Center for Disability Services

Where people get better at life™

CENTER HEALTH CARE
Patient Registration

Patient # ______________

OFFICE USE ONLY
Received by__________ Date __________
Given to __________ Date __________
2nd review needed? ☐ N ☐ Y If yes, person given to for follow up on additional information needed __________ Date __________
Given to for 2nd review ________ Date __________
Approved/Rejected by ________ Date __________
Person assigned to schedule or follow up w/rejection ________ Date __________

What service are you requesting ☑:

☐ Primary Care *(ages 5 up)* ☐ Dental ☐ Psychiatry: for Developmental Disabilities/Intellectual Disabilities **only** *(ages 5 up)*
☐ Preventive Women's Health ☐ Physiatry ☐ Autism Assessment ☐ Social Work/Counseling *(ages 5 up)*
☐ Audiology ☐ Podiatry ☐ Neurology *(ages 12 up)* ☐ OT / PT (OPWDD recipients **only**) *(ages 5 up)*

Indicate your main medical concern: ______________________________

Name (First, Middle, Last)

Preferred Name

Date of Birth / /

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

Primary Address

City **State** **Zip**

E-Mail

☐ YES - Patient Portal Access Authorization

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

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

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

Primary Care Physician Name

Office Phone ( )

Office Fax # ( )

Address **City** **State** **Zip**

Primary Language
☐ English
☐ Something else, please specify:

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

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

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

Sex
☐ Male
☐ Female
☐ Undefined

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

PERSON RESPONSIBLE FOR CO-PAY & CO-INSURANCE

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

Name (First, Last)

Address

City **State** **Zip**

Home Phone ( )

Work Phone ( )

Cell Phone ( )

Date of Birth	E-Mail	Primary Spoken Language
Employer Name Employer Address		Relationship to Patient ☐ Self ☐ Child ☐ Spouse ☐ Partner

INSURANCE INFORMATION - PLEASE ATTACH A COPY OF YOUR INSURANCE CARD

☐ **MEDICARE** Medicare #_________________________________

☐ **MEDICAID** Medicaid #_________________________________

☐ **If Uninsured – Sliding Scale Requested**

OTHER INSURANCE INFORMATION

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

DENTAL INSURANCE INFORMATION

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

EMERGENCY / CAREGIVER CONTACT

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

SERVICE COORDINATOR / CARE MANAGER

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

PHARMACY INFORMATION

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

ADDITIONAL INFORMATION REQUESTED *(Required Per Federal Guidelines)*

Veteran Status	Educational Level	Agriculture Work Status
☐ Veteran ☐ Non-Veteran	☐ High School ☐ AS College ☐ BS College	☐ Non Agricultural ☐ Seasonal ☐ Migrant

Citizenship
- ☐ US Citizen by Birth
- ☐ US Citizen First Generation
- ☐ Immigrant
- ☐ Naturalized
- ☐ Permanent Resident or Alien
- ☐ Other

- ☐ Masters Degree
- ☐ Doctorate Degree
- ☐ None

Income Status
- ☐ Unknown/Refused to Provide
- ☐ Patient has income

- ☐ Employee Year - Round
- ☐ Retired Farm Worker

Family Size

What is your family size?

INCOME INFORMATION

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

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

Amount of Income $________________

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

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

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

Amount of Income $________________

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

HOUSING / LIVING ARRANGEMENT

What is your current housing status/living arrangement?

☐ Private Home/Apartment ☐ OPWDD Residence/Supportive Living ☐ Public Housing ☐ Homeless

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

____

If you are experiencing homelessness, please specify what your current situation is:

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

REFERRAL INFORMATION

Who referred you to Center Health Care?

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

____

The reason you are being referred:

FORM COMPLETED INFORMATION

Who completed the above information?

