UROLOGICAL INSTITUTE OF NORTHEASTERN NEW YORK
23 Hackett Boulevard, Albany NY 12208
One West Avenue, Suite 330, Saratoga Springs NY 12866
101 Jordan Road, North Greenbush NY 12180
Tel (518) 262-3341 - Fax (518) 262-6660

Dear Urological Client,

Welcome to the Urological Institute of Northeastern New York. We look forward to meeting you at our first appointment.

Forms

In order to accomplish as much as possible during this visit, we request that you fill out the enclosed paperwork ahead of time and either mail or fax it in. This is important even if you have seen another urologist in our office. It serves two purposes for your benefit:

1) We will best be able to address your needs in the first visits.
2) We will provide safer, more comprehensive care with your accurate information.

Be assured that although much of the information is private, your confidentiality is optimally protected in our office.

Medical Records

If you have seen other doctors for treatment, surgeries, or diagnostics related to your visit, copies of those records will be very useful. Due to privacy laws, your other doctors will require that you sign a release of medical records. This paperwork is inconvenient for everyone, but is designed for your protection. Your referring physicians will need to fax your records to our office (Fax # 518-262-6660).

To better serve you, please **MAIL** forms or records to **23 HACKETT BLVD, ALBANY NY 12208 ATT: HEATHER R up to 1 week before your visit**
At any time, or if less than 1 week before your visit, please **FAX** forms or records to **518-262-1973 OR 518-262-6660 ATT: HEATHER R**
PLEASE DO NOT DROP/SEND IN ANY MATERIALS TO OTHER CLINIC LOCATIONS

Important to Remember

Bring with you:

A Copy of the Completed Patient History and Registration Form
Actual images of Abdomen, Pelvis, Bladder, Urethra or Kidney X-rays you have had, plus written reports
Your insurance card
A book and snack in case there is a wait

To avoid inconvenience, please note the following:

Please plan to arrive early, allow at least 15 minutes prior to appointment time for parking and registration.
If you are a member of an HMO, you will need a referral form that is generated by your primary care physician and can be faxed to our office prior to your appointment. If you arrive at your appointment and we do not have a referral, the office staff will ask you to sign a waiver. Co-payments are due at the time of the visit.

Questions

If you have any questions, please call our office at 518-262-3341
Thank you for your time. We will use this information to the best of our ability to serve your needs.

Sincerely,

Elise De, M.D., F.A.A.C.S
Laura Chang Kit, M.D., FRCSC
Center for Pelvic Medicine and Reconstructive Surgery
The Urological Institute of NENY

PLEASE BRING THIS FORM WITH YOU THE DAY OF YOUR APPOINTMENT

PATIENT REGISTRATION FORM

NAME:_____
(Last) (First) (MI)
MAIDEN NAME:_____
ADDRESS: _____
_____
City State Zip Code
HOME PHONE: (_____) _____-_____ WORK PHONE: (_____) _____-_____Ext._____
CELL PHONE: (_____) _____-_____
SS#:_____-_____-_____ DOB: _____/_____/_____ SEX: M____ F____

NEXT OF KIN (will be called if we cannot reach you as back up for abnormal lab results etc):
NAME:_____ RELATIONSHIP TO PATIENT:_____
ADDRESS: _____
HOME PHONE: (_____) _____-_____ WORK PHONE: (_____) _____-_____Ext,_____
2nd EMERGENCY CONTACT NAME AND PHONE (will be called as back up for abnormal lab results etc):
NAME/RELATION: _____ PHONE: (_____) _____-_____

OCCUPATION:_____
EMPLOYER: _____

GUARANTOR: (Person responsible for payment. This is usually the patient if 18 years of age or older.)
NAME:_____ DATE OF BIRTH:_____
ADDRESS: _____
_____
HOME PHONE: (_____) _____-_____ WORK PHONE: (_____) _____-_____Ext,_____
RELATIONSHIP TO PATIENT:_____

INSURANCE INFORMATION: (Will take copy of insurance card)
PRIMARY (FIRST TO BE BILLED)
Insurance Company Name:_____
Address: _____
Phone Number: (_____) _____-_____
Subscriber Name:_____ SS#_____-_____-_____
Subscriber Date of Birth: _____/_____/_____
SECONDARY INSURANCE
Insurance Company Name:_____
Address: _____
Phone Number: (_____) _____-_____
Subscriber Name:_____ SS#_____-_____-_____
Subscriber Date of Birth: _____/_____/_____

PRIMARY CARE PHYSICIAN:
NAME OF PHYSICIAN:_____
SPECIALTY:_____
ADDRESS: _____
PHONE: (_____) _____-_____ FAX: (_____) _____-_____

