Community Memorial
Quality Healthcare Close to Home
A CROUSE HEALTH PARTNER

New Patient Packet: Adult

Welcome!

Welcome to Community Memorial Hospital Family Health Centers! Thank you for entrusting us with your care.
At Community Memorial Hospital's Family Health Centers, we provide quality healthcare close to home, with a 5-star rated team. Our healthcare providers are focused on helping you achieve better overall health and wellness.
Our Family Health Centers are conveniently located in communities across Madison and Oneida Counties.

What is included in this packet?

Authorization for Release of Information Form
allows us to get records from your previous healthcare providers

Patient Information Form
contains insurance and demographic information

Notice of Privacy Practices
describes how medical information about you may be used and disclosed

Consent for Treatment & Financial Responsibility Agreement
allows our providers to provide medical treatment to you, explains our professional relationship in regards to feeds, financial policy and financial responsibility

New Patient Pre-Examination Information
a way for you to share your past medical history with your new provider to ensure excellent continuity of care

Health e-Connections Consent
allows CMH to access your medical records through a secure NYS health information exchange

Surescripts Consent
gives CMH secure, electronic access to your prescription information

What you need to return to the office:

Within 5 days before appointment, return:
Authorization for Release of Information form
Patient Information Form
Consent for Treatment and Financial Responsibility Agreement
New Patient Pre-Examination Information Form
Health e-Connections consent
Surescripts Consent

You may also fax the information to (315) 824-8447 or drop off completed paperwork to any of our 5 locations.

Contact with problems/questions:

Please contact our Family Health Centers at
(315) 824-4600
if you have any questions or concerns

If you have never had a primary care provider:

Please indicate this on the **Authorization for Release of Information** form.
Our office will work with you to set up an appointment with one of our providers.

The new patient process:

Once we receive your **Authorization for Release of Information** form, our office will send that to your former primary care provider. That provider has up to 30 days to release your medical records to us.

The forms included in the New Patient Packet must be received within 5 days before your appointment.

Thank you for entrusting your medical care to our team. We look forward to working with you.

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Family Health Centers
Notice of Privacy Practices

This notice describes how medical information about you may be used/disclosed and how you can get access to this information. Please review it carefully.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

There are some situations when we do not need your specific written authorization before using your health information or sharing it with others. These situations are described below.

Treatment - We may use and disclose your health information to provide you with medical treatment and services. As an example of this, we may provide information to a provider to make available the use of a wheelchair or home oxygen to assist you during your recovery.

Community Memorial Hospital utilizes an electronic medical records system for medical imaging services called the PACS system (Picture Archiving Communication). Any medical imaging tests performed by Community Memorial such as x-rays and CAT scans) are electronically stored on the PACS system. The PACS system also stores examinations done at other locations where Crouse Radiology Associates are the radiologists. Your physicians haveiInternet access to the films and reports. For example, an x-ray you had done at Community Memorial Hospital would be available to a physician who orders a test for you done at Crouse Health.

Community Memorial Hospital is affiliated with Crouse Health located in Syracuse, New York. Your health care providers working at Crouse Health and Community Memorial Hospital may access health information, about you created at either hospital location as necessary to provide you with services.

National Security and Intelligence Activities or Protective Services - We may disclose your health information to authorized officials who are conducting activities such as providing protective services to the President or other important officials or for national security activities.

Military and Veterans - We may disclose your health information to authorized military agencies for certain activities if you are a member of the US armed forces (including veterans). We may also release health information about foreign military personnel to foreign military authorities.

Inmates and Correctional Institutions - If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers for your or another's health and safety.

Coroners, Medical Examiners and Funeral Directors, Organ and Tissue Donation - In the event of your death, we may disclose your health information to a coroner or medical examiner to determine the cause of death. We may also release your information to funeral directors as necessary to carry out their duties. We may disclose your health information to organ donation organizations to determine whether donation or transplantation is possible.

Research - In most cases, we will ask for your written authorization before using your health information or sharing it with others in order to conduct research. However, under some circumstances, we may use and disclose your health information without your authorization if we obtain approval through a special process to ensure that research without your authorization poses minimal risk to your privacy. Under no circumstance, however, would we allow researchers to use your name or identity publicly. We may also release your health information without your authorization to people who are preparing a future research project, so long as any information identifying you does not leave our facility. In the unfortunate event of your death, we may share your health information with the people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you.

Workers' Compensation - We may use or disclose your health information as necessary to comply with workers' compensation laws.