☐ Patient named on top of form

☐ Caregiver Print Name________________________________ Date ____________

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CENTER HEALTH CARE

#__________

Health History

Personal Information (Please print)

Date____/____/_____

Indicate your main medical concern ______________________________

Name______________________________ **Age**_______ **Date of Birth** ____/____/_____

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

Occupation____________________ Religion ____________________ How far did you go in school?__________

Additional Information Requested *(Required Per Federal Guidelines)*

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

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

Language of Patient: ☐ English ☐ Spanish ☐ Other

Medical History

Diagnosis ☐ Developmental Disability ☐ Traumatic Brain Injury ☐ Autism

☐ Other______________________________

List allergies to medicines ____________________ Any other allergies? ____________________

Do you smoke? YES ☐ NO ☐ How much? ______________ For how many years? _________

Do you want to stop smoking? YES ☐ NO ☐ Have you tried? YES ☐ NO ☐

Do you drink alcohol? Never ☐ Rarely ☐ Daily ☐ Socially ☐ Do you have a drinking problem? YES ☐ NO ☐

Do you want to stop? YES ☐ NO ☐ Have you tried? YES ☐ NO ☐

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

List all your Medications & Prescribing Provider's Name (including those not needing a prescription)

Previous Hospitalizations (not including normal pregnancies)

Operation or Illness	Hospital / Doctor	Year

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

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

Are you currently seeing any other providers/specialists? *Please list name and specialty.*

Check ✓ if you have ever had:

EARS		GI		Headaches		Blood Transfusion	
Hearing Impairment		Diverticulitis		Multiple Sclerosis		Breast Lump	
		Gall Bladder Disease		Neuropathy		Cervical Disorder	
ENT		Jaundice		Parkinson's Disease		Developmental Disability	
Gag Reflex Concerns		Ulcer		Seizure/Epilepsy		Diabetes (Specify type):	
Swallowing Disorder				Shunt (Cerebral)			
		GU		Strokes		Positive TB	
EYES		Kidney Disease		Traumatic Brain Injury		German Measles (Rubella)	
Cataracts		Urinary Infections		Tremors		History of Cancer (Specify):	
Glaucoma							
Vision Impairment		MUSCULAR SKELETAL		RESPIRATORY		Radiation/Chemotherapy:	
		Arthritis/Lupus		Asthma		☐ Current ☐ Past	
CARDIOVASCULAR		Fractures		Emphysema/COPD		Measles	
Valve Disorder		Gout		Hay Fever		Mumps	
Circulatory Problems		Joint Replacement (Specify):		Pneumonia		Organ Transplant (Specify):	
Elevated Cholesterol				Tracheostomy (Specify):			
Enlarged Heart				☐ Current ☐ Past		Rheumatic Fever	
Heart Attack		Osteoporosis				Sexually Transmitted Infection	
Heart Murmur				OTHER		Thyroid Disease	
High Blood Pressure		NEUROLOGICAL		ADHD		Sleep Apnea	
Low Blood Pressure		Cerebral Palsy		Autism			
		Dementia		Bladder Disorder			

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

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

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CENTER HEALTH CARE

#___________

Dental History

Please be aware that your first dental visit will consist of an evaluation by a Dentist and a full series of x-rays in order to determine an accurate treatment plan that will address your current state of dental health. Please bring a copy of any x-rays you may have had within the past year to your first visit.

Dental Information (Please print)

Date____/____/_____

Name______________________________ **Age**_____ **Date of Birth** _____/_____/_____

Date of last dental visit ________________

Name of Dental Office ____

Address of Dental Office____

Date of most recent dental cleaning and exam: ____________________ (date); X-Rays ______________ (date)

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

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

▢ Nitrous Oxide

▢ Oral Anti-anxiety Medication (Name & Dose) ________________________________

Has the patient ever required medical immobilization / protective stabilization support to facilitate dental treatment? YES ▢ NO ▢

Please check below:

▢ Papoose Board

▢ Head Stabilization

▢ Hands Held

▢ Arm restraints

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

Are there any current dental concerns? YES ▢ NO ▢

Please explain____

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

____

____

____

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CENTER HEALTH CARE

Consent to Treat & Patients' Bill of Rights

Patient Name (please print)____ **Patient ID #** ______________

Patient Date of Birth ___________________________

AUTHORIZATION FOR MEDICAL TREATMENT

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

____. To provide medical, clinical, or dental services, and perform such treatment, operations, or procedures that are necessary during the normal course of providing these services. Certain procedures may require an additional signed consent. This consent includes medical, clinical, and dental services provided through telehealth and telephonic platforms.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA/NOTICE OF PRIVACY PRACTICES

