PATIENT INFORMATION

Patient's Legal last name:	Legal first name:	Middle:	Todays Date:
Preferred name:		DOB:	Email:
Street address:		SSN:	Home phone number:
City:	State:	Zip Code:	Work phone number:

Language Needs (Federal requirement)

Would you prefer to communicate in a language other than English? (Y/N) If so, what language (including American Sign Language-ASL)?

____

Preferred Method of Contact for Appointment Confirmation:

- ☐ Phone
- ☐ Text
- ☐ Email

Cell phone number:

Emergency Contact:
Name:____________________
Relationship:________________
Phone Number:_______________

Insurance Information

☐ **I am insured (please provide a copy of your insurance card to the Administrative Assistant)**

1. Primary Insurance Name:______________________________ ID#:__________________________

Who is the primary subscriber? (Circle) Patient/Self Spouse Parent/Guardian Other-Name______________

If other, insured date of birth:____________________ Insured relationship to patient:____________________

2. Secondary Insurance Name (if applicable):______________________ID#:____________________

Who is the secondary subscriber? (Circle). Patient/Self Spouse Parent/Guardian Other-Name_____________

If other, insured date of birth:____________________ Insured relationship to patient:____________________

HOW DID YOU HEAR ABOUT US?

Circle the answer that applies: Internet Radio Insurance Ad Social Media
Family Member Friend Other:_____________

Referral from Healthcare Provider: Name and Address of Provider:_______________________________________

Is this Provider your PCP? Circle: Yes No If Provider listed is <u>not</u> your PCP, list PCP:_________________

Signature

I certify that the above information is true and correct to the best of my ability.
Name of the person completing this form:

Print:____

Relationship to Patient:______________**Signature:**_________________________**Date:**______________

GETTING TO KNOW YOU

We require the following information for the purposes of understanding our population better and to satisfy our reporting requirements to the federal government. The options for these questions were provided by those organizations which analyze this information, and in no way impacts the care you receive. Please help us serve you better by selecting the best answer to these questions. Thank you.

Race (Collected as a Federal Requirement): You may select one or more (Please Circle the Appropriate Answer):

White/ Caucasian	Black or African American	Asian	Native Hawaiian
American Indian/ Alaska Native	Pacific Islander	Other:_______	I decline to provide this information

Sex assigned at birth (Circle):

Male Female

Marital status (Circle):

Single Married Partnered/Other

Sexual Orientation and Gender Identity (Collected as a Federal Requirement)

Sexual Orientation (Circle Appropriate Answer):

- ☐ Lesbian, gay, or homosexual
- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Something else/other
- ☐ Don't know
- ☐ Choose not to disclose

Gender Identity (Select One):

- ☐ Male
- ☐ Female
- ☐ Transgender Male/Female to Male
- ☐ Transgender Female/Male to Female
- ☐ Gender Queer
- ☐ Other
- ☐ Choose not to disclose

Ethnicity (Collected as a Federal Requirement). Please Circle the Appropriate Answer:

Non-Hispanic	Hispanic	I decline to provide this information

Employment Status (Only for patients 18 years and older; Collected to assess potential exposures to health risks) Circle the Appropriate Answer:

Employed Full-Time Employed Part-Time Occupation:_________________________________

Retired Disabled Student Other I decline to provide this information

What is the preferred pharmacy you wish to keep on file for medications to be sent to?

Pharmacy name:____

Pharmacy Address:____

Are you a veteran of the U.S. Military? (Circle)

Yes No

Responsible Party (Only if patient is under the age of 18 or Legal Dependent)

Name (Last, First, Middle)	SSN	DOB	Sex
Mailing Address	City, State, Zip		
Primary Phone	Day/Work Phone		

Acknowledgment/Authorization

I consent to examination and treatment by CVHMPC practitioners and staff.
I request that payment of authorized Medical, No-Fault or Government insurance benefits be made on my behalf to CVHMPC for services furnished to me by the provider.
I authorize the release of any medical or other information necessary to process claims.
I understand and agree that, regardless of my insurance status, I am ultimately responsible for my balance on my account for any professional services rendered.
I have read all the information on this form and have completed the answers.I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature of Patient: ____ **Date:** _________/_______/_________

Name__________________ **History Form - Primary Care** Date___________________

Please list information in the spaces provided. Information is confidential and will not be released without your permission.

