Dear Patient,

Welcome to CapitalCare Family Practice Niskayuna. Thank you for choosing us as your healthcare provider and Medical Home. We’d like this office to be the first place you think of for all your medical needs. Our team is dedicated to the health and wellness of our patients.

Please complete the following and mail back to us prior to your appointment:

- Patient Registration Form
- Notice of Privacy Practices
- Permission to Share Form
- HIXNY Form
- No Show Policy
- Medical Record Release of Information
- Specialty Office Form
- FollowMyHealth Portal Form
- Medication List
- Patient Health Questionnaire (PHQ9)

The Authorization for Release of Health Information form needs to be completed by you and sent to your previous primary care physician for us to obtain your medical records.

We ask that you bring your insurance card and photo ID to your appointment. We need to enter this information in our system in order to see you. If you are unable to keep this appointment, please cancel at least 24 hours in advance. Failure to arrive for your appointment can result in a $50 fee and we will not re-book at our office.

We look forward to seeing you here at CapitalCare Family Practice Niskayuna. Thank you for giving us the opportunity to serve you.

Sincerely,
CapitalCare Family Practice Niskayuna
Date: ____________________  Patient ID#: ___________________

PATIENT INFORMATION

Social Security Number ________/_____/________ (Providing your SSN is optional. However, for patients with Medicare and/or Medicaid having this information may help us determine eligibility for certain health benefits).

LAST NAME: _____________________________  FIRST NAME: ________________________  MI: _______

E-mail Address: __________________________

Street Address: ________________________________________________________________________________

City: __________________________  State: ________  Zip: _________  Home Phone #: (  ) ______________

Work #: (  ) _____________  Cell #: (  ) ______________  Preferred daytime phone: ☐Home ☐Work ☐Cell

Date of Birth: _____/_____/_______  Marital Status: ☐Single  ☐Married  ☐Widowed  ☐Divorced

Gender: ☐Male  ☐Female

It is known that some medical conditions such as high blood pressure and osteoporosis, tend to have a higher incidence in certain ethnic groups. Therefore we ask that you please provide us with information regarding your race and ethnicity so we can assess if you are at increased risk for the development of these conditions.

Race:  Select one
☐ American Indian/Alaska Native
☐ Asian
☐ Native Hawaiian or other Pacific Islander
☐ Black/African American
☐ White
☐ Other

Ethnicity: Select One
☐ Hispanic/Latino
☐ Not Hispanic/Latino

Preferred Language: __________________________

Emergency Contact: _____________________________  Relationship to Patient: ______________________

Emergency Phone #1: (  ) _____________________________  Phone #2: (  ) _____________________________

Primary Care Physician: ____________________________  Referring Physician: ____________________________

(in our Practice)

In addition to telephone, which other methods of communication are acceptable? Please check all that apply
☐ E-Mail (when available)  ☐Confidential Fax ____________________________  ☐Office may leave a message at home

Revised: 10/2018
MEDICAL INSURANCE INFORMATION
(The subscriber is the same person as the policy holder)

Primary Insurance: ___________________________ Subscriber’s Name: ___________________________
Subscriber’s Date of Birth: ___/___/___ Relationship to Subscriber: □Self □Spouse □Child □Other _________
Co-pay: $_____________ Policy ID #: ___________________________________ Group #: _________________

Secondary Insurance: ___________________________ Subscriber’s Name: ___________________________
Subscriber’s Date of Birth: ___/___/___ Relationship to Subscriber: □Self □Spouse □Child □Other _________
Co-pay: $_____________ Policy ID #: ___________________________________ Group #: _________________

INSURANCE COVERAGE WAIVER
I understand that my eligibility for coverage by the insurance named in the MEDICAL INSURANCE
INFORMATION section of this document may not be confirmed at this time. I wish to receive medical services
from Community Care Physicians, P.C. If it is determined that I am not eligible for coverage, I understand that I
will be responsible for payment of all services provided.

ASSIGNMENT OF INSURANCE BENEFITS / RELEASE OF MEDICAL INFORMATION
I hereby assign to Community Care Physicians, P.C. (CCP) any insurance or other third-party benefits available for
health care services provided to me. If these benefits are not assigned to CCP, I agree to forward to CCP all health
insurance and other third-party payments that I receive for services rendered to me immediately upon receipt of
such payments.

