THE UROLOGICAL INSTITUTE OF NORTHEASTERN NEW YORK

at Albany Medical Center, South Clinical Campus, 23 Hackett Blvd, Albany, NY 12208
Phone: (518) 262-3341 ♦ Fax: (518) 262-6660

Barry A. Kogan, M.D.
Falk Chair in Urology
Professor, Surgery and Pediatrics
Chief, Division of Urology
Albany Medical College

Donald Bentrovato, M.D.
Clinical Associate Professor of Surgery

Laura Chang Kit, M.D.
Assistant Professor of Surgery

Elise J.B. De, M.D.
Assistant Professor of Surgery

Hugh A.G. Fisher, M.D.
Associate Professor of Surgery

Jean G. Hollowell, M.D.
Associate Professor of Surgery and Pediatrics

Ronald P. Kaufman, Jr., M.D.
Associate Professor of Surgery

Andrew R. McCullough, M.D.
Professor of Surgery

Badar M. Mian, M.D.
Associate Professor of Surgery

Rebecca L. O'Malley, M.D.
Assistant Professor of Surgery

Donald J. Rivard, M.D.
Clinical Associate Professor of Surgery

Barry Stein, M.D.
Professor of Surgery

R. Charles Welliver, M.D.
Appointment Pending

Mark D. White, M.D.
Associate Professor of Surgery

Harry J. Wilbur, M.D.
Associate Professor of Surgery

Carl E. Diaz-Parker, R.P.A.-C.
Instructor of Surgery

Karla M. Giramonti, F.N.P., M.S.
Instructor of Surgery

Randi Daniels, F.N.P., M.S.

Robert M. Levin, Ph.D.
Adjunct Professor of Surgery

Paul J. Higgins, Ph.D.
Adjunct Professor of Surgery
Professor and Co-Director,
Center for Cell Biology & Cancer Research

Dear Patients:

Welcome to The Urological Institute of the Northeastern New York. In order to provide quality care, we ask that you take the time to review the following:

1. Please complete the enclosed Personal History Form and **bring it with you to your appointment.**

2. Please have all your records related to your current problem faxed to (518) 262-6660 prior to your appointment.

3. **Bring all pertinent X-rays, CT scans, MRI's and Biopsy Slides that have been done with you to your appointment.**

4. Bring a list of all your current medications and dosages. We have enclosed a form for your pharmacy information.

5. **Please bring your insurance cards and photo identifications with you. Payments or co-payments are due at the time of check in**. If you don't have your co-payment you will be asked to reschedule your appointment. We accept cash, checks and credit/debit cards. If you are a member of an HMO please have your referral faxed to (518) 262-6660 prior to your appointment. **If you arrive to your appointment and we do not have a referral you will be asked to sign a waiver.**

6. Please plan to arrive at least 15 minutes early for your appointment time for parking and registration.

7. If you have small children who cannot be left alone in the waiting room there should be an adult who can accompany them while you're in the exam room.

8. Although we do our best to be prompt, please be patient as we occasionally fall behind. Emergencies do arise and can sometimes lead to delays. We respect your time and will warn you as much as possible in advance about any delay; this however, is not always possible. We do encourage and advise you to bring reading material or your laptop if you wish.

We look forward to helping in your care!

Sincerely,

The Urological Institute of Northeastern New York

23 Hackett Boulevard, Albany, NY 12208 (Main office)
Albany IVF 399 Albany-Shaker Rd, Loudonville, NY 12211
713 Troy Schenectady Rd, Ste 124, Latham NY 12110
2125 River Rd, Ste 103, Niskayuna, NY 12309
5 Southside Dr, Clifton Park, NY 12065 (Dr Mark White)
1735 Rte 9, Clifton Park, NY 12065 (Dr Rebecca O'Malley/Enter through Physical Therapy)
5 Hemphill Place, Malta, NY 12020
One West Ave, 3rd Floor, Ste 330, Saratoga Springs NY 12866
81 Miller Rd, Schodack, NY 12033
101 Jordan Rd, North Greenbush, NY 12180

UROLOGICAL INSTITUTE OF NORTHEASTERN NEW YORK
HISTORY FORM

NAME:_____ TODAY'S DATE:_____

AGE:_____ DATE OF BIRTH:_____ HEIGHT:_____ WEIGHT:_____

FAMILY PHYSICIAN OR INTERNIST:_____
EMAIL ADDRESS: _____

ALLERGIES: 1. 4.
2. 5.
3. 6.

