Center for Disability Services
Where people get better at life

CENTER HEALTH CARE

314 S. Manning Blvd., Albany, NY 12208
8:00 am – 5:00 pm (Monday - Friday)

Main Phone # (518) 437-5900
Fax # (518) 437-5554

Partners in Care: ***Patients and Health Care Teams working together on your health care and ongoing wellness. Together we can make your medical appointment work for you!***

Your Enrollment Packet includes the following forms to be completed and additional information:

- **Patient Registration Form**
- **Health History Form & Dental History Form** *(also complete if requesting Dental Services)*
- **Consent for Treatment Form**
- **Obtain PHI (Medical Records) Information Form**
- **HIXNY Consent Form** (ONLY for Primary Care, Behavioral Health & Neurology services)
- Center Health Care Services
- Directions to Center Health Care

Before your appointment:

- **Read all information in your Enrollment packet, complete necessary forms and return in self addressed envelope.**
- **When calling for an appointment at (518) 437-5900, please allow 2 weeks for Center Health Care to receive and process your paperwork.**
- Make a list of your questions and concerns.
- If you have seen a specialist, ask them to send your reports to our Medical Records Department.
- Check with your insurance company regarding co-pays, deductibles and co-insurance fees.
- If you will be a patient of our Primary Care practice, call your insurance company to choose a Center Primary Care Provider.
- You will receive a confirmation call 2 days prior to your appointment.
- Call our office at (518) 437-5900, well in advance, if you need to reschedule your appointment.

On the day of your appointment:

- Keep your scheduled appointment.
- **Arrive 15 minutes before your scheduled appointment time to allow time for** parking, check-in and additional paperwork, if necessary.
- Bring the following information to your appointment:
  - Photo ID
  - All your Medicaid, Medicare and/or Insurance Cards
  - All completed forms included in the Enrollment Packet, if not returned by mail.
- Bring payment or co-pay for your appointment. We accept cash, checks, MasterCard & Visa credit cards and flex spending accounts.

During your appointment:

- Your commitment:
  - Ask your medical provider questions about your health concerns, treatment plans, wellness recommendations and disease prevention, and lifestyle changes.
- Our Health Team's commitment:
  - Make you feel comfortable and welcome
  - Provide best treatment and advice based on current medical evidence
  - Manage acute illness and chronic conditions
  - Support you in your health care goals
  - Answer your questions
  - Respect your privacy

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Patient Registration

☐ PC ☐ DEN ☐ BH ☐ SPMED ☐ OT/PT

☐ PC ☐ DEN ☐ BH

PATIENT INFORMATION

Patient #_____

What service(s) are you requesting: ☐ Primary Care ☐ Dental ☐ Behavioral Health ☐ Specialty Medical ☐ OT / PT

Indicate your main medical concern _____

Name (First, Middle, Last)

Preferred Name

Date of Birth _____

Marital Status
☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Primary Address

City **State** **Zip**

E-Mail

☐ Patient Portal Access Authorization

Home Phone
( )
Can we call? ☐ Yes ☐ No
Leave Voicemail? ☐ Yes ☐ No

Work Phone
( )
Can we call? ☐ Yes ☐ No

Cell Phone
( )
Can we call? ☐ Yes ☐ No
Leave Voicemail? ☐ Yes ☐ No
Text? ☐ Yes ☐ No

Primary Care Physician Name

Office Phone
( )

Office Fax #
( )

Address _____

City **State** **Zip**

Primary Language
☐ English
☐ Something else, please specify:

Ethnicity
(can select up to 2 options)
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Patient Declined

Race *(can select up to 2 options)*
☐ White ☐ African American
☐ Chinese ☐ Japanese
☐ Asian ☐ Filipino
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ Something else, please specify:
☐ Patient Declined

Gender Identity
☐ Identifies as Male ☐ Identifies as Female
☐ Female to Male ☐ Male to Female
☐ Gender Queer (neither male/female)
☐ Other Gender, please specify:
☐ Choose not to disclose