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

RELEASE OF MEDICAL INFORMATION

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

ASSIGNMENT OF BENEFITS

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

____ ________________
Signature of Patient / Responsible Party Date

Updated: 9/16/20

Patients' Bill of Rights for Diagnostic & Treatment Centers (Clinics)

As a patient of Center Health Care at the Center for Disability Services, you have the right, consistent with law, to:

(1) Receive service(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, gender identity, national origin or sponsor;

(2) Be treated with consideration, respect and dignity, including privacy in treatment;

(3) Be informed of the services available at the center;

(4) Be informed of the provisions for off-hour emergency coverage;

(5) Be informed of and receive an estimate of the charges for services, view a list of the health plans and the hospitals that the center participates with; eligibility for third-party reimbursements and when applicable, the availability of free or reduced cost care;

(6) Receive an itemized copy of his/her account statement, upon request;

(7) Obtain from his/her health care practitioner, or health care practitioner's delegate, complete and current information concerning his/her diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand;

(8) Receive from his/her physician information necessary to give informed consents prior to the start of any nonemergency procedure or treatment or both. An informed consent shall include, as a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision;

(9) Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action;

(10) Refuse to participate in experimental research;

(11) Voice grievances and recommend changes in policies and services to the center staff, the operator, and the New York State Department of Health without fear of reprisal;

(12) Express complaints about care and services provided and to have the center investigate such complaints. The center is responsible for providing the patient and/or his/her designee with a written response within 30 days if requested by the patient indicating the findings of the investigation. The center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the center response, the patient may make a complaint to the New York State Department of Health's Office of Health;

(13) Privacy and confidentiality of all information and records pertaining to the patient's treatment;

(14) Approve or refuse the release of disclosure of the contents of his/her medical record to any health-care practitioner and/or health-care facility except required by law or third party payment contract;

(15) Access to his/her medical record per Section 18 of the Public Health Law and Subpart 50-3. For additional information link to: https://www.health.ny.gov/publications/1449/section_1.htm#access;

(16) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors;

(17) When applicable, make known your wishes in regard to anatomical gifts. Persons sixteen years of age or older may document their consent to donate their organs, eyes and/or tissues, upon their death, by enrolling in the NYS Donate Life Registry or by documenting their authorization for organ and/or tissue donation in writing in a number of ways (such as health care proxy, will, donor card, or other signed paper). The health care proxy is available from the center;

(18) View a list of the health plans and the hospitals that the center participates with; and

(19) Receive an estimate of the amount that you will be billed after services are rendered.

______________________________________ _______________

Signature of Patient / Responsible Party Date

Patients' Rights, 10NYCRR, Section 751.9

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

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

Print Patient Name and Address here

Patient Name:______________________ Phone: ( )__________
Former/Maiden Name:______________________ DOB:____/____/____
Address:____
Street City State Zip

Name of Agency Sending Records to us

I,______________________ hereby authorize ______________________
Address:____
Street City State Zip
to disclose Protected Health Information (PHI) to:

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

Indicate specific information is to be disclosed here

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

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

The PHI is being disclosed for the following purposes:

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

Sign and date here

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

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

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CENTER HEALTH CARE

Hixny *Electronic Data Access Consent Form*

ONLY for Primary Care, Behavioral Health, or Neurology

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

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

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

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

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

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

You have two choices.

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

I AM ENROLLING IN THE FOLLOWING SERVICE(S):

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

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

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

Print Name of Patient	Date of Birth	Date

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

Revised: 4/9/2019

Health Care Proxy

(1) I, ____________________

hereby appoint ____________________
(name, home address and telephone number)

____

____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint ____________________
(name, home address and telephone number)

____

____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (*Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions):*

____

____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary):*

____

____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)*, your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

Health Care Proxy

(1) I, ______________________________

hereby appoint ______________________________

(name, home address and telephone number)

____

____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint ______________________________

(name, home address and telephone number)

____

____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (*Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions):*

____

____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary):*

____

____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)*, your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.