MEDICATIONS: (please include dosages and times)
1. 4.
2. 5.
3. 6.

You are required to pay your payment/co-pay at the time of check in at every appointment. We accept cash, credit/debit cards and checks. If you do not have your payment/co-pay you will be asked to reschedule.

REVIEW OF SYSTEMS (do you have any of the following). Please circle all that apply

1. CONSTITUTIONAL SYMPTOMS			8. INTEGUMENTARY		
Fever	YES	NO	Skin problems	YES	NO
Chills	YES	NO	Breast problems	YES	NO
Headaches	YES	NO	Rashes	YES	NO
2. EYES			Hives	YES	NO
Poor vision	YES	NO	9. NEUROLOGICAL		
Double vision	YES	NO	Dizziness	YES	NO
Glaucoma	YES	NO	Tremors	YES	NO
Cataracts	YES	NO	Memory loss	YES	NO
3. EARS, NOSE, THROAT			Seizures	YES	NO
Hearing loss	YES	NO	10. PSYCHIATRIC	YES	NO
Sore throat	YES	NO	Depression	YES	NO
Vertigo	YES	NO	Schizophrenia	YES	NO
4. CARDIOVASCULAR			Anxiety	YES	NO
Chest pain	YES	NO	Sleep disorder	YES	NO
Angina	YES	NO	11. ENDOCRINE		
High blood pressure	YES	NO	Thyroid problem	YES	NO
Heart failure	YES	NO	Excessive weight	YES	NO
5. RESPIRATORY			Tired/sluggish	YES	NO
Shortness of breath	YES	NO	Sugar	YES	NO
Cough	YES	NO			

Emphysema	YES	NO	12.HEMATOLOGIC/LYMPHATIC		
Asthma	YES	NO	Enlarged glands	YES	NO
6. GASTROINTESTINAL			Easy bruising/bleeding	YES	NO
Bloody stool/hemorrhoids	YES	NO	Anemia	YES	NO
Ulcers	YES	NO	Cancer	YES	NO
Colitis/irritable bowel	YES	NO	13.ALLERGIC/IMMUNOLOGIC		
7. MUSCULOSKELETAL			Allergies	YES	NO
Arthritis	YES	NO	Hay fever	YES	NO
Joint problems	YES	NO			
Gout	YES	NO			
Osteoporosis	YES	NO			

You must bring any films/CDs of radiology and any biopsy slides with you to your appointment. Your PCP will not send these. You must bring them with you to the appointment. We cannot get them for you.

PAST MEDICAL HISTORY:

1. PREVIOUS ILLNESS: (circle all that apply and write in anything not listed)

AIDS	Constipation	Parkinson Disease
Anemia	Diabetes	Prostate Disease
Asthma	Diarrhea	Rheumatic Fever
Back Problems	Heart Attack	Stroke
Bleeding Problems	Heart Murmur	Ulcers
Bowel Problems	Hepatitis	Other_____
Breast Cancer	High Blood Pressure	_____
Bronchitis		_____
Cancer		

2. OPERATIONS: (circle all that apply and write in anything not listed)

Appendix	Gallbladder	Prostate Surgery
Back/Disc Surgery	Heart Value	Stone Removal
Bladder Surgery	Hemorrhoids	Testicle Surgery
Bowel Surgery	Hernia	Tonsils
Breast Surgery	Hysterectomy	Ulcer Surgery
Circumcision	Kidney Surgery	Vasectomy
Cystoscopy		

