IN HEALTH FAMILY MEDICINE

NEW PATIENT REGISTRATION

NAME:			Date of Birth:	
ADDRESS:			GENDER: M / F	AGE:
SS #:	HOME #:		CELL #:	
IS IT OKAY TO LEAVE A MESSAGE WITH THE NUMBERS PROVIDED? (please circle yes or no for each.)		HOME: YES/NO	CELL: YES/NO	
EMAIL ADDRESS:				
EMPLOYER:			PHONE #:	

FAMILY MEMBERS SEEN HERE:

INSURANCE INFORMATION			
PRIMARY INSURNCE:			
SUBSCRIBER:	DOB:	ADDRESS:	
PHONE #:	PATIENTS RELATIONSHIP TO SUBSCRIBER:		
POLICY #:	GROUP #:		CO PAYMENT:

SECONDARY INSURNCE:			
SUBSCRIBER:	DOB:	ADDRESS:	
PHONE #:	PATIENTS RELATIONSHIP TO SUBSCRIBER:		
POLICY #:	GROUP #:		CO PAYMENT:

EMERGENCY CONTACT/ PERMISSION TO SPEAK WITH		
NAME:	RELATIONSHIP:	NUMBER:
NAME:	RELATIONSHIP:	NUMBER:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize In Health Family Medicine to release any information required to process my claims.

Patient Signature:	Date:

IMMUNIZATION					
Chickenpox or Shot		Yes		No	Date:
Hep B series		Yes		No	Date:
Influenza Shot		Yes		No	Date:
Pneumonia Shot		Yes		No	Date:
Rubella Shot or Blood Test		Yes		No	Date:
Tetanus Shot		Yes		No	Date:

FAMILY HISTORY (please note if maternal or paternal relative)s			
	AGE	IF DECEASED, AGE & CAUSE	MEDICAL ISSUES
Father:			
Mother:			
Brother/Sister			
Children:			

PLEASE CHECK FOR ANY CONDITION WHICH APPLIES TO A BLOOD RELATIVE					
	CONDITION	WHO:		CONDITION	WHO
	Alcohol/Drug abuse			High Cholesterol	
	Allergy Asthma			HIV/AIDS	
	Arthritis			Kidney Disease	
	Bleeding Disorder			Mental Illness	
	Cancer			Migraine Headaches	
	Diabetes			Sickle Cell Condition	
	Epilepsy/Seizures			Stroke	
	Glaucoma			Suicide/ Depression	
	Heart Disease			Thyroid Disease	
	High Blood Pressure			Other	

SOCIAL HISTORY	
Current Status	
Whom do you reside with?	
Highest Education achieved?	
Occupation	

PERSONAL HISTORY

Questions for Woman:

Age periods Began		How often:		Date of last period:	

Currently Pregnant?		Yes		No
Vaginal Discharge?		Yes		No
PMS?		Yes		No
Menopause?		Yes		No
Unexplained Vaginal Bleeding?		Yes		No
Discharge from Nipples?		Yes		No
Skin Changes in Breasts?		Yes		No

Pregnancies: (woman Only)			
Total # of Pregnancies		Full Term:	
Date of last Pap smear			
Miscarries			
Abortions			
Premature Births			
Tubal			
Date of Last Mammogram			

MEN ONLY				
Prostate Trouble		Yes		No
Discharge from Penis		Yes		No
Sore on Penis		Yes		No
Do you examine you testicles		Yes		No

Men and Woman									
What kind of Birth control/Protection do you and your partner use?									
What is your sexual orientation?									
Do you use sunscreen		Yes		No	Do you floss regularly?		Yes		No
Do you wear a seatbelt		Yes		No	Do you where dentures?		Yes		No
Any guns/weapons in your home?		Yes		No	Do you where glasses?		Yes		No
When was you last dental visit?					When was your last eye exam				
Have you had a colonoscopy?					If so when was your last?				

Diet, Exercise & Habits					
Do you follow a specific Diet?		If yes, Please explain			
What kind of exercise do you do and how often?					
Current weight?		Desired?		One year ago?	

Tobacco & Alcohol Use					
Do you Smoke?		What type?		How long and often	
Have your tried quitting?		When?			
Do you drink Alcohol?		How many per week			
Is anyone concerned about your drinking?					

