Syracuse Community Health Center

Main Clinic/Corporate Office
819 South Salina Street
Syracuse, NY 13202 (315) 476-7921

East Office
1938 E. Fayette Street

West Office
603 Oswego Street

PATIENT REGISTRATION/REGISTRO DE PACIENTES-English

TODAY'S DATE/FECHA DE HOY: _____/_____/_____ **DATE OF BIRTH/ FECHA DE NACIMIENTO:** _____/_____/_____

Last Name/ Apellido: _____ **First Name/Primer Nombre:** _____

Middle Name/ Segundo Nombre:_____ **SSN Number** ---------- _____

Address/Dirección: _____**APT**: _____

City/ Ciudad:_____**State/Estado:** _____**Zip code/Código Postal** : _____

Cell phone #/Número de Teléfono Celular: _____**Home phone #/ Número del Teléfono de Casa:** _____

E-Mail/ Correo electrónico: _____**@**_____

Marital Status/Estado Civil: ☐ Single/Soltero (a) ☐ Married/Casado (a) ☐ Partner/Unión Libre
☐Divorce/Divorciado (a) ☐ Widowed/Viudo (a) ☐ Other _____

Gender Identity/Genero de Identidad:
☐ Female/Femenino ☐Male/Masculino ☐Transgender (Male->Female)/Transgenero (Masculino>Femenino)
☐Transgender (Female->Male)/Transgenero (Femenino>Masculino) ☐Others/Otros

Sexual Orientation/Cuál es su oración sexual:
☐Straight/Heterosexual ☐Gay/Lesbian/Gay/ Lesbiana ☐Bisexual/Bisexual ☐Others/Otros ☐Undecided (Don'tKnow)/Indeciso

Do you need a Translator/Necesita un traductor? ☐ Yes/Si ☐ No/No

What is your preferred language/Cuál es su lenguaje preferido? ☐ English/Ingles ☐Spanish/Español ☐Other/Otro _____

Emergency contact (other than your phone number listed above)/Contacto de Emergencia (Otro Número de teléfono que es diferente al que usted ha mencionado anteriormente)
Name/ Nombre: _____**Relationship/Relacion:** _____**Phone** ---------- _____

Preferred Pharmacy/ Farmacia Preferida

☐Walgreens ☐ Wegmans ☐Wal-Mart ☐Westside ☐SCHC ☐Other/ Otro _____

Pharmacy Phone/ Número de Teléfono de la farmacia: _____ Pharmacy Zip Code/Código Postal de la Farmacia: _____

Insurance Information/ Información de su Seguro Medico

☐ None/Ninguna ☐ Medicaid ☐ Medicare ☐ CHIP ☐ Private insurance/Seguro Privado ☐ Market place ☐ Other _____

Insurance Name/Nombre del Seguro de Salud	Member ID #/Numero de miembro:	Group Number/ Numero de grupo	Policy Holder's Name/ Beneficiario Primario	Policy Holder's DOB/ Fecha de Nacimiento del Beneficiario

Due to the Privacy Act Bill/ Debido a la Factura de la Ley de Privacidad: If you would like us to disclose any medical information to your family members, you must state their full name and sign below./ Si usted quisiera revelar información médica a miembros de su familia, debe indicar su nombre completo y firmar abajo

Name/Nombre: _____ Phone Number/Número de teléfono: _____

Relationship/Relación: _____ Patient's Signature/Firma del paciente: _____

SYRACUSE COMMUNITY HEALTH

Demographic Data/ Información Demográfica

Race (Mark all that applies)/Raza (Por favor seleccione todos los que califican):

☐ American Indian or Alaska Native/Indio Americano o Nativo de Alaska ☐ Asian/Asiático

☐ African-American ☐ Pacific Islanders/Polynesia ☐ White

☐ Native Hawaiian/Hawaiano Nativo

☐ More than one Race/Más de una raz: _____and/y _____ and/y_____

☐ Refuse to answer/Me niego a responder

Ethnic Group/Grupo étnico: ☐Hispanic or Latino/Hispano o Latino

Employment Status/Estatus de Empleado:

☐Full time/Tiempo completo ☐ Part time/Medio tiempo ☐ Self Employment/ Trabaja por su cuenta