Sex
☐ Male
☐ Female
☐ Undefined

Sexual Orientation
☐ Straight/Heterosexual
☐ Lesbian, Gay or Homosexual
☐ Bisexual
☐ Something else, please specify:
☐ Don't know
☐ Choose not to disclose

PERSON RESPONSIBLE FOR CO-PAY & CO-INSURANCE

☐ **Same as Patient** ☐ **If NOT same as Patient, please complete.**

Name (First, Last)

Address

City **State** **Zip**

Home Phone
( )

Work Phone
( )

Cell Phone
( )

Date of Birth

E-Mail

Primary Spoken Language

Employer Name _____

Employer Address

Relationship to Patient
☐ Self ☐ Child
☐ Spouse ☐ Partner

INSURANCE INFORMATION

☐ **MEDICARE** Medicare #_____

☐ **MEDICAID** Medicaid #_____

☐ **If Uninsured – Sliding Scale Requested**

OTHER INSURANCE INFORMATION

Insurance Carrier	Group #	ID #
Subscriber's Name (First, Last) Subscriber's Date of Birth	Relationship to Patient ☐ Self ☐ Child ☐ Spouse ☐ Partner	Gender ☐ Male ☐ Female

DENTAL INSURANCE INFORMATION

Dental Insurance Carrier	Dental Insurance Address City State Zip	
Dental Insurance Phone ( )	Dental Group #	Dental ID #
Subscriber's Name (First, Last) Subscriber's Date of Birth	Relationship to Subscriber ☐ Self ☐ Child ☐ Spouse ☐ Partner	

EMERGENCY / CAREGIVER CONTACT

Name (First, Last)	Address City State Zip	
Home Phone ( )	Work Phone ( )	Cell Phone ( )
Relationship to Patient ☐ Partner/Spouse ☐ Parent/Guardian ☐ Other :	Other Information or Contact	Primary Spoken Language

SERVICE COORDINATOR

Name of Service Coordinator (First, Last)	Work Phone ( )	E-Mail
Agency Name	Agency Address City State Zip	

PHARMACY INFORMATION

Pharmacy Name	Pharmacy Phone ( )	Pharmacy Fax # ( )
Pharmacy Address	City State Zi	

ADDITIONAL INFORMATION REQUESTED *(Required Per Federal Guidelines)*

Veteran Status ☐ Veteran ☐ Non-Veteran **Citizenship** ☐ US Citizen by Birth ☐ US Citizen First Generation ☐ Immigrant ☐ Naturalized ☐ Permanent Resident or Alien ☐ Other	**Educational Level** ☐ High School ☐ AS College ☐ BS College ☐ Masters Degree ☐ Doctorate Degree ☐ None **Income Status** ☐ Unknown/Refused to Provide ☐ Patient has income	**Agriculture Work Status** ☐ Non Agricultural ☐ Seasonal ☐ Migrant ☐ Employee Year - Round ☐ Retired Farm Worker **Family Size** What is your family size?

INCOME INFORMATION

Source of Income
- ☐ Child Support
- ☐ Other
- ☐ Salary
- ☐ Salary 2
- ☐ Social Security

Type of Income
- ☐ W-2
- ☐ 1099
- ☐ Form 1040
- ☐ Paystub
- ☐ Employer Letter
- ☐ Other

Amount of Income $_____

Frequency of Income
- ☐ Weekly
- ☐ Bi-Weekly
- ☐ Bi-Monthly
- ☐ Monthly
- ☐ Annually

Source of Income (if more than 1)
- ☐ Child Support
- ☐ Other
- ☐ Salary
- ☐ Salary 2
- ☐ Social Security

Type of Income
- ☐ W-2
- ☐ 1099
- ☐ Form 1040
- ☐ Paystub
- ☐ Employer Letter
- ☐ Other

Amount of Income $_____

Frequency of Income
- ☐ Weekly
- ☐ Bi-Weekly
- ☐ Bi-Monthly
- ☐ Monthly
- ☐ Annually

HOUSING / LIVING ARRANGEMENT

What is your current housing status/living arrangement?

☐ Private Home ☐ Residence ☐ Supportive Living ☐ Public Housing ☐ Homeless

If Residence/Supportive Living, please specify which **Agency:** _____

If homeless, please specify what your current situation is.