List any not covered above:_____

3. INJURIES:_____

_____

4. TREATMENTS: (list all previous hospitalizations and any long term treatments)

_____

_____

If you are male please skip to question #6

5. OBSTETRIC: # of pregnancies_____ # of live births_____
   # of vaginal deliveries_____# of cesarean sections_____

   Any complications: _____
   Age menstruation began: _____

6. FAMILY HISTORY: (list all diseases that run in your family)

Kidney disease	Heart disease	Prostate cancer
Alcoholism	Diabetes	Father
Anemia	Stroke	Brother

7. SOCIAL HISTORY:

   Your occupation: _____
   If you are retired, please list what your occupation was when you were working:

Tobacco use: packs per day started at age: quit at age:
Alcohol use: none occasional 1-2 drinks per day
Drug use (in past) marijuana opium cocaine other:
Drug use (present) marijuana opium cocaine other

THE UROLOGICAL INSTITUTE OF NORTHEASTERN NEW YORK

Phone: (518) 262-3341 • **Fax:** (518) 262-6660 • **Albany:** 23 Hackett Blvd, Albany 12208

We are pleased you have selected our practice for your treatment. The Urological Institute of Northeastern New York is dedicated to be the leading provider of urological care in the Capital Region. Whether you are new to our practice or a returning patient, the following information is important for you to know in order for you to receive the best possible care.

Providers: We have several faculty physicians in our practice that provide care in general urology but also have expertise in specific areas of urology.
Specialty Areas
Urological Cancers: Dr. Hugh Fisher, Dr. Ronald Kaufman, Dr. Badar Mian, Dr. Rebecca O'Malley
Kidney Stones: Dr. Mark White
Pediatric Urology: Dr. Barry Kogan, Dr. Jean Hollowell
Female Urology: Dr. Laura Chang Kit, Dr. Elise De
Infertility and Men's Health: Dr. Andrew McCullough, Dr. Charles Welliver
General Urology: Dr. Donald Rivard, Dr. Donald Bentrovato

Nurse Practitioners/Physician's Assistants: Carl Diaz- Parker, Randi Daniels, Karla Giramonti
They see both new and follow-up patients under the guidance of our MDs.

RESIDENT PHYSICIANS: Because we are an academic medical center, one of our missions is to provide educational opportunities to the next generation of health care providers. The students and young physicians we work with are just beginning their careers. Their questions and input help to provide better patient care. They are always supervised by our faculty physicians.

PHONE CALLS: Our regular office hours are 8:30am-4:30pm, Monday through Friday. If you leave a message you can expect to receive a return call within 24 hours. If you believe that your call is urgent, please let the receptionist know this at the time of your call so that we can expedite your call.

REFERALS AND CO-PAYS: If your insurance requires a referral it will need to be obtained prior to your visit. **PLEASE BRING YOUR INSURANCE CARD AND ID AT EVERY VISIT** or we may not be able to see you. We collect your co-pay at the time you check in. It is illegal for us not to collect your co-pay.

WALK-IN APPOINTMENTS: We do not have walk- in appointments. If you feel you need to be seen immediately, please call our office and ask to speak to a nurse/medical assistant.

APPOINTMENT CANCELLATION/RESCHEDULING: If you are unable to keep this appointment, please call our office as soon as possible at (518) 262-3341 to reschedule. Cancellations must be made at least 24 hours in advance or you will be subject to a $25.00 fee.

PRESCRIPTIONS: Please give us a minimum of 48 hours advance notice. This will give adequate time for us to review your medical record and fill out the required forms. Also, please be aware that some prescriptions need insurance pre-authorization. This process takes at least 72 hours. When you phone in for a refill, be sure to have the pharmacy name and phone number.