Medical History (Please check if applies)

- ☐ No Medical Conditions or chronic diseases
- ☐ Alcohol Abuse Disorder
- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Apnea
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Cancer

What Kind?_______________
- ☐ Chronic Pain
- ☐ COPD/Emphysema
- ☐ Diabetes
- ☐ Eczema/Psoriasis
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Attack/Mi
- ☐ Heart Burn/GERD
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ IBS
- ☐ Kidney Disease/Kidney Stones
- ☐ Migraines
- ☐ Neuropathy
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Seasonal Allergies
- ☐ Seizures
- ☐ Strokes
- ☐ Substance Use Disorder

What Substance(s)?

____
- ☐ Thyroid Disease
- ☐ Please list any other medical conditions:

____

____

Surgical History

(Please Include Surgical Type / Reason / Date)

____

____

____

____

____

Health Maintenance

HPV/PAP (Z01.419) When? _______________Where?__________

Mammogram (Z12.31) When? _____________Where?__________

Colonoscopy (Z12.11) When? _____________Where?__________

Immunizations - Attach Record / Name Office & Contact Info

____

____

Family Medical History

(List Medical Condition for each Blood Relative)

Maternal Grandmother_____________________________

Maternal Grandfather______________________________

Paternal Grandmother_____________________________

Paternal Grandfather ______________________________

Mother____

Father____

Sibling(s)______________________________________

Children(s)_____________________________________

Drug / Environment / Food Allergies

(List Drug, Environment, or Food Allergies and The Type of Reaction)

____

____

____

____

Personal - Social History

Relationship Status

- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Domestic Partner
- ☐ Widowed

Occupation Status

- ☐ Employed
- ☐ Unemployed
- ☐ Retired
- ☐ Disabled

Occupation_______________

Caffeine Use History

- ☐ Never/rarely a user
- ☐ Former user
- ☐ Current Sometime user
- ☐ Current Everyday user

What is the usual type of caffeine consumed?

____

Herbal Use History

- ☐ Never/rarely a user
- ☐ Former user
- ☐ Current Sometime user
- ☐ Current Everyday user

What is the usual type of herb consumed?

____

Smoking/Vaping History

- ☐ Smoker
- ☐ Vaper
- ☐ Never to rarely user
- ☐ Former user
- ☐ Current Sometime user
- ☐ Current Everyday user

How many Packs/Cartridges per Day?______

How Many Years?__________

Date Stopped?_____________

Alcohol Use History

- ☐ Never to rarely user
- ☐ Former User
- ☐ Current Sometimes User
- ☐ Current Everyday User

What is the usual type of alcohol consumed?_________

How Much/Often?__________

Date Stopped (if applicable)________________

Recreational Drug Use History

- ☐ Never/rarely a user
- ☐ Former user
- ☐ Current Sometime user
- ☐ Current Everyday user

What is the usual type of drug used?____________________

How Much/Often?__________

Date Stopped______________

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Name___________________ **ROS Intake Form** Date___________________

Do you now or have you had any problems related to the following systems? Please check off any that applies.

Constitutional Symptoms

- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Fatigue
- ☐ Headache
- ☐ Unexplained Weight Change
- ☐ Decreased Appetite
- ☐ Problems Sleeping
- ☐ Other_________________

Eyes

- ☐ Redness
- ☐ Pain
- ☐ Change in Vision
- ☐ Eye Pain
- ☐ Discharge
- ☐ Other_________________

Ear / Nose / Throat

- ☐ Ear Pain
- ☐ Hearing Loss
- ☐ High Pitch Ringing
- ☐ Sore Throat
- ☐ Sinus Pressure
- ☐ Stuffy Nose
- ☐ Runny Nose
- ☐ Other_________________

Cardiovascular

- ☐ Chest Pain
- ☐ Palpitations
- ☐ Positional Change in Breathing
- ☐ Swelling in Legs / Feet
- ☐ Varicose Veins
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Fainting Spells
- ☐ Leg Cramps