☐ Shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other ☐ Unknown

REFERRAL INFORMATION

Who referred you to Center Health Care?

If a Physician's Office, please give Name and Address

The reason you are being referred:

FORM COMPLETED INFORMATION

Who completed the above information?

☐ Patient named on top of form

☐ Caregiver Print Name_____ Date _____

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#_____

Health History

Personal Information (Please print) **Date**_____/____/_____

Indicate your main medical concern _____

Name_____ **Age**_____ **Date of Birth** _____/____/_____

Marital status: Single ☐ Married ☐ Separated ☐ Divorce ☐ Widow ☐ Birthplace_____

Occupation_____ Religion _____ How far did you go in school?_____

Medical History

Diagnosis ☐ Developmental Disability ☐ Traumatic Brain Injury ☐ Autism
☐ Other_____

List allergies to medicines _____ Any other allergies? _____

Do you smoke? YES ☐ NO ☐ How much? _____ For how many years? _____
Do you want to stop smoking? YES ☐ NO ☐ Have you tried? YES ☐ NO ☐

Do you drink alcohol? Never ☐ Rarely ☐ Daily ☐ Socially ☐ Do you have a drinking problem? YES ☐ NO ☐
Do you want to stop? YES ☐ NO ☐ Have you tried? YES ☐ NO ☐

Are you on a special diet? YES ☐ NO ☐ _____

List all Medications you use (including those not needing a prescription)

Previous Hospitalizations (not including normal pregnancies)

Operation or Illness	**Hospital / Doctor**	**Year**

Check ✓ if you have ever had:

EARS		Low Blood Pressure		Dementia		Alzheimers	
Hearing Impairment				Fainting		Autism	
		GI		Headaches		Bladder Disorder	
ENT		Diverticulitis		Multiple Sclerosis		Blood Transfusion	
Dry Mouth		Gall Bladder Disease		Neuropathy		Breast Lump	
Gag Reflex Concerns		Jaundice		Parkinsons		Cervical Disorder	
Swallowing Disorder		Ulcer		Seizure/Epilepsy		Developmental Disability	
				Shunt (Cerebral)		Diabetes	
EYES		**GU**		Strokes		Exposure to TB	
Cataracts		Kidney Disease		Traumatic Brain Injury		German Measles (Rubella)	
Glaucoma		Urinary Infections		Tremors		History of Cancer	
Vision Impairment				Unconsciousness		Joint Replacement:	
		MUSCULAR SKELETAL				(Specify)	
CARDIOVASCULOR		Arthritis/Lupus		**RESPIRATORY**		Measles	
Central Valve Disorder		Fractures		Asthma		Mumps	
Circulatory Problems		Gout		Emphysema/COPD		Organ Transplant:	
Elevated Cholesterol		Joint Replacement		Hay Fever		(Specify)	
Enlarged Heart		Osteoporosis		Pneumonia		Radiation/Chemotherapy	
Heart Attack						Rhuematic Fever	
Heart Murmur		**NEUROLOGICAL**		**OTHER**		Sexually Transmitted Disease	
High Blood Pressure		Cerebral Palsy		ADHD		Thyroid Disease	

List the year you last had: (write NONE if never had)

Chest X-ray _____
Electrocardiogram _____
TB Test (Skin) _____
Tetanus Shot _____
Diphetheria Shot _____
Polio Vaccine _____
Flu Vaccine _____
Measles Shot _____
Rubella Shot _____
Mumps Shot _____
Pap Smear Test _____
Vision Test _____
Breathing Test _____
Hearing Test _____

Family History

For your family members below, follow the line across the page and **mark an X** in those boxes which indicate any illness they have ever had.

	NAME	AGE	Diabetes	Cancer	Heart	High Blood	Stroke	Mental	BleedingTen	Kidney	Age of Death	If Deceased, Cause of Death
Father												
Mother												
Brothers												
Sisters												
Spouse												
Children												

Dental History

Date of last dental visit _____ Name of Dental Office _____

Date of most recent dental x-ray? _____ Location _____

Has the patient taken any of the following to assist with dental treatment:

☐ Nitrous Oxide ☐ General Anesthesia ☐ Anti-anxiety Medication (Name & Dose) _____

Has the patient ever required medical immobilization/protective stabilization support to facilitate dental treatment?