I authorize Community Care Physicians, P.C. (CCP) to release the minimum necessary medical or other
information to persons employed or retained by or affiliated with CCP for purposes of my diagnosis and treatment
or that may be required in order to process insurance payment. I agree that these provisions will remain in effect
until I provide written notice to CCP that this authorization has been changed or discontinued.

____________________________________________________  _____ / ____/________
Signature of Patient / Guardian            Date
Date: ___________________  Patient ID#: ___________________

PATIENT INFORMATION

Social Security Number ________/_____/________ (Providing your SSN is optional. However, for patients with Medicare and/or Medicaid having this information may help us determine eligibility for certain health benefits).

LAST NAME: ___________________________  FIRST NAME: ________________________  MI: _______

E-mail Address: ____________________________

Street Address: ________________________________________________________________________________

City: ____________________________  State: __________  Zip: ______  Home Phone #: (      ) ______________

Work #: (      ) _______________  Cell #: (      ) _______________  Preferred daytime phone: □ Home □ Work □ Cell

Date of Birth: ______/_____/_______  Marital Status: □ Single □ Married □ Widowed □ Divorced

Gender: □ Male □ Female

It is known that some medical conditions such as high blood pressure and osteoporosis, tend to have a higher incidence in certain ethnic groups. Therefore we ask that you please provide us with information regarding your race and ethnicity so we can assess if you are at increased risk for the development of these conditions.

Race:  Select one

□ American Indian/Alaska Native  □ Asian
□ Native Hawaiian or other Pacific Islander  □ Hispanic/Latino
□ Black/African American  □ White
□ Other

Ethnicity:  Select One

□ American Indian/Alaska Native  □ Asian
□ Native Hawaiian or other Pacific Islander  □ Hispanic/Latino
□ Black/African American  □ White
□ Other

Preferred Language: ______________________________

Emergency Contact: (Other than parents) __________________________ Relationship to Patient: _____________

Emergency Phone #1: (        )____________________________     Phone #2: (         )  ___________________

Mother’s maiden*  ____________________________________  Primary Care Physician: __________________

First                      Maiden                     Last  (in our Practice)

In addition to telephone, which other methods of communication are acceptable? Please check all that apply

□ E-Mail (when available)  □ Confidential Fax ____________________  □ Office may leave a message at home

FINANCIALLY RESPONSIBLE PARTY

In accordance with Community Care Physicians' Financial Policy, this is defined as the adult accompanying a child under the age of 18, and/or the parent or guardian of the child. This is the person who will receive bills and correspondence. Co-pays are due and expected at time of service.

Financially Responsible Parent/Guardian’s  Last Name: ___________________________  First: _____________

Relationship to Patient: □ Mother □ Father □ Other _____________

Address: □ Same as Above ___________________________  City/State/Zip: __________________________

Home Phone #: (      ) _______________  Work Phone#: (      ) _______________  Cell Phone#: (      ) _______________

Date of Birth ___________________________

Other Parent/Guardian’s  Last Name: ___________________________________  First: ___________________

Relationship to Patient: □ Mother □ Father □ Other ______________________

Address: □ Same as Above ___________________________  City/State/Zip: __________________________

Home Phone #: (      ) _______________  Work Phone#: (      ) _______________  Cell Phone#: (      ) _______________

Date of Birth ___________________________

*Required for NYS Immunization Registry
MEDICAL INSURANCE INFORMATION
(The subscriber is the same person as the policy holder)

Primary Insurance: ___________________________ Subscriber’s Name: ___________________________
Subscriber’s Date of Birth: ___/___/___ Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other _________
Co-pay: $__________ Policy ID #:___________________________________ Group #:  _________________

Secondary Insurance: ___________________________ Subscriber’s Name: ___________________________
Subscriber’s Date of Birth: ___/___/___ Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other _________
Co-pay: $__________ Policy ID #:___________________________________ Group #:  _________________

INSURANCE COVERAGE WAIVER

I understand that my eligibility for coverage by the insurance named in the MEDICAL INSURANCE INFORMATION section of this document may not be confirmed at this time. I wish to receive medical services from Community Care Physicians, P.C. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

ASSIGNMENT OF INSURANCE BENEFITS / RELEASE OF MEDICAL INFORMATION

I hereby assign to Community Care Physicians, P.C. (CCP) any insurance or other third-party benefits available for health care services provided to me. If these benefits are not assigned to CCP, I agree to forward to CCP all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt of such payments.