REFERRING PHYSICIAN INFORMATION: (If not the same as Primary Care Physician)
NAME OF PHYSICIAN:_____
SPECIALTY:_____
ADDRESS: _____
PHONE: (_____) _____-_____ FAX: (_____) _____-_____

Please Help us Serve your Needs by Completing the Initial Visit History Form

NAME: (Mr./Mrs./Ms./Dr.)_____ **Date of Birth:**_____

MY MAIN COMPLAINT IS:_____

1) I have had the problem for _____ □ Days □ Weeks □ Months □ Years
2) What other symptoms are related to the problem? Describe: _____
3) How bad is it (effect on daily life)? 0 1 2 3 4 5 6 7 8 9 10
Not bad----------→Worst imaginable
4) HAVE YOU SEEN OTHER DOCTORS OR PROVIDERS FOR TODAY'S PROBLEMS? □ NO □ YES

I ALSO HAVE:

Problems with urination □ NO □ YES Describe: _____
□ Frequency every ____ hours while awake □ # voids in 24 hours _____ □ # Nighttime voids ____ □ Urgency
□ Slow stream □ Incomplete emptying □ Complete urinary retention □ Post-void dribbling □ Pain during void
□ Difficulty starting stream □ Straining □ Stopping and starting □ Having to urinate in odd positions to get urine out

Urine leakage □ NO □ YES Describe: _____
I leak with: □ Cough/Sneeze □ Rush to bathroom □ I can't tell it is happening □ Constant (Circle Worst)
I use pads: # per day: _____ Type: □ Light □ Medium □ Heavy □ Full Diaper

Pelvic pain (below belly button) □ NO □ YES Describe: _____

Blood in your urine □ NO □ YES (Please have lab results sent)

Urinary tract infection □ NO □ YES □ > 3 in 12 months (Please have lab results sent)

Sexual Symptoms □ NO PROBLEMS □ Would prefer not to discuss
□ Not sexually active □ Lack of desire □ Poor arousal □ Poor orgasm
Women: □ Pain Deep Inside □ Pain on Surface □ Dryness □ Birth control method:_____
Men: □ Unsatisfactory erections □ Bend □ Pain

Bowel symptoms: □ NO □ YES Describe: _____

PAST MEDICAL HISTORY: **Please list ALL of your medical problems, past and present.**
□ No medical problems □ Diabetes □ High blood pressure □ High cholesterol □ GERD (heartburn)
□ Heart/Lung disease _____
□ Kidney disease _____
□ Liver/Intestinal disease _____
□ Neurological disease (Spinal Stenosis, MS, Stroke, Back Problems)_____
□ Sexually transmitted disease _____ □ Blood clots - where?_____
□ Other: _____

For Men: PSA value: _____ Date: _____ Any Prostate Cancer? □ NO □ YES
For Women: LAST PAP Date: _____ MAMMO Date: _____ Any abnormal? □ NO □ YES
Date of last menstrual cycle? _____ Is there a bulge exiting vagina (prolapse?) □ NO □ YES
Prior Hysterectomy? □ NO □ YES: __Vaginal __Laparoscopic __Abdominal Why?_____
# of pregnancies _____ # of live births _____ # of vaginal deliveries _____ # Csections _____
□ Forceps □ Vacuum □ Major tears: _____ Biggest baby delivered vaginally: _____ lbs _____ oz

Smoking: □ Never □ Current □ Prior: (Age quit: ____) □ # years smoking: _____ □ # Packs per day: _____
Alcohol: Average drinks per week: ____ Ever have "trouble" with alcohol? □ NO □ YES Details:_____
Drugs: Have you ever had trouble with drugs? □ NO □ YES Details: _____

PAST SURGICAL HISTORY: Please list ALL prior surgeries, including childhood surgery.

Operation type	**Year**	**Surgeon/Hospital if Known**

MEDICATIONS: Include all over-the-counter AND herbal medications

Medication and Dosage	# Tablets Taken Each Time	Times taken per day	Reason Taken
1)			
2)			
3)			
4)			
5)			
6)			
7)			

ALLERGIES: Medication — Reaction (e.g. hives, rash, vomiting, anaphylaxis

1) _____ _____

2) _____ _____

FAMILY HISTORY: List any **major** medical problems, such as Kidney/Bladder/Prostate Disease, Female Disease (breast, cervical, ovarian or uterine), Neurological disease, Heart disease, Blood clots or Sickle disease.