TEST RESULTS: Test results are **NOT** given out over the phone. Results of any procedures done in our office will be discussed at your next scheduled office visit. Results of any tests or blood work ordered by your provider will be discussed at your next scheduled office visit.

EMERGENCY ROOM OR HOSPITAL ADMISSIONS: If you are seen in the ER of any hospital or are admitted to any hospital prior to your scheduled visit please let our office know so that appropriate records can be requested by our medical records staff.

PLEASE BRING THE REPORTS, PATHOLOGY SLIDES AND ANY X- RAY FILMS/CD's WITH YOU TO YOUR APPOINTMENT.

COPIES OF MEDICAL RECORDS: Medical record releases must be made in writing and signed by the patient or legal guardian of the patient. If you are requesting medical records be mailed a return address must be provided. If you are requesting medical records be faxed a fax number must be provided. Medical records may also be picked up in our office. **Please allow 7-10 days from the time your request is received by our office for your request to be processed and completed.**

FORMS: Disability forms, Social Security forms, insurance forms, etc., are very complex. In order for us to fill them out correctly, please allow 1-2 weeks turnaround. There is a $20.00 fee for form completions.

Thank you for your understanding, and cooperation with these issues. In our effort to ensure quality care for our patients, we welcome your opinions and suggestions. If you would like to comment or have concerns, please feel free to call the Practice Manager, Linda Hall at (518) 262-3341.

The Urological Institute of Northeastern New York

South Clinical Campus
23 Hackett Boulevard
Albany, New York 12208
Tel.: (518) 262-3341 • Fax: (518) 262-6660

Patient name _____
(Please Print)

Patient date of birth_____

Please list pharmacy name_____

Telephone #_____and fax # _____

Of pharmacy that is used for most refills.

Sincerely,

Medical Providers
The Urological Institute of Northeastern New York

COMMUNITY CARE PHYSICIANS, P.C.

Community Care Physicians, P.C.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Community Care Physicians, P.C.'s
Print Patient Name

Notice of Privacy Practices.

_____ _____ _____
Signature of Patient or Guardian Date of Birth Date

_____ _____
Witness Date

COMMUNITY CARE
PHYSICIANS, P.C.
www.communitycare.com

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize _____ to use and/or disclose certain protected health information (PHI) about me to:

Person or Entity to Receive the Information:

Dr. _____
Urological Institute of Northeast New York
23 Hackett Boulevard
Albany, New York 12208

This authorization permits the entity above to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.):

_____

_____

The information will be used or disclosed for the following purpose:

_____

If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on: _____.
{Expiration Date or Defined Event}

Unless specified otherwise above, this authorization shall expire one year from the date below.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to my personal physician.

Signed by: _____
Signature of Patient or Legal Guardian

_____
Print Name of Patient or Legal Guardian

Relationship to Patient: _____

Patient Date of Birth: _____

Date: _____

COMMUNITY CARE PHYSICIANS, P.C.

PATIENT REQUEST FOR COPY OF MEDICAL RECORDS

COMMUNITY CARE PHYSICIANS, P.C.
www.communitycare.com

Patient Name: _____ DOB: _____ MRN: _____
(First) (Last)

Address: _____ _____
(Street Address) (City, State, Zip)

Phone: _____

HOW WOULD YOU LIKE TO OBTAIN YOUR RECORDS?

☐ **Paper Copy**

How would you like to receive them?

- ☐ Mail to the address above
- ☐ Pick up in office
- ☐ Mailed to the following address:

_____
(Name)

_____
(Street Address)

_____
(City, State, Zip)

_____
(Phone)

_____
(Relationship to the Patient)

☐ **Faxed to the following fax number:** _____
According to New York State law, you may be charged up to $0.75 per page for these requests.

☐ **Electronic Copy on a USB storage device supplied by CCP**

If you choose this option, you must provide an e-mail address here, so we can send you the password for the device:

_____
(E-mail Address)

How would you like to receive the device?