USES AND DISCLOSURES THAT WILL ONLY BE MADE WITH YOUR WRITTEN AUTHORIZATION

We will only make the following uses and disclosures with your written authorization:

- Most uses and disclosures of psychotherapy notes;
- Uses and disclosures for marketing purposes;
- Uses and disclosures that would be considered a sale of health information· and
- Other uses and disclosures not otherwise described in this Notice or covered by the laws that apply to us.

In these instances, we will provide you with an authorization form to sign. You may revoke the authorization at any time as indicated above under "Specific Authorization."

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

You have the following rights to access and control your health information. These rights are important because they will help you make sure that the health information we have about you is accurate, help you control the way we use and share your information, or help the way we communicate with you about your medical matters.

Right to Inspect and Copy Records

You have the right to inspect and obtain a paper or electronic copy of your health information, including medical and billing records, for as long as we maintain your information. In certain circumstances, Community Memorial Hospital is authorized by law to deny your request. To inspect or obtain a copy of your health information, please submit your request in writing to: Health Information Management
Community Memorial Hospital
150 Broad Street
Hamilton, NY 13346

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Family Health Centers
Notice of Privacy Practices

This notice describes how medical information about you may be used/disclosed and how you can get access to this information. Please review it carefully.

Our Legal Obligations

Community Memorial Hospital is required by law to protect the privacy of your health information. We must provide you with a copy of this notice which describes our legal duties and privacy practices and your rights concerning your health information. The following individuals at Community Memorial Hospital will follow this notice when they provide services to you:

- Our medical staff, affiliated health professionals, and students;
- Our employees, personnel or representatives in every department having access to your health information;
- Our affiliates, including independent contractors having access to your health information.
- Any member of a volunteer group we allow to help you while you receive services in the hospital.
- All of the Hospital-affiliated Family Health Centers.

Community Memorial Hospital and the above individuals may share your health information with each other as may be necessary to provide you treatment, for payment of your treatment, or to support our healthcare operations to the extent authorized by law.

Community Memorial Hospital is required to notify you of a breach of unsecured protected health information. A copy of our current notice is posted throughout our hospital and affiliated Family Health Center's registration areas. You may also obtain a copy at www.communitymemorial.org or by contacting the Patient Access Department at (315) 824-6575, or by asking for one at the time of your next visit. If you have any questions about this Notice or would like further information, please contac the Compliance Coordinator at 315-824-7064.

IMPORTANT INFORMATION

General Consent

We will generally obtain your written consent to use and disclose your health information for treatment, payment or health care operations.

Specific Authorization

Uses and disclosures of your health information not covered by this notice may require your specific authorization. For example, you may request that we release a copy of your health records to another person or entity by completing a Community Memorial Hospital Authorization Form.

You may cancel your consent or authorization at any time in writing, except to the extent we have already relied upon it. To cancel your consent or authorization, please write to: Compliance Department
Community Memorial Hospital
150 Broad Street
Hamilton, NY 13346
315-824-7064

Depending on the nature of your health information, we may be required to comply with additional laws. For example, use and disclosure of HIV-related, genetic, and mental health information and alcohol and substance abuse records may need your specific permission.

How Someone May Act On Your Behalf - You have the right to name a representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

How to Obtain a Copy of Our Notice (or a Revised Notice) - Community Memorial Hospital must abide by the terms of the notice currently in effect, however, we reserve the right to change our privacy practices from time to time and to make the new Notice effective for all protected health information we maintain. If we do revise the notice, we will post the revised notice in our registration areas, and also post a copy at www.communitymemorial.org so you will have an accurate summary of our practices. You have the right to a paper copy of our notice. You may request a paper copy at any time, even if you have previously agreed to receive this Notice electronically.

How to File a Complaint - If you believe an improper use or disclosure has occurred, or your privacy rights have been violated, you may file a complaint with us at: Compliance Department
Community Memorial Hospital
150 Broad Street
Hamilton, NY 13346
315-824-7064

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights. Community Memorial Hospital will not take action or retaliate against you for filing a complaint.

WHAT HEAL TH INFORMATION IS PROTECTED

Community Memorial Hospital is committed to protecting the privacy of your health information. Some examples of protected health information are:

- Information about your health condition (such as a disease you may have);
- Information about health care services you have received or may receive in the future (such as an operation);
- Information about your health care benefits under an insurance plan (such as whether a prescription is covered);
- Geographic information (such as where you live or work);
- Demographic information (such as your race, gender, ethnicity, or marital status);
- Unique numbers that may identify you (such as your social security number, your phone number, or your driver's license number); and
- Other identifying information.