☐ Retired/Retirado ☐ Unemployed/Sin empleo

Student Status/Estatus de estudiante: ☐ Full time/Tiempo completo ☐ Part time/Tiempo Medio ☐ Not in School/No estoy estudiando

Are you a U.S. Veteran/Es usted un Veterano de los estados Unidos? ☐ Yes/Sí ☐ No

Are you a Seasonal Farm Worker/Es usted un trabajador agrícola estacional? ☐ Yes/Sí ☐ No

Are you a Migrant Farm Worker/Es usted un trabajador agrícola migrante? ☐ Yes/Sí ☐ No

Are you a Refugee/Es usted un Refugiado? ☐ Yes/Sí ☐ No

Are you a U.S Citizen/Es usted un Ciudadano (a) Americano (a)? ☐ Yes/Sí ☐ No

Are you Pregnant/Está usted embarazada? ☐ Yes/Sí ☐ No (If "Yes" pregnant, do you need help? ☐ Yes/Sí ☐ No)

Are you in Public Housing/Esta usted viviendo en una casa publica? □ Yes/Sí □ No

Are you homeless/Es usted un desamparado? ☐ Yes/Sí ☐ No

If "Yes", where are you living/Si usted lo es, adonde vive? ☐ Shelter/En un refugio ☐ Street/En la calle

☐ Transitional Housing/Vivienda de transición ☐ Doubling Up/Conjunto ☐ Other/Otro _____

Within the last 12 months, did you worry that your food would run out before you got money to buy more/ En los últimos 12 meses, usted se preocupo de que su comida se iba a terminar antes de que usted obtuviera dinero para comprar más?? ☐ Yes/Sí ☐ No

Do you have any other concerns that impact your health?/¿Tiene otras preocupaciones que afecten su salud? Yes/Sí No
Please list here/Por favor enumere aqui

_____

_____

Federal Poverty Level (FPL) assessment/Evaluación Federal de Nivel de Pobreza.
You may receive a discount if you qualify.

Family Size/Número de miembros en la familia: _____ Total Household Monthly Income/Ingreso Mensuales del hogar: $_____

(Yourself, Spouse, & Children/(Usted, esposo (a), e hijos (as))

How did you hear about us?/Como Escucho Acerca De La Clinica

☐ Family/Friends/Familiar/Amigo ☐ Radio /TV ☐ Community Event/Evento Comunitario ☐ Other_____

May we send you reminders & health messages via text? (You may opt out anytime by notifying SCHC)
Podemos enviarle recordatorios y mensajes de salud a través de un mensaje de texto?
(Puede optar por no pero por favor notifique al personal de la clínica). ☐ Yes/Sí ☐ No

For Internal Use Only: Date Entered _____/_____/_____

MR#_____ PCP Assigned_____

SYRACUSE
COMMUNITY
HEALTH

CONSENT FOR TREATMENT AND
AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME: _____
(please print)

D.O.B.: _____ MR # _____

CONSENT FOR TREATMENT

I hereby authorize Syracuse Community Health Center, Inc. to provide ambulatory services to me (or to my child if I am consenting to this agreement as a parent, custodial parent or legal guardian to a minor child). I hereby consent to the performance of such diagnostic studies, medical treatment, and supportive services as may be ordered or performed by licensed or authorized clinical providers, including, but not limited to, routine and/or emergency examinations and procedures, obtaining specimens, injection of medications and immunizations for myself or a minor child as may be deemed necessary.

_____ _____
Patient's Signature
(Parent or Legal Guardian if Patient is a Minor)
Relationship to Patient

_____ _____
Witness
Date

_____ _____
Department
Title

If this treatment consent/authorization is for someone other than myself, I hereby authorize the following individual(s) to bring the patient to the Health Center for treatment:

_____ _____ _____
Name **Relationship to Patient** **Date of Birth**

AUTHORIZATION FOR RELEASE OF INFORMATION / CONSULTATION REFERRAL / MINOR AUTHORIZATION

I hereby authorize and consent to the use of my (or the above named individual for whom I am the parent, custodial parent or legal guardian) health information for treatment, payment, and Syracuse Community Health Center, Inc.'s (SCHC) healthcare (business) operations and authorize SCHC to release any information necessary regarding my/the patient's diagnosis and treatment to my insurance company regarding this and subsequent visits to SCHC, as well as providing a copy of my/the patient's medical records/x-rays to the SCHC provider or other provider or agency to which I may be referred to for consultation. I further consent to the sharing of my/the patient's health information between SCHC and any other provider or agency to which I/the patient have been referred who are involved or may potentially be involved in my/the patient's care, as necessary, for coordination and management of my/the patient's continuing care needs. I also authorize the release of any contact information I provide to SCHC (including home, work and cellular telephone numbers, address, and e-mail address) to the health care professionals rendering care on my/the patient's behalf, including any billing service, collection agency, or attorney who may work on behalf of these entities. In order to perform the necessary treatment, payment and health care business operations associated with my/the patient's care, including patient outreach and appointment reminders, I authorize SCHC and the health care professionals rendering my/the patient's care, as well as any billing service, collection agency, or attorney who may work on behalf of these entities, to contact me using any methods of contact I have provided to SCHC, including contacting me on my cellular phone and/or home phone using an automatic telephone dialing system, an artificial pre-recorded voice, or other computer-assisted technology, or by e-mail, text message or other form of electronic communication. This authorization will remain in effect until all account balances related to this encounter have been fully satisfied.

SYRACUSE COMMUNITY HEALTH

I understand that if I am a minor receiving contraceptive counseling, pregnancy testing services and/or supplies that I MUST sign an authorization for these services and I understand that parental consent or knowledge is NOT required. To improve the efficiency and effectiveness of the health care system, SCHC complies with all aspects of the Health Insurance Portability and Accountability Ace of 1996 (HIPAA), Public Law 104-191.

I understand that if I (or the above-named individual for whom I am the parent, custodial parent or legal guardian) am in need of a referral for community services, including the Onondaga County Department of Health, Onondaga County Department of Social Services and WIC, this authorization allows the exchange of medical information with agents of those community service(s). I understand that as part of SCHC's comprehensive ambulatory care services, my medical record information (and/or that of my minor child) is shared between SCHC's provider teams and the Regional Perinatal Data System for Onondaga County. If I am a patient aged 19 or older, I consent to my immunization information and identifying demographic information being placed in the New York State Immunization Information System (NYSIIS). The immunization information will be released to (1) the patient, if over 18 years of age; (2) the parent, custodial parent or legal guardian of a minor; (3) their insurance company; (4) their school or licensed daycare; (5) the local and state health departments; and/or (6) to a medical provider authorized to provide medical care for me and/or my child. I understand that if I am a patient aged 19 or older, I can withdraw from NYSIIS at any time with notification to my medical care provider. I understand that my child's immunization information will be disclosed to the NYSIIS and my child's lead records will be shared by the Central New York Immunization Registry. I hereby release and hold SCHC harmless for loss or any damage to any personal belongings while a patient at SCHC.

HEALTH INFORMATION EXCHANGE AND CONSENT

I may choose whether or not to allow SCHC to obtain access to my medical records through **HealtheConnections** (or any successor), a Health Information Exchange Organization. If I give consent, my/the patient's medical records from different places where I/the patient obtain 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. The choice I make on this form will NOT affect my ability to get medical care. The choice I make on this form does 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.

I understand that I may complete this consent now or in the future. I may also change my decision at any time by completing a new consent form. I request that health information regarding my/the patient's care and treatment be accessed as set forth below:

Please check ONE box to the left of your choice:

☐ I GIVE CONSENT for SCHC to access ALL of my electronic health information through **HealtheConnections** to provide health care services (including emergency care).

☐ I DENY CONSENT for SCHC to access my electronic health information through **HealtheConnections** for any purpose, ***even in a medical emergency***.

To learn more and for full details of the consent process, or if you wish to deny consent for all provider organizations and health plans participating in **HealtheConnections**, or to access to your electronic health information through **HealtheConnections**, you may do so by visiting the **HealtheConnections** website at *http://healtheconnections.org/* or calling **HealtheConnections** at 315.671.2241 ext. 5. Details about the information accessed through **HealtheConnections** is attached to this form.