I authorize Community Care Physicians, P.C. (CCP) to release the minimum necessary medical or other information to persons employed or retained by or affiliated with CCP for purposes of my diagnosis and treatment or that may be required in order to process insurance payment. I agree that these provisions will remain in effect until I provide written notice to CCP that this authorization has been changed or discontinued.

____________________________________________________  ______ /______/________
Signature of Patient / Guardian  Date
NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is committed to the privacy of your individually identifiable health information (IIHI). In conducting our business, we will collect, use, and disclose your IIHI to others who may provide you with health-related benefits or services that we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this Notice of our legal duties and privacy practices that we maintain in our practice concerning your IIHI. By binding and stated that we will follow the policies and practices described in this notice, we will be bound. Any changes to those policies and practices will be reflected in this notice.

B. YOU HAVE THE RIGHT TO REVIEW AND REQUEST AMENDMENTS TO THIS NOTICE

You have the right to request a revision or amendment of this notice. We must provide you with a revised notice in a timely manner. We may change our notice at any time, and new notices of any changes will be posted in our offices and on our website. You may request a copy of a most recent Notice at any time.

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING CIRCUMSTANCES

The following categories describe the different ways in which we may use and disclose your IIHI. The uses and disclosures that are not identified by this notice or that are made for reasons not noted in this notice are prohibited by law.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may use your IIHI in order to provide you with health care and related services, to include payment for such services. We may use your IIHI in the course of providing services to you, our doctors and nurses may use or disclose your IIHI in order to treat you or to assist those in your care, or we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment. Our practice may use and disclose your IIHI in order to help the practice collect money owed to the practice. For example, we may use your IIHI to bill a third party (such as an HMO or insurer) for the services you received from the practice or to bill the government for services you received from the practice. We may also use and disclose your IIHI to obtain payment from you for health care services that you do not have to pay for, such as through your health insurance plan.

3. Health Care Operations. Our practice may use and disclose your IIHI for health care operations purposes. For example, your IIHI may be used in the course of the collection and analysis of data to review the quality of health care services provided, or to conduct business operations. When we use and disclose your IIHI for purposes other than treatment, payment and health care operations and pertains to a health care item or service for which you have been paid in full by you or your health plan, we are required to request your authorization before we can disclose your IIHI, except where we are required by law to report to you your most current Notice at any time.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique circumstances in which we may use and disclose your identifiable health information:

1. Public Health. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for public health purposes.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include quality oversight activities, audit functions, investigations, inspections, audits, reviews, licensure, and disciplinary actions; civil, criminal, or administrative proceedings; and functions related to the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in order to prepare a report or evaluation for a lawsuit or similar proceeding. We may also disclose your IIHI in response to a lawsuit or similar proceeding. We also may disclose your IIHI in response to a request for information from a government agency or person authorized to obtain information for medical or law enforcement purposes.

4. Right to a Paper Copy of This Notice. If you are entitled to receive a paper copy of this notice, we may not distribute a revised notice to you in a timely manner. When asked to give you a copy of this notice at any time. To obtain a copy of this notice, contact Michael O'Connor, Esq. at (518) 782-3767.

5. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Michael O'Connor, Esq. at (518) 782-3767. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

6. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that we are not identified by this notice that are not permitted by applicable law. Types of uses and disclosures requiring authorization include, but are not limited to, marketing, the sale of your IIHI, and the use or disclosure of your psychotherapy notes (with limited exceptions to include certain treatment, payment, or healthcare operations) or use or disclosure of your IIHI for research purposes.