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Right to Amend Records

You have the right to request an amendment of your health information if you believe your record is incorrect or incomplete, as long as we maintain the information. Community Memorial Hospital has the right to deny the request if the information: was not created by us (unless the original health care provider is no longer available to amend the record); is not part of the information you have a right to inspect or copy; or is correct. To obtain a Request for Amendment form, please write to the address listed under "Right to Inspect and Copy Records."

Right to an Accounting of Disclosures

You have a right to request an "accounting of disclosures" which identifies information we have shared with others. This does not include:

- Disclosures we made to you;
- Disclosures for treatment, payment or health care operation purposes;
- Disclosures made in the hospital directory;
- Disclosures made to your family and friends involved in your care and treatment;
- Disclosures made to federal officials for national security and intelligence activities;
- Disclosures made about inmates to correctional institutions or law enforcement officers;
- Disclosures made six years prior to your request.

To request an **Accounting of Disclosures**, please write to the address listed under "Right to Inspect and Copy Records." You may obtain one accounting listing within every 12-month period without charge. We may charge for additional requests within the same 12-month period, but we will let you know in advance.

Right to Request Additional Privacy Protections

You have the right to request in writing that we further restrict the way we use and disclose your health information. You may also request that we limit how we disclose information about you to family or friends involved in your care. For example, you could request that we not disclose information about a surgery you had. Generally, Community Memorial Hospital is not required to agree to your request to restrict how we use and disclose your medical information. However, if you request Community Memorial Hospital to restrict the disclosure of your health information to a health plan (your health insurer) related to services or items we provide to you and you pay us for such services or items out-of-pocket in full, we must agree to your request, unless we are required by law to disclose the information. Please note: This restriction will apply only when requested and services are paid in full. Future services without a restriction request and for which no out-of-pocket payment is received will be billed as required by your health plan, which may include current provider notes that reference prior treatments or services previously restricted. If we do agree to a restriction, our agreement will be in writing and we will follow your request unless your health information is needed to provide you emergency care or we terminate the agreement.

To make a request for a **Request for Special Privacy Protections** form, see the address under "Right to Inspect and Copy Records." Your request should include 1) what information you want to limit; 2) whether you want to limit how we use the information, how we share it with others, or both; and 3) to whom you want the limits to apply.

Right to Request Confidential Communications

You have the right to request in writing that we communicate with you about your medical matters by alternate means or at alternate locations. For example, you may ask that we contact you at work instead of at home.

Thank you for choosing Community Memorial Hospital for your health care needs.

If you would like to talk to someone about your health care or services please call:

Administration

Community Memorial Hospital

315-824-6080

Community Memorial
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Family Health Centers Consent for Treatment & Financial Responsibility Agreement

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Your clear understanding of our policies are important to our professional relationship. Please understand that payment for services is a part of that relationship. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc). The following are statements of our Consent for Treatment & Financial Policy, which we require you read and sign prior to any treatment.

Consent for Treatment

This consent provides us with permission to perform reasonable and necessary medical examinations, testing and treatment at this office or any other Family Health Center of Community Memorial Hospital. The consent will remain fully effective until it is revoked in writing. Patients have the right at any time to discontinue services. All patients have the right to discuss the treatment plan with the physician regarding the purpose, potential risks and benefits of any test ordered. If any concerns regarding test or treatment recommended by the health care provider arise, we encourage you to ask questions. Please understand that if additional testing, invasive or interventional procedures are recommended, patients will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Co-pays

The patient is expected to present an insurance card at each visit. Please remember that all co-payments and past due balances are due at time of check-in unless previous arrangements have been made with our Billing Supervisor or with **Practice Resources, LLC (PRL)**. We accept cash, check or credit cards.

Outstanding Balance Policy

All patients who have accounts with outstanding balances will have statements mailed on a monthly basis. All past due accounts be sent 3 statements. If payment is not made after the 3 statements, the account will be sent to the collection agency (**Rothman Evans**).In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service.

Insurance Claims

All patients must complete our Patient Information form before seeing our providers. Providing insurance information on that form authorizes the Family Health Centers to release medical information to the patients insurance company for processing of claims.

If you have insurance coverage, and we are a participating provider, we will bill your insurance company as a courtesy to you. In order to properly bill your insurance company we require all insurance information including primary and secondary insurance. Failure to provide complete information may result in patient responsibility for the entire bill. Assignment of benefits will occur after your first visit. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. Insurance is a contract between you and your insurance company.

By law insurance carriers must remit payment or deny your insurance claim within 30 days of initial notice of claim. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier. In the event that we are not participating providers with your insurance carrier, you will be responsible for the payment of all fees at the time service is rendered. We will provide you with a copy of your bill to submit to your insurance company, and reimbursement will be made directly to you. Medicare beneficiaries with current entitlement are responsible only for deductibles, coinsurance or non-covered services.