- ☐ Mail to the address above
- ☐ Pick up in office
- ☐ Mailed to the following address:

_____
(Name)

_____
(Street Address)

_____
(City, State, Zip)

_____
(Phone)

_____
(Relationship to the Patient)

The charge for this request is $20.00 payable in advance. Please be sure you have provided a valid e-mail address above. CCP will not be able to fulfill your request otherwise due to security concerns.

☐ **E-mail a Copy to the Following Address:** _____
The charge to e-mail your records is $5.00 payable in advance. Please note that your file may be too large to e-mail. If so, you will be notified and you will need to select an alternative option above. Additional charges may apply.

WHICH INFORMATION WOULD YOU LIKE TO RECEIVE?

- ☐ **Entire Record**
- ☐ Only the information in the time period _____ through _____.
- ☐ HIV/AIDS related information. (*Please note: this box must be checked in order to receive this information, even if you opted for your* ***Entire Record.***)
- ☐ Other (please be specific):

_____
_____

Specific criteria may include: laboratory results, provider orders, consultations, and imaging records.

IMPORTANT INFORMATION

a. I understand that the content of my file is not medical advice and is not to be used or relied on for diagnosis or treatment. The content does not take the place of instructions or advice from my doctor or health care provider. I will talk to my doctor or other health care provider before making any major health care decisions based on this electronic file.

b. I understand that the information disclosed pursuant to this request may be subject to re-disclosure by the party who receives it because it may no longer be protected by the federal privacy laws.

c. I understand that records in electronic form can be distributed on a wide scale with relative ease and losses or unintended releases of the requested information may occur under circumstances beyond the control of CCP once it is in my possession. By requesting records in this format, I am knowingly and voluntarily assuming this risk and all consequences, losses and damages that might result.

I agree to pay $_____ to Community Care Physicians, P.C. for fees necessary to complete my request, including but not limited to: clerical work, processing, mailing, and storage devices.

_____ _____
Patient/ Legal Representative Signature Date

COMMUNITY CARE PHYSICIANS, P.C.
www.communitycare.com

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Community Care Physicians, P.C. to use and/or disclose certain protected health information (PHI) about me to:

Please list other medical providers, family, friends, etc. whom, with your permission, may receive your medical information.	→	Person or Entity to Receive the Information
		_____
		_____
		_____

This authorization permits Community Care Physicians, P.C. to use and/or disclose the following individually identifiable health information about me. Please specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.:

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 below. In the event the health information described below includes any of these types of information, and I initial the line below, I specifically authorize release of such information to the person(s) indicated above.

Specific information to be released:

☐ Entire Medical Record from (insert date) _____ to (insert date) _____ (If not specified, all dates.)

Only Include:		Include: *(Indicate by Initialing)*
☐ Prescriptions	☐ Office Notes	_____ Alcohol/Drug Treatment
☐ Lab Results	☐ Billing	_____ Mental Health Information
☐ Referrals	☐ Other _____	_____ HIV-Related Information

Reason for release of information: ☐ At request of individual ☐ Other: _____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on: _____.
{Expiration Date or Defined Event}

Unless specified otherwise above, this authorization shall expire one year from the date below.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Community Care Physicians, P.C.. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to my personal physician.

Signed by: _____
Signature of Patient or Legal Guardian

_____
Print Name of Patient or Legal Guardian

Relationship to Patient: _____

Patient Date of Birth: _____

Date: _____

* Not for patients 10-18yrs

HIXNY
HEALTHCARE INFORMATION XCHANGE
New York

COMMUNITY CARE
PHYSICIANS, P.C.
www.communitycare.com

HIXNY ELECTRONIC DATA ACCESS CONSENT FORM
Community Care Physicians

In this Consent Form, you can choose whether to allow Community Care Physicians to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (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 Community Care Physicians 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, Community Care Physicians'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, Community Care Physicians 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). To learn more about HIXNY and ehealth in New York State, read the brochure, "Your Health Information – Always at Your Doctor's Fingertips." You can ask Community Care Physicians for it, or go to the website www.hixny.org.