Allergies	
Do you have any allergies?	
If yes, please list any allergies to medications or other substances	

Surgery/Hospitalization

Date	*Reason*

Medical Concerns

List all current medical concerns

Medications

Medication	Dose
What is your preferred Pharmacy?	

CHECK ANY THAT YOU HAVE HAD OR NOW HAVE

Past	Present		Past	Present	
		Abnormal Electrocardiogram			Gallstones
		Abnormal Pap			Glaucoma
		AID/HIV			STD
		Alcohol or Drug Abuse			Skin Growth
		Allergies or Hay Fever			Hearing problems
		Anemia (Low Iron)			Heart Attack
		Ankles Swell Frequently			Heart Murmur
		Anxiety or Panic Attacks			Hepatitis or Cirrhosis
		Arthritis or Gout			Herniated or Ruptured Disc
		Asthma			High Blood Pressure
		Frequent Backaches			Hodgkin's Disease, Lymphoma, leukemia
		Bladder Infection			Intolerance to Dairy or Fats
		Blood Clots or Bleeding prob.			Irregular Heartbeat
		Blood in bowel movement			Irritable Bowel Syndrome
		Blood transfusion			Kidney Disease
		Boils or Cysts			Lung Problem
		Bone or Joint Disease			Lupus
		Bowel or Colon Disease			Malaria
		Breast Lumps			Seizures, convulsions, Epilepsy
		Bronchitis (recurrent)			Meningitis
		Bruise easily			Migraines
		Bursitis or Tendonitis			Muscle Disease or Weakness
		Cancer			Pancreatitis
		Chest Pain			Phlebitis
		Chills or Night sweats			Pleurisy
		Cholesterol			Pneumonia
		Chronic Cough			Polio
		Colitis			Sickle Cell Disease
		Color-Blindness			Skin Disease
		Concussion			Stomach Pain
		Constipation			Swelling in the Joints
		Depression or Suicide			Thyroid Disease
		Diabetes			Tremors or Shaking
		Difficulty Swallowing			Tuberculosis
		Dizziness			Ulcer Disease
		Emphysema			Unexpected Weight loss
		Excessive Stress			Urinate frequently at night
		Frequent Cold or Sinus Issues			Varicose Veins
		Frequent Earaches			Venereal Disease
		Frequent or painful urination			Wheezy or Whistling Chest
		Frequent sore throats			Yellow Jaundice
		Severe nose bleeds			Gallbladder disease

IN HEALTH FAMILY MEDICINE
FINANCIAL/ ATTENDANCE POLICIES

INSURANCE:
You are responsible for providing current proof of medical insurance, and an insurance card must be presented at the time of your visit in order to be seen. Incorrect information will result in nonpayment to IN HEALTH FAMILY MEDCINE, and you will be considered a "self-pay" patient. If your insurance has not paid after 45 days from the date of service, it is your responsibility to contact your insurance and notify us of the problem After 60 days of non-payment, the balance will be transferred to you for payment in full. Any balance over90 days will be considered non-payment, and a 30 day demand for payment in full letter will be issues. At that point requests for appointments and prescription refills will not be honored, and your account will be assigned to a collection agency. You be responsible for any fees charged by the collection agency.

Co-payments and Deductibles:
Co-payments listed on the front of your insurance card will be collection upon CHECK-IN, prior to seeing the doctor. If you have a balance from your previous visits, that amount is also due upon CHECK-IN. If circumstances prevent you from paying a balance over 60 days, we reserve the right to reschedule your appointment. In reference to deductibles: Until you meet your annual deductible, the insurance company will not pay us and payment is due from you upon receipt of our deducible notice. We accept Cash, Check, and Credit Card payments.

Missed Appointments:
Failure to keep a scheduled appointment without 24 business hours' notice of cancellation denies access to other patients wishing to be seen and will result in a $50.00 no show/cancellation fee. Courtesy reminder calls are not guaranteed and are not valid excuses to miss appointments. We recognize many inconveniences come up unexpectedly, but please do your best to keep your scheduled appointments. After 2 no call/no show appointments, you may be discharged from In Health Family Medicine.