Self-pay Accounts

Self-pay patients will be responsible for the payment of all fees at the time service and may be eligible for a self-pay percent discount. If full payment is not able to be made patient will be asked to make payment arrangements for the balance. Extended payment arrangements and Financial Assistance Forms are available if needed. Please ask to speak with our Billing Supervisor to discuss a payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

The Family Health Centers firmly believe that a good physician/patient relationship is based upon understanding and good communications. If you have any questions or need clarification of any of the above policies, please feel free to contact us. To speak with our **Revenue Cycle Manager, Vikki Anthony**, please call 315-824-7089 or you may call our **billing company, PRL**, at 315-937-3015. We will make every effort available to clarify any concern you are having.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its content.

Signature _____ Date _____

Community Memorial
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New Patient Pre-Examination Information

Patient Information

Patient Name _____ Date of Birth _____ / _____ / _____

Do you have a ☐ Health Care Proxy If so, Agent _____
☐ Living Will ☐ DNR ☐ Medical Order for Life-Sustaining Treatment

Past History

Have you ever had: ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Disease ☐ Pneumonia ☐ Asthma
☐ Lung Disease ☐ Diabetes ☐ Cancer ☐ Ulcers/Reflux ☐ Hepatitis ☐ Chicken Pox
☐ HIV ☐ Blood Transfusion(s) ☐ Other _____

Family History

Who in your family has:

Cancer	☐ Father	☐ Mother	☐ Brother(s)	☐ Sister(s)	☐ Other
Lung Disease	☐ Father	☐ Mother	☐ Brother(s)	☐ Sister(s)	☐ Other
Stroke	☐ Father	☐ Mother	☐ Brother(s)	☐ Sister(s)	☐ Other
Tuberculosis	☐ Father	☐ Mother	☐ Brother(s)	☐ Sister(s)	☐ Other
High Cholesterol	☐ Father	☐ Mother	☐ Brother(s)	☐ Sister(s)	☐ Other
Diabetes	☐ Father	☐ Mother	☐ Brother(s)	☐ Sister(s)	☐ Other
Heart Disease	☐ Father	☐ Mother	☐ Brother(s)	☐ Sister(s)	☐ Other
High Blood Pressure	☐ Father	☐ Mother	☐ Brother(s)	☐ Sister(s)	☐ Other
Osteoporosis/Arthritis	☐ Father	☐ Mother	☐ Brother(s)	☐ Sister(s)	☐ Other
Mental Illness	☐ Father	☐ Mother	☐ Brother(s)	☐ Sister(s)	☐ Other

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New Patient Pre-Examination Information

Patient Information

Patient Name _____ Date of Birth _____ / _____ / _____

Do you have a Health Care Proxy If so, Agent _____
Living Will DNR Medical Order for Life-Sustaining Treatment

Past History

Have you ever had: High Blood Pressure High Cholesterol Heart Disease Pneumonia Asthma
Lung Disease Diabetes Cancer Ulcers/Reflux Hepatitis Chicken Pox
HIV Blood Transfusion(s) Other _____

Family History

Who in your family has:

Cancer	Father	Mother	Brother(s)	Sister(s)	Other
Lung Disease	Father	Mother	Brother(s)	Sister(s)	Other
Stroke	Father	Mother	Brother(s)	Sister(s)	Other
Tuberculosis	Father	Mother	Brother(s)	Sister(s)	Other
High Cholesterol	Father	Mother	Brother(s)	Sister(s)	Other
Diabetes	Father	Mother	Brother(s)	Sister(s)	Other
Heart Disease	Father	Mother	Brother(s)	Sister(s)	Other
High Blood Pressure	Father	Mother	Brother(s)	Sister(s)	Other
Osteoporosis/Arthritis	Father	Mother	Brother(s)	Sister(s)	Other
Mental Illness	Father	Mother	Brother(s)	Sister(s)	Other

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New Patient Pre-Examination Information

Patient Name _____ Date of Birth _____ / _____ / _____

Pre-Examination Information

Have you had any operations or been a patient in a hospital? ☐ No change since last visit or last physical

Type/Reason	Year	Hospital/Location	Physician/Surgeon

Please list present medication with dosage and how taken: (bring all medications to your appointment)

Medicine	Dosage	Medicine	Dosage

Do you use non-prescription medicines, diet supplements, vitamins, calcium, iron? ☐ Yes ☐ No
If yes, please list: _____

