Capital*Care* Medical Group CHILD Patient Registration Form

Date: _____ **Patient ID#:** _____

PATIENT INFORMATION **(for office use only)**

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: (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 Capital*Care*'s 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**

Revised: 12/21/05; 12/2011

Please see reverse side

Capital*Care* Medical Group CHILD Patient Registration Form

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 CapitalCare Medical Group. 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 CapitalCare Medical Group (CCMG) any insurance or other third-party benefits available for health care services provided to me. If these benefits are not assigned to CCMG, I agree to forward to CCMG all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt of such payments.

I authorize CapitalCare Medical Group (CCMG) to release the minimum necessary medical or other information to persons employed or retained by or affiliated with CCMG 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 CCMG that this authorization has been changed or discontinued.

_____ _____ /_____/_____

Signature of Patient / Guardian Date

Please see reverse side

Patient Health Information Release Authorization

_____ *hereby authorize* _____

PATIENTS FULL NAME — MEDICAL FACILITY or PHYSICIAN NAME RELEASING INFORMATION

to disclose my health information under the terms described below. Pursuant to this authorization, my health information may be disclosed to, and used by, the following individual or organization.

PLEASE **CAREFULLY** CHECK **ONE**

☐ **My Self** (*Records will be mailed to your home address)* ☐ **OTHER** *(Please detail below)*

NAME AND ADDRESS OF **OTHER** INDIVIDUAL OR ORGANIZATION YOU ARE AUTHORIZING YOUR HEALTH INFORMATION BE DISCLOSED TO:		
Name:		
Address:		Apt/Ste #:
City:	State:	Zip:

Specific information to be used and/or disclosed:

☐	**All** medical records			
☐	**All** records regarding treatment for the following condition or injury:			
		Dated From		Dated To
☐	Specific 'Progress Notes':			

Please state the purpose for this request:

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING AT THE BOTTOM

I understand that if my records contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome **(AIDS)** or human immunodeficiency virus **(HIV)** related information, such information will be released pursuant to this authorization. Confidential HIV related information is any information indicating that an HIV test was done; HIV virus is present; HIV related illness or AIDS; or any information which could indicate that a person has been potentially exposed to HIV. I also understand that if my records contain information concerning **Drug**, **Alcohol** abuse and/or treatment, or behavioral, mental health services or **Psychiatric** treatment, such information will be released pursuant to this authorization. **Unless otherwise revoked, this authorization will expire in 90 days**

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical facility. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 90 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the medical facility or ROI Solutions, Inc. at 1-(800) 281-7001.

Exceptions to the above, I do not authorize the release of the following:
☐ Mental Health
☐ HIV/AIDS
☐ Substance Abuse/Alcohol Abuse

DOB: / /		Phone: ( ) -	
SS: - -		Fax: ( ) -	
Address:			City
State	Zip:	Email:	
X		Date:	
Patient Signature/Authorized Representative:		Relationship to Patient:	

THIS AUTHORIZATION WILL BE CONSIDERED INVALID WITHOUT APPROPRIATE SIGNATURE AND THE PATIENT DOB AND SS#. Social Security Number only used for identification purposes.

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 Capital*Care* Medical Group 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, Capital*Care* Medical Group 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 Capital*Care* Medical Group . 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 Capital*Care* Medical Group's medical staff who are involved in your medical care; health care providers who are covering or on call for Capital*Care* Medical Group's 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 Capital*Care* Medical Group 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 Capital*Care* Medical Group 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 Capital*Care* Medical Group. 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**.**

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 dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services 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 the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE CONTACT:

Michael O'Connor, Esq.
Privacy Officer, Operations Manager
711 Troy-Schenectady Road Suite 201
Latham, NY 12110 (518) 782-3767

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

The following categories describe the different ways in which we may use and disclose your IIHI. The uses are for Treatment, Payment, and Operations (TPO).

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including, but not limited to, our doctors and nurses - may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

   Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you. We will not sell your data to an outside entity, nor will we permit an outside entity from accessing your information for purposes of informing you of health-related benefits or services.

7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you in some limited circumstances. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. **Disclosures Required By Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

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

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

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
   - Maintaining vital records, such as births and deaths
   - Reporting child abuse or neglect
   - Preventing or controlling disease, injury or disability
   - Notifying a person regarding potential exposure to a communicable disease
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - Reporting reactions to drugs or problems with products or devices
   - Notifying individuals if a product or device they may be using has been recalled
   - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - Concerning a death we believe has resulted from criminal conduct
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena or similar legal process
   - To identify/locate a suspect, material witness, fugitive or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. **Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an IRB or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to the individual's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

6. **Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

7. **Military.** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

8. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

9. **Inmates**. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

10. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

E. **YOUR RIGHTS REGARDING YOUR IIHI**

Although your health records are the physical property of the health care provider who completed it, you have the following rights with regard to the information contained therein and the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to your physician specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

   You also have the right to request a restriction in our use or disclosure of your IIHI to a health plan where the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full. In this circumstance, we are required to agree to your request, except where we are required by law to make a disclosure.