7. Right to高标准的Chinese (zh-Hans)

This notice is in English, and the translation is not a substitute for the English notice. If you have questions about the translation or you need a translation of this notice in another language, please contact Michael O'Connor, Esq. at (518) 782-3767.
I, ____________________________, have received a copy of Community Care Physicians, P.C.’s Notice of Privacy Practices.

_____________________________  ____________________________  ________________
Signature of Patient or Guardian  Date of Birth                  Date

_____________________________
Witness

__________________________
Date
Permission to share protected health information
for coordination of care

CapitalCare, a division of Community Care Physicians, P.C., using our best judgement, may disclose health-related information to a relative, close friend or any other person you identify as being involved in your care. Please provide us with the names of those individuals who are involved with your care, with whom we may share your protected health information to coordinate your care.

(In the event that you are a parent or legal guardian of a child treated by CapitalCare, please provide us with the names of those individuals who are involved with the child’s care, with whom we may share your protected health information to coordinate the child’s care)

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<th>Name of individual</th>
<th>Relationship</th>
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I understand that if I wish to revoke permission to release protected health information to any and all of these individuals, it will be my obligation to notify CapitalCare of this decision.

Patient’s name (print): ____________________________  DOB ____________

Signature of patient/parent/legal guardian: ____________________________

If other than the patient, please indicate relationship/authority: ____________________________

Date: _______________  Expiration date: _______________
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, Inc., doing business as Hixny (“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’ 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 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)
Details about patient information in Hixny and the consent process:

1. **How Your Information Will be Used.** Your electronic health information will be used by Community Care Physicians only to:

- Provide you with medical treatment and related services
- Check whether you have health insurance and what it covers
- Evaluate and improve the quality of medical care provided to all patients.

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

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

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

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

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

5. **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 Community Care Physicians at: (518) 452-1337; or call Hixny at (518) 783-0518; or call the NYS Department of Health at (877) 690-2211.

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

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

8. **Withdrawing Your Consent.** You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Community Care Physicians. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 783-0518. **Note:** Organizations that access your health information through Hixny while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

9. **Copy of Form.** You are entitled to get a copy of this Consent Form after you sign it.
CO-PAY/NO SHOW POLICY

_________________________  ____________________________
NAME                        DATE OF BIRTH

I acknowledge that I have been informed of and understand that if I do not pay the co-payment at the time of service I will be charged an additional fee of $15.00.

I acknowledge that I have been informed of and understand the no show policies for CapitalCare Family Practice Niskayuna, a division of Community Care Physicians, P.C, and I will be charged a fee of $50.00.

_________________________  ____________________________
SIGNATURE                  DATE ___/___/___
**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA**

[This form has been approved by the New York State Department of Health]

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
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I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. 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 in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9(b).**

7. Name and address of health provider or entity to release this information:

**CapitalCare Family Practice Niskayuna: 976 Balltown Rd, Niskayuna NY T: 518-393-0391 F: 518-372-3281**

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- Medical Record from (insert date) ____________ to (insert date) ____________
- Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consents, billing records, insurance records, and records sent to you by other health care providers.
- Other: ______________________________________________________________________

Include: (Indicate by Initialing)

- Alcohol/Drug Treatment
- Mental Health Information
- HIV-Related Information

Authorization to Discuss Health Information:

(b) [ ] By initialing here ____________ I authorize ____________

Initials ____________ Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:

______________ (Attorney/Firm Name or Governmental Agency Name)

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<th>10. Reason for release of information:</th>
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<td>[ ] At request of individual</td>
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<td>[ ] Other:</td>
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<th>11. Date or event on which this authorization will expire:</th>
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<th>12. If not the patient, name of person signing form:</th>
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<th>13. Authority to sign on behalf of patient:</th>
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All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of patient or representative authorized by law.

Date: ____________________________

---

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.
Specialty Offices

PLEASE LIST ANY SPECIALISTS THAT YOU SEE:

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<tr>
<th>SPECIALITY</th>
<th>NAME OF OFFICE</th>
<th>NAME OF DOCTOR</th>
<th>PHONE NUMBER</th>
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FollowMyHealth Adult Patient Portal Proxy Consent

This form must be filled out entirely and signed and dated

Patient’s Full Name: ____________________________________                    Date of Birth: ____/ ____/ ____

I hereby authorize Community Care Physicians to allow the following individuals to access all information in my Community Care Physicians FollowMyHealth Patient Portal Account for the purpose of assisting with coordination of my medical care.