Please list any allergies to medications and your reaction: _____

Did you ever smoke? ☐ Yes ☐ No Do you smoke now? ☐ Yes ☐ No
Did you ever use e-cigarettes or vape? ☐ Yes ☐ No If yes, how much? _____ What? _____ How long? _____
Do you drink alcohol? ☐ Yes ☐ No If yes, what and how much? _____ Have you ever used illegal substances? ☐ Yes ☐ No
Have you had immunizations? ☐ Shingles: Year _____ ☐ Pneumovax: Year _____ ☐ Tetanus: Year _____ ☐ Flu: Year: _____
Have you had any of the following: ☐ Chest X-ray ☐ MRI ☐ Barium Enema ☐ Tuberculin Skin Testing ☐ Stress Test
☐ Sigmoid/Colonoscopy ☐ GI Series
List other doctors you see: _____
What is your weight? _____ Height? _____ Has it changed in the last 6 months? ☐ Yes ☐ No Gain _____ Lost _____
Do you sleep well? ☐ Yes ☐ No How many hours? _____ Has it changed in the last 6 months? ☐ Yes ☐ No
Have you ever been employed in an area that exposed you to hazardous infections or substances? ☐ Yes ☐ No
If yes, explain: _____
Do you follow any special diet? ☐ Yes ☐ No If yes, explain: _____
Amount of coffee, tea, soda daily: _____ Amount of salt: ☐ Large ☐ Medium ☐ Small

For Men AND Women

Are you sexually active? ☐ Yes ☐ No
Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

For Women ONLY

Name of OB/GYN Provider: _____
Date of last pap smear: _____
Date of last mammo: _____
Date of last bone density: _____
Date of last breast exam: _____
Do you do self-exams? ☐ Yes ☐ No

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New Patient Pre-Examination Information

Patient Name _____ Date of Birth _____ / _____ / _____

Pre-Examination Information

Have you had any operations or been a patient in a hospital? No change since last visit or last physical

Type/Reason	Year	Hospital/Location	Physician/Surgeon

Please list present medication with dosage and how taken: (bring all medications to your appointment)

Medicine	Dosage	Medicine	Dosage

Do you use non-prescription medicines, diet supplements, vitamins, calcium, iron? Yes No
If yes, please list: _____

Please list any allergies to medications and your reaction: _____

Did you ever smoke? Yes No Do you smoke now? Yes No
Did you ever use e-cigarettes or vape? Yes No If yes, how much? _____ What? _____ How long? _____
Do you drink alcohol? Yes No If yes, what and how much? _____ Have you ever used illegal substances? Yes No
Have you had immunizations? Shingles: Year _____ Pneumovax: Year _____ Tetanus: Year _____ Flu: Year: _____
Have you had any of the following: Chest X-ray MRI Barium Enema Tuberculin Skin Testing Stress Test Sigmoid/Colonoscopy GI Series
List other doctors you see: _____
What is your weight? _____ Height? _____ Has it changed in the last 6 months? Yes No Gain _____ Lost _____
Do you sleep well? Yes No How many hours? _____ Has it changed in the last 6 months? Yes No
Have you ever been employed in an area that exposed you to hazardous infections or substances? Yes No
If yes, explain: _____
Do you follow any special diet? Yes No If yes, explain: _____
Amount of coffee, tea, soda daily: _____ Amount of salt: Large Medium Small

For Men AND Women

Are you sexually active? Yes No
Sexual Orientation: Heterosexual Homosexual Bisexual

For Women ONLY

Name of OB/GYN Provider: _____
Date of last pap smear: _____
Date of last mammo: _____
Date of last bone density: _____
Date of last breast exam: _____
Do you do self-exams? Yes No

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New Patient Pre-Examination Information

Patient Name _____ Date of Birth _____ / _____ / _____

For Women ONLY

Menstrual History

Age at onset _____ Length of cycle (between periods) _____ Days of flow _____

☐ Heavy ☐ Medium ☐ Light
Are they regular ☐ Yes ☐ No

Pain or Cramps? ☐ Yes ☐ No

Date of last period _____ Vaginal discharge _____

Pregnancies

How many pregnancies? _____ How many miscarriages? _____ Any stillbirths? _____
Any complications? ☐ Yes ☐ No If yes, explain: _____

For Men ONLY

Date of last PSA _____ Date of last rectal exam _____ Do you perform regular testicular exams? ☐ Yes ☐ No

Symptoms

Are you having (please check):

EYES
- ☐ Blurred or double vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ See floating spots
- ☐ Wear glasses, contact lenses
- ☐ Macular Degeneration