   In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to your physician. Your request must describe in a clear and concise fashion:

   (a) the information you wish restricted;
   (b) whether you are requesting to limit our practice's use, disclosure or both; and
   (c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to your physician in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to your physician. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non- treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to your physician. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Michael O'Connor, Esq. at (518) 782-3767.**

7. **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.**

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

   Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

9. **Right to be Notified of a Breach.** You have the right to be notified in the event that we (or a Business Associate) discover a breach of your unsecured IIHI.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Michael O'Connor, Esq. (518) 782-3767.**

Effective Date of Notice: April 14, 2003
Revised: June 1, 2013

COMMUNITY CARE
PHYSICIANS, P.C.
www.communitycare.com

Community Care Physicians, P.C.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Community Care Physicians, P.C.'s
Print Patient Name

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's health professionals, using their best judgment, may disclose health-related information to a relative, close personal 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.)

Name of individual	Relationship	Telephone
Name of individual	Relationship	Telephone
Name of individual	Relationship	Telephone
Name of individual	Relationship	Telephone

I understand that if I wish to revoke permission to release protected health information to any or 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 patient, please indicate relationship/authority:_____

Date:_____

Revised: 02/19/2008

Financial Policy

This financial policy contains important information about billing and payment for our professional services. It is intended to help ensure the best possible medical care for our patients, while also controlling administrative costs. It outlines our responsibilities, and those of our patients, with regard to billing and payment for our services.

- Our practice participates with many health insurance companies and managed care programs. Our business office will submit a claim for any services rendered to a patient who is a member of one of these plans. Patients must provide all necessary insurance information and complete any required forms before leaving the office.

- If a patient is a member of an insurance plan with which we do not participate, our office will also file the claim on the patient's behalf; **however, the patient is expected to make payment in full at the time of service**.

- It is the patient's responsibility to make payment at the time of service for any co-payment or co-insurance due. Any services not covered by a patient's insurance plan are the patient's responsibility and payment in full is expected at the time of service. Failure to make a co-payment on the day of service will result in an administrative charge of $15 in addition to the co-payment.

- Payment for professional services can be made by cash, check, credit card or debit card. We accept VISA®, MasterCard®, American Express® and Discover® Card. You may also pay online at www.capcare.com -- just click the link for Online Bill Pay.

- Capital*Care* Medical Group charges a fee of $20 for each check returned for insufficient funds.

- It is the patient's responsibility to ensure that any required authorization or referral for treatment is provided **prior to the visit.** In the absence of a required authorization or referral, the patient's visit may be rescheduled or the patient may be personally responsible for payment for the services rendered by Capital*Care* Medical Group.

- It is the patient's responsibility to provide us with current insurance information and to present an active insurance card at each visit.

- Our staff is happy to help with insurance questions relating to a claim that has been filed, or to provide additional information required by the insurance carrier to process the claim. However, patients should direct questions about coverage for specific procedures to a representative of their insurance company's member services department. The phone number for member services is usually on the insurance card.

- An adult accompanying a child under 18, and/or the parent or guardian of the child, is responsible for payment according to the terms described above. Non-emergency treatment for children unaccompanied by an adult may be rescheduled by Capital*Care* Medical Group unless charges have been pre-authorized, or payment by credit card, debit card, cash or check at time of service has been arranged.

- If a patient requires the completion of medical forms at a time other than an office visit, each form will be subject to an administrative fee of $15.

- Please understand that when a patient does not cancel an appointment he or she is unable to keep, it may prevent other patients from receiving care they need. Therefore, Capital*Care* charges a fee of $50 for appointments not cancelled with at least 24 hours' notice. This fee is subject to change. A patient who fails to keep three or more appointments in a twelve-month period—without prior notice of cancellation—may be discharged from Capital*Care* Medical Group at the discretion of the patient's physician.

In the event of personal financial hardship, Capital*Care* Medical Group is able to offer special financial arrangements, including payment plans.

We firmly believe that effective communication is the key to a successful physician-patient relationship, and we are eager to help in any way we can.

Please direct all questions about payment for services to our Billing Department at (518) 452-1337.