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 Community Care Physicians to access ALL of my electronic health information through HIXNY in connection with providing me any health care services, including emergency care.**
- ☐ **I DENY CONSENT for Community Care Physicians 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

Patient Date of Birth

Signature of Patient or Patient's Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

mycare DOT™

Community Care Physicians, PC

TERMS AND CONDITIONS

Terms and Conditions for email collection and patient portal mycareDOT™ communications:

Please follow the below guidelines when using email and portal communication with Community Care Physicians, PC (CCP).

1. You should never use email to communicate sensitive medical information with a Community Care Physicians' doctor/office. If you wish to connect with your doctor online, please use the mycareDOT™ patient portal and follow the below guidelines.

FOR MYCAREDOT™ Content:

A. The following types of information and content are acceptable for inclusion in communications using mycareDOT™:
   1. Prescription requests for non-controlled substances.
   2. Appointment requests.
   3. Medical reminders.
   4. Disclosure of some test results.
   5. Message your provider

B. mycareDOT™ cannot be used for emergencies or time-sensitive matters. It should be used with caution and on a limited basis. This communication should not replace your regularly scheduled office visits or times when your doctor suggests you come into the office for a visit. It is an additional option and not a replacement. Not all issues can be handled with mycareDOT™. Your doctor alone will decide which medical topics are appropriate for online communications and with whom we communicate with online. You may be directed to contact us via telephone or in person at any time.

2. Risk of Using Email

Transmitting patient information has a number of risks you should consider before using email, including:

a. Email can be circulated, forwarded, stored, and sent to unintended recipients

b. Email senders can easily misaddress an email

c. Backup copies of email may exist even after the original copy has been deleted

d. Employers have a right to inspect email transmitted through their system

e. Email can be intercepted, deleted, forwarded or used without authorization or detection

f. Email can be used to transmit viruses

g. Email can be used as evidence in court

h. Emails may not be secure and confidentiality of communications may be breached by a third party

**Using the secure patient portal helps to avoid the risks associated with emails.

3. Community Care Physicians, P.C. will use reasonable means to maintain security and confidentiality with your email address and messages. Community Care Physicians, P.C. is not responsible for improper disclosure of confidential information that isn't caused by intentional misconduct.

4. Email is never appropriate for urgent situations or emergencies. Community Care Physicians, P.C. cannot guarantee any email will be read and responded to within a particular time.