EARS/NOSE/THROAT
- ☐ Deafness/hearing aids
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Frequent colds/hoarseness/ sore throat
- ☐ Nose Bleeds
- ☐ Swollen glands
- ☐ Runny nose, post nasal drip
- ☐ Phlegm/sputum
- ☐ False teeth
- ☐ Bleeding from teeth or gums
- ☐ Difficulty chewing
- ☐ Sores on tongue

SKIN
- ☐ Easily bruised
- ☐ Sores that won't heal
- ☐ Rashes
- ☐ Acne

LYMPH NODES
- ☐ Swelling

CHEST
- ☐ Asthma
- ☐ Persistent cough
- ☐ Wheezing
- ☐ Lung disease
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Shortness of breath
- ☐ Pain/pressure/discomfort in chest
- ☐ Palpitations/irregular beats
- ☐ Heart trouble
- ☐ High blood pressure
- ☐ Dizziness/fainting
- ☐ Blood clots in lungs/legs
- ☐ Swelling in ankles
- ☐ Leg discomfort when walking/at rest

CONSTITUTIONAL
- ☐ Energy level
- ☐ Stamina
- ☐ Fatigue
- ☐ Fever/chills

ENDOCRINE
- ☐ Ability to tan easily
- ☐ Feel warmer/colder than rest of family
- ☐ Anemia
- ☐ Thyroid disease
- ☐ Diabetes

URINARY TRACT
- ☐ Kidney/bladder trouble
- ☐ Discomfort passing urine
- ☐ Urge to urinate at night
- ☐ Loss of urine when coughing/sneezing
- ☐ Trouble making a stream
- ☐ Reoccurring UTIs
- ☐ Kidney stones
- ☐ Difficulty with sexual ability
- ☐ Venereal disease

MUSCLES/NERVES
- ☐ Difficult to walk/stand
- ☐ Broken bones
- ☐ Arthritis
- ☐ Bursitis
- ☐ Pain/swelling in joints
- ☐ Muscle weakness
- ☐ Back pain/problems
- ☐ Headaches, frequent/severe
- ☐ Migraine headaches
- ☐ Convulsions/seizures
- ☐ Paralysis
- ☐ Tremor
- ☐ Pain/numbness/tingling
- ☐ Finders/toes
- ☐ Around mouth

MENTAL STATUS
- ☐ Memory issues
- ☐ Depression/ suicidal thoughts
- ☐ Anxiety
- ☐ Irritability
- ☐ Feeling of panic

ABDOMEN
- ☐ Indigestion/heartburn
- ☐ Nausea/vomiting
- ☐ Hiatal hernia
- ☐ Ulcers
- ☐ Gallbladder problems
- ☐ Loss of appetite
- ☐ Intolerance of certain foods
- ☐ Abdominal pain
- ☐ Pulse sensation
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody/black bowel movements
- ☐ Pain in rectum
- ☐ Hemorrhoids (piles)

Patient Signature _____ Date _____

Reviewed by _____ Date _____

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New Patient Pre-Examination Information

Patient Name _____ Date of Birth _____ / _____ / _____

For Women ONLY

Menstrual History

Age at onset _____ Length of cycle (between periods) _____ Days of flow _____ Heavy Medium Light

Are they regular Yes No

Pain or Cramps? Yes No

Date of last period _____ Vaginal discharge _____

Pregnancies

How many pregnancies? _____ How many miscarriages? _____ Any stillbirths? _____

Any complications? Yes No If yes, explain: _____

For Men ONLY

Date of last PSA _____ Date of last rectal exam _____ Do you perform regular testicular exams? Yes No

Symptoms

Are you having (please check):

EYES
- Blurred or double vision
- Glaucoma
- Cataracts
- See floating spots
- Wear glasses, contact lenses
- Macular Degeneration

EARS/NOSE/THROAT
- Deafness/hearing aids
- Earaches
- Ringing in ears
- Frequent colds/hoarseness/ sore throat
- Nose Bleeds
- Swollen glands
- Runny nose, post nasal drip
- Phlegm/sputum
- False teeth
- Bleeding from teeth or gums
- Difficulty chewing
- Sores on tongue

SKIN
- Easily bruised
- Sores that won't heal
- Rashes
- Acne

LYMPH NODES
- Swelling

CHEST
- Asthma
- Persistent cough
- Wheezing
- Lung disease
- Snoring
- Sleep apnea
- Shortness of breath
- Pain/pressure/discomfort in chest
- Palpitations/irregular beats
- Heart trouble
- High blood pressure
- Dizziness/fainting
- Blood clots in lungs/legs
- Swelling in ankles
- Leg discomfort when walking/at rest