Mother _____ Current age: ____ or Deceased (circle)

Father _____ Current age: ____ or Deceased (circle)

Sibling(s) _____ Current age: ____ or Deceased (circle)

Child(ren) _____ Current age(s): _____

Other: _____

SOCIAL HISTORY: Living situation: □ Private House/Apartment □ Facility _____ □ Services (VNA) _____

Relationships: □ Married □ Separated □ Divorced □ Widow □ Stable relationship □ Single

Present/Prior Occupation: _____ □ Currently employed □ Retired □ Unemployed □ Disabled

SAFETY: We ask these OPTIONAL questions to help prepare for physical exams and tests (tell us if you are worried.)

The National Domestic Violence Hotline is: 1-800-799-SAFE (7233)

Have you ever been hit, hurt, threatened or abused? □ NO □ YES Currently? □ NO □ YES

Have you ever been sexually abused? □ NO □ YES

REVIEW OF SYSTEMS: CIRCLE if you have had any of these symptoms in the last FOUR MONTHS:

General:	**Recent Illness (e.g. ER visit):** _____			
	Fever	**Chills**	**Itchiness**	**Rashes**
	Breast lump	**Skin lesions**	**Allergies**	**Immunity problems**
Heart:	**Chest pain, pressure**	**Shortness of breath with exertion**	**Ankle swelling**	**Pain in calves with exertion**
	Needed >1 pillow to sleep	**Awoke breathless at night**	**Noticed heart racing**	
Lungs:	**Cough: sputum, blood**	**Shortness of breath**	**Wheeze**	**Snored loudly**
GI:	**Abdominal pain**	**Weight gain > 10 lbs**	**Weight Loss > 10 lbs**	**Bloating, distention**
	Nausea	**Vomiting**	**Blood in stool**	**Diarrhea**
Neuro:	**Change in vision**	**Change in hearing**	**Change in speech**	**Headaches**
	Balance Trouble	**Fainting**	**Dizziness**	**Tremors**
	Weakness	**Numbness**	**Concentration**	**Seizures**
	Memory	**Sleep disturbances**	**Blackouts**	

Psych:	**Depression**	**Anxiety**	**Other:** _____	
Endocrine:	**Intolerance hot weather** **Neck swelling**	**Intolerance to cold weather** **Hair changes**	**Sweating** **Voice changes**	**Fatigue** **Thirst**
Heme:	**Difficulty stopping bleeds**	**Lumps under arms, neck, loin**	**History of clots in legs, lungs**	
Rheum:	**Joints: pain, stiffness** **Back pain**	**Fingers painful/ blue in cold** **Neck pain**	**Dry mouth** **Prior work-up for back pain:** _____	**Dry eyes**

Referring Doctor:_____ **Other Doctors to receive copy of notes:** _____
Address, phone, and fax: _____ **Address phone and fax:** _____
_____ _____
_____ _____

Name and signature_____Date_____
Thank you very much for providing this information. We will do our absolute best to take care of your health care needs.

APPENDIX: PLEASE COMPLETE REGARDING PRIOR CARE FOR YOUR URINARY PROBLEMS:

□ **NO TREATMENT YET (SKIP)**

Do you already have a diagnosis for the problem? □ NO □ YES (Describe:)_____
What have you or other doctors/urologists done so far? (Records will help): _____

Medications Tried (circle all):

Ditropan (Oxybutynin)	Oxytrol Patch (Oxybutynin Patch)	Gelnique (Oxybutynin Gel)	Detrol (Tolterodine)
Vesicare (Solifenacin)	Enablex (Darifenacin)	Sanctura (Trospium)	Toviaz (Fesoterodine)
Amitriptyline (Elavil)	Nortriptyline (Pamelor)	Imiprimine (Tofranil)	Elmiron (Pentosan Polysulfan)
Atarax (Hydroxyzine)	Vistaril (Hydroxyzine)	Alfuzosin (Uroxatral)	Doxazosin (Cardura)
Terazosin (Hytrin)	Tamsulosin (Flomax)	Rapaflow (Silodosin)	Pyridium (Phenazopyridine)
Vaginal Estrogen Cream	Vaginal Steroid	Pain Medications	Antibiotics for _____ days

Other Medications: _____
What worked best? _____

Treatments Tried FOR MY PROBLEMS and Results *(Please fax records to 518 262-6660)*:

Surgery (Type): _____
Please have written operative note transferred for any prostate, kidney, urethra, uterus, prolapse or bladder surgery.
Bladder Instillation Therapy: _____
Bladder Hydrodistention: _____
Sacral Nerve Stimulation (Interstim): _____
Botox: _____
Biofeedback: _____
Pelvic Floor Physical Therapy: _____
Other: _____

RECENT PRIOR TESTING	***(Please fax records)*:**	**Approximate Date/ Result/ Doctor/ Hospital:**
LABS:	**Urinalysis and Culture**	_____
	PSA (Recommended in all men > 50)	_____
	Creatinine	_____
XRAYS (actual images please):	**CT/MRI scan of the abdomen**	_____
	Voiding Cystourethrogram:	_____
	Ultrasound of the kidneys	_____
DIAGNOSTIC TESTING:	**Cystoscopy**	_____
	Urodynamics	_____

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

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.