YES ☐ NO ☐ Please check: ☐ Papoose Board ☐ Head Stabilization ☐ Hands Held ☐ Arm restraints

If the patient utilizes a wheelchair, can they transfer to a dental chair? YES ☐ NO ☐

Are there any current dental concerns? YES ☐ NO ☐

Please explain_____

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CENTER HEALTH CARE

#_____

Dental History

Dental Information (Please print) **Date**____/___/_____

Name_____ **Age**_____ **Date of Birth** _____/_____/____

Date of last dental visit _____

Name of Dental Office _____

Address of Dental Office_____

Treatment Completed (please check):

- ☐ Exam by Dentist
- ☐ Cleaning
- ☐ Full Services X-rays
- ☐ Bitewing X-rays
- ☐ Filling
- ☐ Extraction

Is the patient comfortable receiving dental treatment? YES ☐ NO ☐

Has the patient taken any of the following to assist with dental treatment?

☐ Nitrous Oxide ☐ General Anesthesia

☐ Oral Anti-anxiety Medication (Name & Dose) _____

Has the patient ever required medical immobilization / protective stabilization support to facilitate dental treatment? YES ☐ NO ☐ **Please check below:**

☐ Papoose Board ☐ Head Stabilization ☐ Hands Held ☐ Arm restraints

If the patient utilizes a wheelchair, can they transfer to a dental chair? YES ☐ NO ☐

Are there any current dental concerns? YES ☐ NO ☐

Please explain_____

If the patient has been referred by a dental professional, please state the reason:

_____

_____

Additional Information Requested *(Required Per Federal Guidelines)*

Race of Patient: ☐ Caucasian ☐ African American ☐ Asian ☐ Native American/Alaska Native ☐ Native Hawaiian

Ethnicity of Patient: ☐ Non-Hispanic ☐ Hispanic/Latino ☐ Decline

Language of Patient: ☐ English ☐ Spanish ☐ Other

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Consent to Treat

Patient Name (please print)_____ **Patient ID #** _____

Patient Date of Birth _____

AUTHORIZATION FOR MEDICAL TREATMENT

I hereby give consent to Center Health Care staff physicians, nurse practitioners, physician assistants, nurses, dentist providers, and therapists involved in the care of *(patient's name):*

_____. To provide medical or dental services, and perform such treatment, operations, or procedures that are necessary in the normal course of providing these services. Certain procedures may require additional informed consent to be signed.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA/NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Center Health Care (HIPAA) Notice of Privacy Practices. This notice describes how CHC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and privacy rights I have regarding my protected health information. In accordance with this policy CHC, its provider(s) and staff, may leave me a detailed phone message related to my care or send me appointment reminder cards.

RELEASE OF MEDICAL INFORMATION

I hereby authorize and direct Center Health Care to release such medical information from my medical records as is necessary to complete forms for continued care, payment by insurance carriers, health care plans and third party payors.

ASSIGNMENT OF BENEFITS

I authorize payment of insurance and/or Medicare benefits directly to Center Health Care for the services of its providers and staff in rendering my care. In addition, I authorize the release of any medical information to allow the insurance company and/or Medicare to process any claim(s) filed.

_____ _____ _____

Signature of Patient / Responsible Party Date

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CENTER HEALTH CARE
AUTHORIZATION TO **OBTAIN** PROTECTED HEALTH INFORMATION

This authorization is written permission for an outside agency to disclose Protected Health Information (PHI) as directed.

Print Patient Name and Address here

Patient Name:_____ Phone: ( )_____

Former/Maiden Name:_____ DOB:_____/_____/_____

Address:_____
Street City State Zip

Name of Agency Sending Records to us

I,_____ hereby authorize _____

Address:_____
Street City State Zip

to disclose Protected Health Information (PHI) to:

Center Health Care
Attn: Medical Records Department/ _____ (Provider's Name)
314 So. Manning Blvd.
Albany, NY 12208 Phone: (518) 437-5710 Fax: (518) 437-5711

Indicate specific information is to be disclosed here

The specific information to be disclosed, includes: (describe the information, including but not limited to, descriptors such as date of services, type of service, level of detail to be released, etc.)