CONSTITUTIONAL
- Energy level
- Stamina
- Fatigue
- Fever/chills

ENDOCRINE
- Ability to tan easily
- Feel warmer/colder than rest of family
- Anemia
- Thyroid disease
- Diabetes

URINARY TRACT
- Kidney/bladder trouble
- Discomfort passing urine
- Urge to urinate at night
- Loss of urine when coughing/sneezing
- Trouble making a stream
- Reoccurring UTIs
- Kidney stones
- Difficulty with sexual ability
- Venereal disease

MUSCLES/NERVES
- Difficult to walk/stand
- Broken bones
- Arthritis
- Bursitis
- Pain/swelling in joints
- Muscle weakness
- Back pain/problems
- Headaches, frequent/severe
- Migraine headaches
- Convulsions/seizures
- Paralysis
- Tremor
- Pain/numbness/tingling
- Finders/toes
- Around mouth

MENTAL STATUS
- Memory issues
- Depression/ suicidal thoughts
- Anxiety
- Irritability
- Feeling of panic

ABDOMEN
- Indigestion/heartburn
- Nausea/vomiting
- Hiatal hernia
- Ulcers
- Gallbladder problems
- Loss of appetite
- Intolerance of certain foods
- Abdominal pain
- Pulse sensation
- Change in bowel habits
- Diarrhea
- Constipation
- Bloody/black bowel movements
- Pain in rectum
- Hemorrhoids (piles)

Patient Signature _____ Date _____

Reviewed by _____ Date _____

Community Memorial
Quality Healthcare Close to Home
A CROUSE HEALTH PARTNER

Authorization for Release of Information

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☐ Community Memorial Hospital	☐ CMH Family Health CTR	☐ CMH Family Health CTR	☐ CMH Family Health CTR	☐ CMH Family Health CTR
Hamilton, NY 13346	Hamilton, NY 13346	Morrisville, NY 13408	Munnsville, NY 13409	Waterville, NY 13480
Phone 315-824- 6529	Phone 315-824-4600	Phone 315-684-3117	Phone 315-495-2690	Phone 315-841-4184
Fax 315-824-6558	Fax 315-824-8447	Fax 315-684-9848	Fax 315-495-3915	Fax 315-202-4031

Patient Name _____ Date of Birth _____ Phone Number _____

Address _____ City, State _____ Zip Code _____

Please check one:

Purpose ☐ Medical Treatment ☐ Disability ☐ Insurance ☐ Legal Reasons ☐ Personal

Upcoming Appointment Date: _____ Medical Record #: _____

Name and address of Person/Institution **Releasing** Information: _____

Name and address of Person/Institution **Receiving** Information: _____

Extent of Information to be Released (including dates, provider, etc. _____

<u>Please do not disclose the following without speaking with your Supervisor:</u> ☐ **HIV-Related Information**

Release Form Valid From _____ to _____ (If blank, 365 days from date of signature)

The releasing provider listed above is hereby authorized to release information from the medical records of the above named patient. This authorization permits release of information to include information such as psychological or psychiatric impairments, drugs use and/or alcoholism, information indicating HIV related test, HIV infection, HIV related illness, AIDS or any information which could indicate potential exposure to HIV and any information related to or regarding genetic testing. I understand that Community Memorial Hospital will not condition treatment on my providing authorization for disclosure. I further understand that I do not have to allow the release of this information in part or entirety. I acknowledge that I have the right to revoke this authorization at any time by sending written notification to Community Memorial Hospital, Privacy Officer, 150 Broad Street, Hamilton, NY 13346. I understand that a revocation will not apply to information that has already been released.

I understand that the information to be released from the medical record is confidential and will not be released except to the person/institution named below. I acknowledge that any disclosure to a third party can lead to unauthorized re-disclosure by that person or others, which may not be subject to federal or state confidentiality laws.

Please select one of the following: **I would like my medical records in:**

☐ Paper Format: Please be advised that a fee of $0.75 per page may be charged for all paper medical records copied/printed

☐ Electronic Format (CD): Medical records can be provided (PDF Format) for a flat rate of $6.50.

☐ Secure Email: (Subject to a $6.50 flat fee) _____

☐ Fax number: _____

Please note: All scanned records to any external email address (e.g. gmail, yahoo, etc.) must be encrypted for security purposes. If the email address you provide is an external address, the information you receive will be encrypted. To open the email, you must follow the directions in the registration process. Electronic medical records requested (CD or Email) are only available (if the medical record is dated from 07/01/2010 to present. Records requested that are older than 10 years are subject to retention and destruction policy and procedure.)