<table>
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<tr>
<th>Name of Proxy</th>
<th>Email</th>
<th>Relationship to Patient</th>
<th>Proxy address</th>
<th>City</th>
<th>State/Zip</th>
<th>Phone</th>
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</table>

1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
2. I understand that Community Care Physicians will not condition treatment on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.
3. I understand that I may revoke this authorization in writing at any time by sending such written revocation to Community Care Physicians. I also understand that such revocation will not be effective as to the disclosure of information whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
4. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

EXPIRATION EVENT: This authorization will expire upon revocation by me.

COPY PROVIDED: Community Care Physicians shall provide a copy of this signed authorization to you upon your request.

New York state law requires an individual or the individual’s authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions.
By signing this form, I authorize release of the following medical information that may be held by Community Care Physicians: information pertaining to HIV disease, records of mental health care and treatment, records of care and treatment for sexually transmitted diseases and records of substance abuse care and treatment.

___/___/___   _______________________________________  ___________________________________
Date             Signature of individual patient or representative     If not the patient, what is your authority or relationship to the patient? If legal guardian, documentation of guardianship is required for release of records.

FOR OFFICE USE:

MRN: _____________________
Please fill out this form (or have your caregiver complete it) and discuss it with your medical provider. Thank you!

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Phone</td>
<td>Cell Phone</td>
</tr>
<tr>
<td>Address</td>
<td>City</td>
</tr>
<tr>
<td>Email Address</td>
<td>Relationship</td>
</tr>
<tr>
<td>Emergency Contact</td>
<td>Address/City</td>
</tr>
<tr>
<td>Mail Order Pharmacy</td>
<td></td>
</tr>
</tbody>
</table>

**Race:** American Indian or Alaska Native | Asian or Pacific Islander | Black | Hispanic | White | Declined | Unknown

**Ethnicity:** Hispanic | Non-Hispanic | Declined | Unknown | Preferred Language:

**Allergies**

<table>
<thead>
<tr>
<th>Name of Substance (drug or food)</th>
<th>Type of Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Check if none</td>
<td></td>
</tr>
<tr>
<td>☐ Check if none</td>
<td></td>
</tr>
<tr>
<td>☐ Check if none</td>
<td></td>
</tr>
<tr>
<td>☐ Check if none</td>
<td></td>
</tr>
</tbody>
</table>

**Current Medications**

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th>Strength</th>
<th>Directions</th>
<th>Prescribed by</th>
</tr>
</thead>
<tbody>
<tr>
<td>(such as Lipitor, eye drops, creams)</td>
<td>(such as 50 mg)</td>
<td>(such as 2 tablets in the am)</td>
<td>(such as John Doe, MD)</td>
</tr>
<tr>
<td>☐ Check if none</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>☐ Check if none</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>☐ Check if none</td>
<td>☐</td>
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<tr>
<td>☐ Check if none</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>☐ Check if none</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Over-the-Counter Medications** (such as Aspirin)

<table>
<thead>
<tr>
<th>Strength</th>
<th>Directions</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Check if none</td>
<td></td>
</tr>
</tbody>
</table>

**Herbs, Vitamins, Minerals, Etc.** (such as St. John’s Wort)

<table>
<thead>
<tr>
<th>Strength</th>
<th>Directions</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Check if none</td>
<td></td>
</tr>
</tbody>
</table>
Part of routine screening for your health includes reviewing mood and emotional concerns. **During the past two weeks, have you been bothered by any of the following problems?**

- Little interest or pleasure in doing things □ YES □ NO
- Feeling down, depressed, or hopeless □ YES □ NO

If you answered “Yes” to either question above, please answer all questions below. **During the past two weeks, how often have you been bothered by any of the following problems?**

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Poor appetite, weight loss, or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself – or feeling that you are a failure, or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, like reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

□ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult

For office use only: Total Score _____