- ❒ Entire Medical Record
- ❒ Copies of progress notes from _____ (Provider/Specialty) for the following dates:_____
- ❒ Immunizations
- ❒ Dental X-rays
- ❒ Dental Treatment Records
- ❒ Tests/Evals :_____ : ____/____/____ ____/____/____
  Type of Test/Eval Date Date
- ❒ Verbal exchange between:_____ / _____ and
  Name of Individual Agency
  _____ at Center Health Care
- ❒ Other (please be specific):_____

_____

The PHI is being disclosed for the following purposes:

☐ Change of provider ☐ Verbal Exchange ☐ At my request ☐Other: _____

_____

Sign and date here

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure (with the exception of HIV information) and may no longer be protected by state or federal law. I understand that this authorization **will expire one (1) year from the date of signature** unless a shorter period is noted here. (_____/_____/_____ - expiration date)

_____ _____ _____/_____/_____
Signature of Patient or Legal Representative Relationship to patient/representative's authority Date

Update: June 2018

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CENTER HEALTH CARE

Hixny *Electronic Data Access Content Form*

In this Consent Form, you can choose whether to allow **Center Health Care** to obtain access to your medical records through a computer network operated by the **Healthcare Information Xchange of New York (Hixny)**, doing business as **Hixny**, which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow **Center Health Care** to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, **Center Health Care's** staff involved in my care may see and get access to all of my medical records through Hixny."

If you check the **"I DENY CONSENT"** box below, you are saying "No, **Center Health Care** may not be given access to my medical records through Hixny for any purpose."

Hixny is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT).

Please carefully read the information on the back of this form before making your decision. Your Consent Choices. You can fill out this form now or in the future.

You have two choices.

☐ **I GIVE CONSENT** for the specified service(s) in **Center Health Care** to access ALL of my electronic health information through Hixny in connection with providing me any health care services, including emergency care.

I AM ENROLLING IN THE FOLLOWING SERVICE(S):

☐ **Primary Care** ☐ **Behavioral Health** ☐ **Neurology**

☐ **I DENY CONSENT** for **Center Health Care** to access my electronic health information through Hixny for any purpose, even in a medical emergency.

NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through Hixny.

_____	_____	_____
Print Name of Patient	Date of Birth	Date
_____	_____	
Signature of Patient or Patient's Legal Representative	Print Name of Legal Representative (if applicable)	

Details about patient information in Hixny and the consent process:

How Your Information will be Used
Your electronic health information will be used by Center Health Care only to:
•Provide you with medical treatment and related services
•Check whether you have health insurance and what it covers
•Evaluate and improve the quality of medical care provided to all patients

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

What Types of Information about You Are Included
If you give consent, Center Health Care may access ALL of your electronic health information available through Hixny. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- •Alcohol or drug use problems*
- •Birth control and abortion (family planning)
- •Genetic (inherited) diseases or tests
- •HIV/AIDS
- •Mental health conditions
- •Sexually transmitted diseases

***If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, such as medications and dosages, lab test results, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social support, and health insurance claims history.**

Where Health Information about You Comes From
Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Hixny. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

Who May Access Information about You, If You Give Consent
Only these people may access information about you: doctors and other health care providers who serve on Center Health Care's medical staff who are involved in your medical care; health care providers who are covering or on call for Center Health Care's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

Penalties for Improper Access to or Use of Your Information
There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call at (518) 437-5710; or call Hixny at (518) 640-0021; or call the NYS Department of Health at (518) 474-4987.

Re-disclosure of Information
Any electronic health information about you may be re-disclosed by Center Health Care to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Hixny and persons who access this information through the Hixny must comply with these requirements.

Effective Period
This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

Withdrawing Your Consent
You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Center Health Care. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 640-0021. **NOTE:** Organizations that access your health information through Hixny while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

Copy of Form You are entitled to get a copy of this Consent Form after you sign it.