TELEHEALTH / TELEPHONIC VISITS

Telehealth is defined as the use of electronic information and communication technologies to deliver health care to patients at a distance. This may include services provided via a two-way electronic audio-visual communication technology, or visits conducted over the telephone. I understand that I have the following rights with respect to Telehealth visits:

1. The right to refuse to participate in services delivered via telehealth at any time and to be made aware of alternatives and potential drawbacks of participating in a telehealth visit versus a face-to-face visit;
2. The right to be informed and made aware of the role and location of the practitioner conducting the visit and to coordination with other qualified professional staff who will be responsible for follow-up or ongoing care;
3. The right to be informed of the risks associated with a telehealth visit, including that the information transmitted may not be

sufficient because of technological glitches or the lack of hands-on care, and to have all questions answered regarding the telehealth equipment and technology;

4. The right to have staff immediately available in the event of an emergency;

5. The right to be informed of all parties who will be present at the other end of the telehealth transmission; and

6. The right to select another provider, though selecting another provider could result in a delay in service and the potential need to travel for a face-to-face visit.

7. The laws that protect privacy and the confidentiality of health information also apply to telehealth. The information captured will be maintained, stored and safeguarded in the same manner as with any face-to-face interaction between a patient and a healthcare provider.

PAYMENT TERMS

I understand that payment is due at the time of service. If SCHC participates with my insurance company or the insurance company of my minor child, I am responsible for any co-payments and/or deductibles for all covered charges. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) and/or Title XIX of the Medicaid Act is correct. I request that payment for authorized services be made on my behalf directly to SCHC. Should any account become past due, I understand that SCHC may send my account or that of my minor child to a collection agency.

VIDEOTAPING/PHOTOGRAPHY

I acknowledge and understand that closed-circuit monitoring, videotaping and photography of patient care may be used for internal organizational purposes, including educational, clinical, healthcare operations and/or safety related purposes. I hereby consent to the use of any such recordings or photographs for the above referenced internal business purposes. I further understand that I have the right to withdraw such consent at any time.

I have read this form in its entirety, or it has been read to me, and I fully understand these statements. I am either the patient, or have the legal authority on behalf of the patient to execute this form and accept its terms, and all information provided is accurate and complete to the best of my knowledge. My questions about this form have been answered and I understand that I may request a copy of this form be provided to me.

_____ _____

Patient's Signature Date

(Parent or Legal Guardian if Patient is a Minor)

_____ _____

Witness Date

_____ _____

Department Title

SYRACUSE COMMUNITY HEALTH

NOTICE OF PRIVACY PRACTICES RECEIPT

Date: ____/_____/_____

PATIENT NAME: _____ DATE OF BIRTH: _____
(please print)

MEDICAL RECORD NO.: _____

I ACKNOWLEDGE THAT I WAS PROVIDED WITH A COPY OF SYRACUSE COMMUNITY HEALTH CENTER, INC.'S NOTICE OF PRIVACY PRACTICES.

_____ _____
Patient Name *(Please Print)* Patient Signature

If completed by patient's personal representative, please print and sign your name in the space below:

_____ _____
Personal Representative *(Please Print)* Personal Representative Signature

_____
Relationship to Patient

For Syracuse Community Health Center Use Only

Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Syracuse Community Health Center, Inc.'s Notice of Privacy Practices from this patient, but it could not be obtained for the following reason:

□ Patient refused to sign
□ Patient unable to sign because _____
□ We were unable to communicate with the patient
□ Other *(please provide specific details)* _____

_____

_____

_____ _____
Employee Name Date

This form should be placed in the patient's medical record.

Rev'd 8/31/17

SYRACUSE COMMUNITY HEALTH

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 SCHC 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 SCHC at 315-476-7921; or visit 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.gov/ocr/privacy/hipaa/complaints/.

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. 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.

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

As a patient in a Clinic in New York State, 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 the 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 consent 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's staff, the operator and the New York State Department of Health without fear of reprisal;

(12) Express complaints about the care and services provided and to have the center investigate such complaints. The center is responsible for providing the patient 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 complain to the New York State Department of Health;

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

(14) Approve or refuse the release or disclosure of the contents of his/her medical record to any health-care practitioner and/or health-care facility except as 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: http://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.

NEW YORK STATE | Department of Health

Patients' Rights, 10NYCRR, Section 751.9