Sputum____	Joint Pain/Stiffness____	Tiredness/Weakness____
Wheezing____	Swollen Joints____	Weight Changes____	Chest Pain____
Muscle Cramps/Spasm____	Change in Appetite____	Purple Fingers/Lips____	Sleeplessness____
Sensitivity to heat/cold____	Swelling hands/feet/ankles____	Seizures____	Persistent Fever____
Difficulty Breathing____	Depression____	Night Sweats/Hot Flashes____	
Palpitations/Heart Flutter____		Memory Loss____	Skin Rash____
Leg Cramps on walking or at night____		Poor Coordination____	Skin Changes____
Enlarged Veins____	Dizziness/Fainting____	Change in Nails/Hair____	Difficulty Swallowing____
Headaches____	Heartburn____	Easy Bleeding/Bruising____	Frequent Belching____
Double Vision____	Abdominal Cramping____	Blurred Vision____	Eye Pain____
Nausea____	Vomiting____	Infected Eyes____	Vomit/Cough Blood____
Chronic Diarrhea____	Chronic Constipation____	Ringing in Ears____	Rectal Bleeding____
Discharge from Ears____	Black, Tarry Stools____	Ear Pain____	Dark Urine____
Decrease in Hearing____	Yellow Jaundice____	Nose Bleeds____	Frequent Urination____
Frequent Colds____	Sinus Problems____	Increased Thrist____	Loss of Smell____
Painful Urination____	Persistent Hoarseness____	Leakage of Urine____	Sore Throat____
Difficulty Urinating____	Blood in Urine____	Sore Tongue/Gums____	Lack of Sex Drive____
Lump in Breast____	Discharge from Breast____	Chronic Cough____	Hemorrhoids____
Shortness of Breath____	Backaches____		

MEN ONLY:
Discharge from Penis____ Pain/Lump in Testicles____ Impotence____

WOMEN ONLY:
Age period began____ How many days do periods last?____ How many days between periods?____

Is the flow heavy? YES or NO Do you bleed or spot between periods? YES or NO?

Do you have pain or cramps? YES or NO Date of last period?_____ Date of last pelvic exam?_____

Date of last mammogram?_____ Pain with intercourse? YES or NO Type of birth control?_____

Vaginal itching? YES or NO

Number of pregnancies____ Number of full term births____ Number of preterm births____

X_____ _____

Signature of patient or parent/legal guardian if patient under 18 Date

Patient Registration
Cortland Health Center
1259 Fisher Avenue, Cortland, NY 13045

Name_____**DOB**_____

Address_____**Zip Code**_____

Home Ph. #_____**Cell Ph. #**_____

Please circle: Single Married Divorced Separated Widowed

Emergency Contact:_____**Home Ph. #**_____

Relationship to you_____**Cell Ph. #**_____

***Is this person authorized to take messages regarding appointments and medical information? YES or NO

HIPPA PRIVACY DOCUMENTATION

I acknowledge, I have been given the opportunity to read/receive a copy of FamilyCare Medical Group's Privacy Notification. YES or NO

I give my permission to leave messages from this office in regards to:

OFFICE APPOINTMENTS	OTHER MEDICAL INFORMATION
Home Machine YES or NO	YES or NO
Office Voicemail YES or NO	YES or NO
Cell Phone YES or NO	YES or NO

I authorize the Emergency Contact and the following person(s) to take messaged and/or discuss the above information if I am not available.

Name:_____**Relationship**_____**Ph.**_____

Name:_____**Relationship**_____**Ph.**_____

I have completed all of the above information to the best of my ability.

I consent to have the practice us and disclose my protected information for payment, treatment, and health care operation purposes and for other such purposes that are permitted under HIPPA or other federal or state laws without written permission.

I authorize the payment of medical benefits to the above stated physicians or supplier for services rendered.

PATIENT SIGNATURE_____DATE_____

Cortland Health Center
1259 Fisher Ave
Cortland, N.Y. 13045
(P) 607-756-4600 (F)607-753-6266

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	
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: (P) (F)

8. Name and address of person(s) or category of person to whom this information will be sent: (P) (F)

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 ☐ TRANSFER
☐ 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.