When Walking? Y N

- ☐ Other________________

Respiratory

- ☐ Dry Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Cough with Phlegm
- ☐ Blood Sputum
- ☐ Other_________________

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Indigestion / Heartburn
- ☐ Bloody Stools
- ☐ Tarry Stools
- ☐ Loss of Appetite
- ☐ Other_________________

Genitourinary / GYN

- ☐ Erectile Dysfunction
- ☐ Testicular Pain
- ☐ Testicular Lump
- ☐ Dribbling with Urination
- ☐ Urinary Urgency
- ☐ Urinary Frequency
- ☐ Urinary Hesitancy
- ☐ Blood in Urine
- ☐ Pain with Urination
- ☐ Abnormal Vaginal Bleeding
- ☐ Vaginal Discharge
- ☐ Vaginal Dryness
- ☐ Vaginal Oder
- ☐ Vaginal Itching
- ☐ Vaginal Pain
- ☐ High Risk Sexual Activity
- ☐ STDs
- ☐ Sexual Dysfunction
- ☐ Painful Sexual Intercourse
- ☐ Irregular Menses
- ☐ Painful Menstruation
- ☐ Infertility
- ☐ Kidney Stones
- ☐ IUD
- ☐ Other_________________

# of Pregnancies_______ # of live births_________________

Breast

- ☐ Lump
- ☐ Nipple Discharge
- ☐ Tenderness
- ☐ Asymmetry
- ☐ Dimpling
- ☐ Swelling
- ☐ Other_________________

Skin

- ☐ Rash
- ☐ Lesion
- ☐ Redness
- ☐ Itchiness
- ☐ Acne
- ☐ Abrasion
- ☐ Insect Bite
- ☐ Hives
- ☐ Other_________________

Musculoskeletal

- ☐ Join Pain / Swelling
- ☐ Body Aches
- ☐ Stiffness
- ☐ Limited Range of Motion
- ☐ Joint Popping
- ☐ Muscle Spasm
- ☐ Muscle Cramping
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Other_________________

Extremities

- ☐ Swelling
- ☐ Numbness/Tingling

Neurological

- ☐ Headache
- ☐ Dizziness
- ☐ Fainting
- ☐ Tremors
- ☐ Weakness
- ☐ Numbness/Tingling
- ☐ Memory Loss
- ☐ Seizures
- ☐ Speech Impairment
- ☐ Change in Smell / Taste
- ☐ Other_________________

Psychologic

- ☐ Do you feel depressed?
- ☐ Have you felt anxious / panicked?
- ☐ Insomnia
- ☐ Change in Mood
- ☐ Sexual Dysfunction
- ☐ Suicidal Thoughts
- ☐ Nightmares
- ☐ Other_________________

Endocrine

- ☐ Excessive Urination
- ☐ Excessive Thirst
- ☐ Excessive Hunger
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Dry Mouth
- ☐ Excessive Sweating
- ☐ Tired / Sluggish
- ☐ Other_________________

Hematologic

- ☐ Anemia
- ☐ Bleeding
- ☐ Easy Bruising
- ☐ Swollen / Tender Lymph Nodes
- ☐ Blood Clotting Problems
- ☐ Other_________________

Allergic / Immunologic

- ☐ Environmental Allergies
- ☐ Difficulty Breathing due to Allergy

Other:___________________

____

____

____

____

____

____

____

____

Medication List

Name of the Medication	Dosage/Strength	Time (s) of Day You Take This Medication

Name:____________________________ Date of Birth:____________________________

Document Acknowledgement Form

Patient Name:____**Date of Birth:**________/______/___________

By signing each statement below I acknowledge that I have received a full version of each document. I understand that this is my responsibility to read each document and ask for clarification or more information if necessary.