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.
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: _____

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**

* 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)

mycareDOT™

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

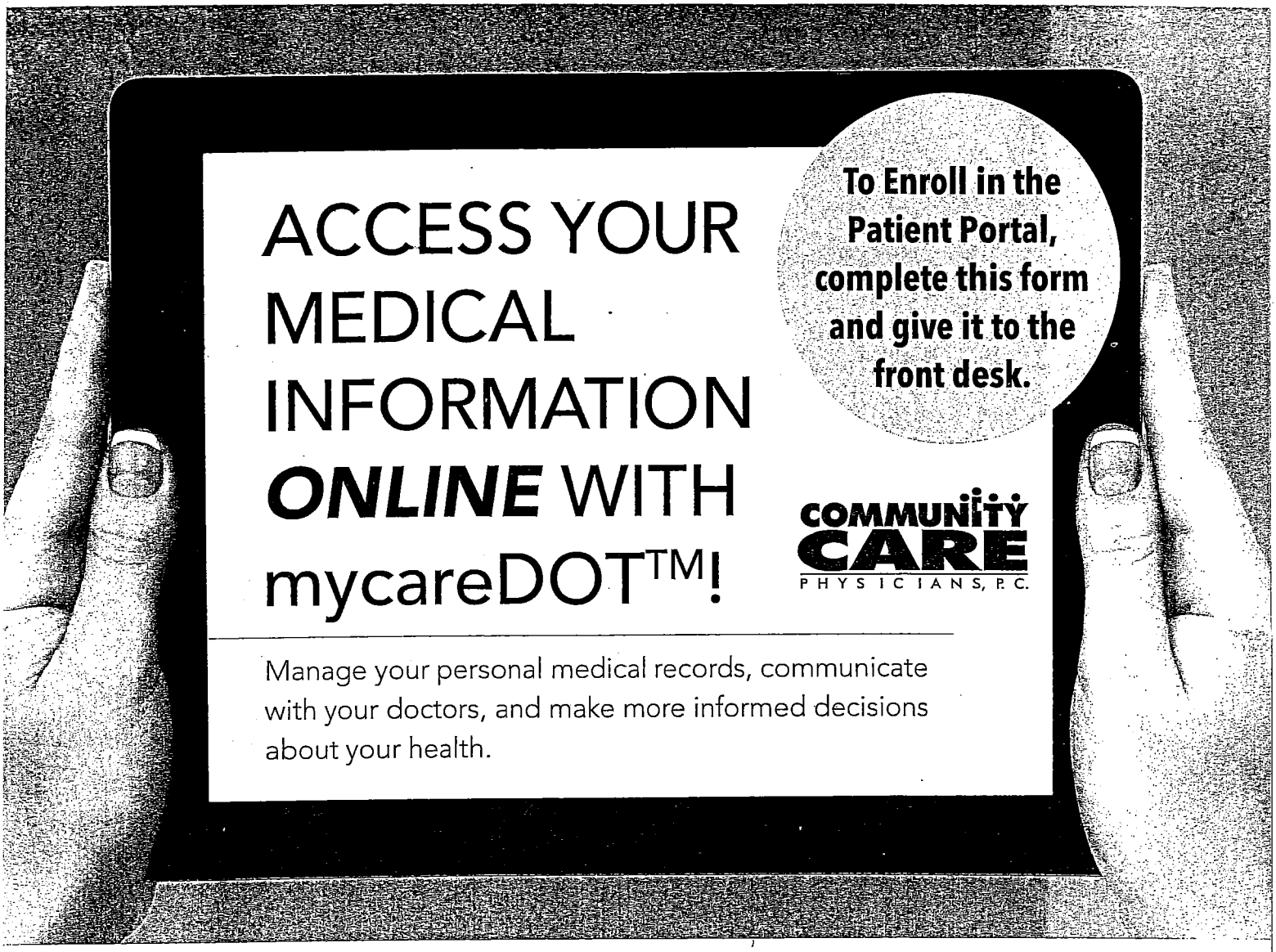
**Using the secure patient portal helps to avoid the risks associated with emails.

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.

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