5. When necessary, email will be printed and scanned into your medical record

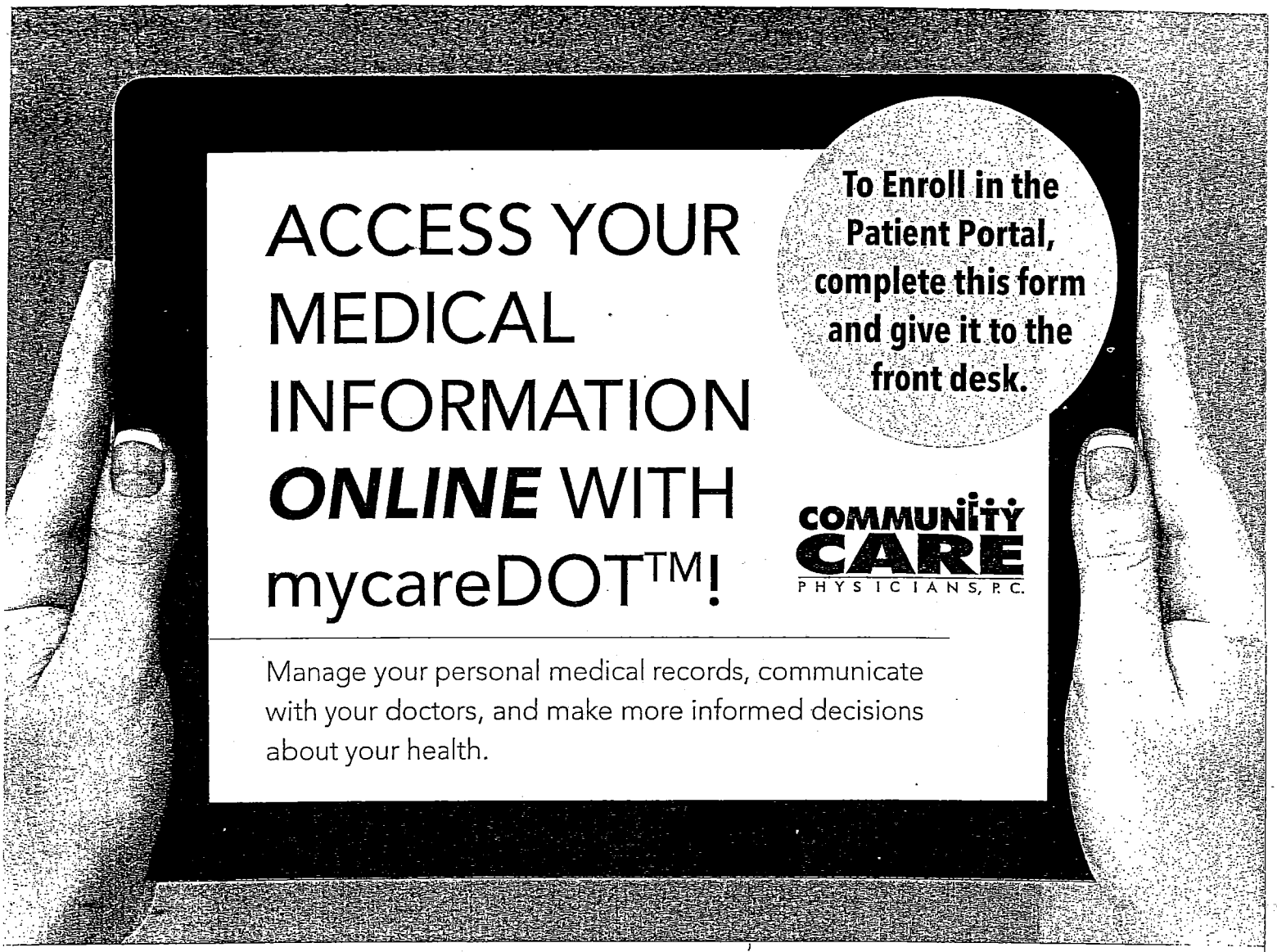
6. It is the responsibility of the patient to follow-up and schedule an appointment if warranted

7. Inform your doctor's office of any changes to your email

A. The following types of information and content are NOT acceptable for inclusion in e-communications:
   1. Highly sensitive information such as mental health records.
   2. HIV or sexually transmitted disease information.
   3. Medical information related to pending legal claims or litigation including worker's compensation

Patient Acknowledgment and Agreement

By submitting your email address, you acknowledge that you have read and fully understand the terms described. CCP may use email to communicate company and health related news and announcements. Access to Community Care Physicians' web portal mycareDOT™ is an optional service and CCP may suspend or terminate access at any time and for any reason. If Community Care Physicians does terminate or suspend this service, you will be notified as promptly as possible. If you do not understand or do not agree to these terms, please do not enroll.



Name (of patient): _____ Date of Birth (of patient): _____

Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Signature: _____

Please read the terms and conditions in this brochure pertaining to the mycareDOT™ patient portal and email communications. By completing this form and submitting it to the front desk of your doctor's office, you are agreeing to the terms and allowing the office to invite you to join the patient portal via email invitation. You may also receive health and company news and announcements from Community Care Physicians, PC. If you do not understand or do not agree to comply with or do not consent to these policies or procedures, please do not complete this form to enroll in the patient portal.

A copy of this form will be scanned into your permanent medical record.

powered by FollowMyHealth