Prescription Refills:
We require 72 BUSINESS hours to process a refill request. In the event you are unable to provide In Health Family Medicine 72 hours' notice to fill a script, you will be subject to a $10.00 emergency refill fee. There are no exceptions. Please plan accordingly.

Attendance:
In Health Family medicine requires all patients to have yearly annuals and be followed up regularly. Any patient on medications are required to be seen every 3-6 months depending on the medication. Any patient who refuses to comply with this policy may be discharged for Noncompliance.

______________________________ ____________________

Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to advise you of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. A copy will be provided upon request.

I acknowledge that I have been made aware of this office's Notice of Privacy Practices.I may refuse to sign this acknowledgement, if I wish.

____

Patient's name *Patient's Date of Birth*

____

Please print your name here(if different from above)Relationship to Patient

____

Signature

____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- ☐ Patient account number ______________________________
- ☐ The patient refused to sign.
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

____

____

____

____________________________________ ________________

Employee signature *Date*

In Health Family Medicine

96 COURT STREET
PLATTSBURGH NY, 12901

Patient Financial Responsibility & Authorization Form

Thank you for choosing in Health Family Medicine for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge you understand of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of treatment and care
- We will bill your insurance for you, However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plans.
- **Copays are due at the time of service**.
- Coinsurance, deductibles and non-covered items are due 30 days from the receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include: charge for returned checks- $30.00

By my signature below, I hereby authorize assignment of financial benefits directly to in Health Family Medicine and any associated health care entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Acknowledgeable and Authorization

- We respect patient confidentiality and only release personal health information about you in accordance with the state and federal law. The attached notice describes our policies related to the use of the records of your care and how you may get access to this information. Please review this policy carefully.

By my signature below, I acknowledge that I have received and read the privacy policy provided by In Health Family Medicine. I hereby authorize In Health Family Medicine and the physicians, staff, and hospitals associated with In Health Family Medicine to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.

Patient Name:_________________________________ (Print)

Patient/Guardian Signature:____

Date__________________________________

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Immunization

Consent For Participation in NYSIIS for Individuals 19 Years of Age or Older

The New York State Immunization Information System (NYSIIS) is a confidential, computerized system that contains immunization records and allows authorized users access to a person's shot record. Strict federal and state laws protect the privacy of your personal information in the system. The benefits of participating in NYSIIS include:

- Your health care provider can use NYSIIS to be sure that you receive the needed immunizations, and proper medical treatment is received when needed.
- There will be a permanent and easily accessible record of your immunizations.

Participation in NYSIIS for people 19 years of age and older is voluntary, so your consent is needed. If you want to participate, please carefully read the consent below and sign in the space provided. For additional information about this consent, please call (518) 473-2839.

I give my consent for __________________________ (name of doctor or organization) to release my immunization(s) and identifying information to the New York State Immunization Information System (NYSIIS). I understand the purpose of NYSIIS is to assist in my medical care and to record the immunizations that I have had or will receive in the future. My immunization information may potentially be used by the Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes. Information used for quality improvement or any research purposes will have my personal identifying information removed.

The immunization information in NYSIIS may be released to the following: myself, my health insurance plan, the state and local health departments, the school that I am registered to attend, and authorized medical providers that deliver my medical care.

I understand that there will be no effect on my treatment, payment, or enrollment for benefits if I choose not to enroll in NYSIIS. This consent may be withdrawn at any time by using the form provided. Information about immunizations received by NYSIIS with my consent will remain in NYSIIS if I later choose to withdraw my consent. However, future immunizations will not be recorded in NYSIIS.

____
Print Name

____
Date of Birth

____
Signature

____
Date

Hixny Electronic Data Access Consent Form
In Health Family Medicine, PC

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

You may use this Consent Form to decide whether or not to allow In Health Family Medicine, PC 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, In Health Family Medicine, PC'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, In Health Family Medicine, PC 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.

Please carefully read the information on both pages of this form before making your decision.
You have two choices:

- ☐ **I GIVE CONSENT for In Health Family Medicine, PC to access ALL of** my medical records through Hixny in connection with providing me any health care services, including emergency care.

- ☐ **I DENY CONSENT for In Health Family Medicine, PC to access** my medical records through Hixny for any purpose, *even in a medical emergency.* Unless you check this box, New York State law allows medical providers 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)

____
Relationship of Legal Representative to Patient (if applicable)