_____ / _____ _____

Signature of Patient, Parent or Legal Guardian (Relationship) Date

_____ _____ _____

Signature of Witness Date Address of Witness

TO BE COMPLETED BY COMMUNITY MEMORIAL HOSPITAL STAFF

RELEASE

(To be completed by **Medical Records Staff ONLY**)

Validation of Requestor's Identity _____

(Please note what form of ID was presented)

Number of Pages Copied _____ Date _____

Completed by _____

REQUEST

(To be completed by **all staff**)

Request sent by _____

Date _____

Department _____

Sent via: ☐Fax ☐Mail ☐Secure Internet File

☐ Sent with Patient of Patient Representative

Number of Pages Copied _____ Date _____

Community Memorial
Quality Healthcare Close to Home
A CROUSE HEALTH PARTNER

Family Health Centers

HealtheConnections

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name _____ Date of Birth _____

Other Names Used (Maiden Name, etc.) _____

I request that health information regarding my care and treatment be accessed as set forth on this form.

I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called **HealtheConnections**. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network.

HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more, visit HealtheConnections website at http://healtheconnections.org/ .

The choice I make on this form will NOT affect my ability to get medical care. The choice I make in this form foes NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My consent choice. ONE box is checked to the left of my choice.
I can fill our this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ 1. I GIVE CONSENT for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services. (including emergency care).

☐ 2. I DENY CONSENT for the Organization named above to access ALL of my electronic health information through HealtheConnections for any purpose, even in a medical emergency.

If I want to deny consent for all Provider Organizations and Health Plans participating in **HealtheConnections** to access my electronic health information through **HealtheConnections**, I may do so by visiting **HealtheConnections** website at http://healtheconnections.org/ or calling **HealtheConnections** at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative _____ Date _____

Print Name of Legal Representative (if applicable) _____ Relationship to Patient (if applicable) _____

Community Memorial
Quality Healthcare Close to Home
A CROUSE HEALTH PARTNER

Family Health Centers

HealtheConnections

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

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Community Memorial
Quality Healthcare Close to Home
A CROUSE HEALTH PARTNER

Family Health Centers

HealtheConnections

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Details about the information accessed through HealtheConnections and the consent process:

1.How Your Information May be Used: Your electronic health information will be used only for the following healthcare services:

•Treatment Services. Provide you with medical treatment and related services.

•Insurance Eligibility Verification. Check whether you have health insurance and what it covers.

•Care Management Activities. These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.

•Quality Improvement Activities. Evaluate and improve the quality of medical care provided to you and all patients.

2.What Types of Information about You Are Included: If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through HealtheConnections. This includes information created before and after the date this form is signed. 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 include sensitive health conditions, including but not limited to:

Alcohol or drug use problems
HIV/AIDS
Birth control and abortion (family planning)
Mental Health conditions Genetic (inherited) diseases or tests
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, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3.Where Health Information About You Comes From: Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete current list is available from HealtheConnections. You can obtain an updated list at any time by checking HealtheConnections website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

4.Who May Access Information About You If You Give Consent: Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5.Public Health and Organ Procurement Organization Access: Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through HealtheConnections for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6.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 the Provider Organization directly by accessing their contact information on the HealtheConnections website at http://healtheconnections.org/; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: http://www.hhs.qovloU!J2rivacv/hipaa/complaintsl.

7.Re-disclosure of Information: Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8.Effective Period: This Consent Form will remain in effect until the day you change your consent choice or until such time as HealtheConnections ceases operation (or until 50 years after your death, whichever occurs first). If HealtheConnections merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9.Changing Your Consent Choice: You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through HealtheConnections while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. Copy of Form: You are entitled to get a copy of this Consent Form.

Community Memorial
Quality Healthcare Close to Home
A CROUSE HEALTH PARTNER

Family Health Centers
Surescripts

surescripts

Surescripts gives healthcare providers secure, electronic access to prescription information that can save their patients' lives and reduce the cost of healthcare for all.
Available during emergencies or routine care, the Surescripts network is used by authorized prescribers nationwide to exchange health information and prescribe without paper.

Surescripts safeguards personal health information.

This is done by implementing administrative, physical, and technical security safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic information that it receives, maintains, or transmits.

I, _____ , give consent to Community Memorial Hospital Family Health Centers to retrieve and use my medication history from Surescripts.

My Primary Pharmacy is: _____
My Secondary Pharmacy is: _____
My Mail Order Pharmacy is: _____

Signature: _____
Witness: _____