Document Name: By signing below you acknowledge that you are responsible for updating CVHMPC of any changes relevant to this document.	Patient Initials
Notice of Privacy Practices & HIPAA Acknowledgement: Cross Valley Health & Medicine, P.C. (CVHMPC) is committed to protecting your Personal Health Information (PHI) and stay in compliance with federal and state laws such as HIPAA. I have received a copy of the Notice of Privacy Practices and understand how my PHI may be used, as well as my rights and CVHMPC rights regarding PHI.	
Consent to Release Medical Information: I herby give consent to the following individuals to have access and obtain copies of my medical information. This included health history, exam information, tests and lab results. Information will be provided, based on my consent below. **Name:**________________________**Phone #:**_______________________**Relationship to me:**__________________ Note: While authorizing the above named person to have access to your records, they are to not be authorized access to sensitive information, such as HIV Status/Information, State reportable results, and/or Alcohol and Substance Use information. If you wish to authorize access to those sensitive records, you must sign a separate consent for each at that time.	
Patient Bill of Rights and Patient Rights & Responsibilities: I have received the Patient Bill of Rights and Patient Rights & Responsibilities document.	
Assignment of Benefits: I authorize payment of insurance benefits to CVHMPC for any/all medical services provided to me. I authorize the release of medical or other information necessary to determine benefits coverage and eligibility. I understand that I am financially responsible for charges not covered by my insurance. It is my responsibility to notify CVHMPC of any changes to my health care coverage.	
Patient Portal Access: I authorize the creation and an email to be sent to my personal email to have access to my patient portal account. I understand that this email contains credentials and link that will allow unrestricted access to view my health information including diagnoses, medications, labs, HIV status and mental health and substance use related information. **Name:**______________________**Email (Required):**____________________**Signature:**____________________**Date:**__________	
Consent to Photograph for Electric Health Records (EHR): I give consent to CVHMPC to take my photograph to be stored in my EHR. This photograph will be used to identify me and protect me against identity theft.	

This permits Cross Valley Health & Medicine PC to allow ______________________, as designated below, to be present in the examination room, and I give permission to CVHMPC, its practitioners, employees and representatives, to discuss all aspects of my medical care and treatment, including, but not limited to my protected health information (PHI), and to discuss all payment issues, with such individual(s).

Patient Name (Print):__________________________**Patient Signature:**_____________________**Date:**_________**Witness Employee Initials:**_____

THIS FORM DOES NOT SERVE AS A NEW YORK HEALTH PROXY OR HEALTH CARE POWER OF ATTORNEY

Version 2020

Patient Representative Form:

Last Name: ________________________________First Name:________________________________

Date of Birth:_____________/___________/____________________

Social Security Number:_________-__________-_______________

Patient Information:

This permits Cross Valley Health & Medicine PC to allow ___________________________, as designated below, to be present in the examination room, and I give permission to CVHMPC, its practitioners, employees and representatives, to discuss all aspects of my medical care and treatment, including, but not limited to my protected health information (PHI), and to discuss all payment issues, with such individual(s).

*THIS FORM DOES NOT SERVE AS A NEW YORK
HEALTH PROXY OR HEALTH CARE POWER OF ATTORNEY*

Representative Information:

Last Name: ________________________________First Name:________________________________

Date of Birth:_____________/___________/____________________

Address:____

Telephone #: +1 (_______)________________________-_____________________________________

Relationship to the Patient:____

*a separate authorization must be completed to share highly sensitive information, such as HIV, alcohol and substance abuse treatment, or mental health information. THIS DOES NOT GRANT THE PATIENT REPRESENTATIVE THE RIGHT TO ACCESS PRINTED MEDICAL CHARTS OR INFORMATION AND DOES NOT GIVE THEM THE RIGHT TO REQUEST THEM ON THE PATIENT'S BEHALF. In order to revoke the rights of the Patient Representative to discus or otherwise access your PHI a revocation must be submitted to Cross Valley Health & Medicine PC.

Patient Signature:____________________________________Date:________/________/___________

Version 2020

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

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

Patient Name	Date of Birth	Social Security Number
Patient Address		

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:

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, consults, 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)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

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.

______________________________ Date: ______________________

Signature of patient or representative authorized by law.

* **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.**

Cancellation/Missed Appointment Policy

In order to be respectful of the health needs of other patients, please be courteous and call **845-561-7075** promptly if you are unable to show up for an appointment. If you are unable to get through to our office during office hours, you can call after hours and leave a voicemail with your cancellation.

You may also cancel your appointment through our website, **www.crossvalleyhealth.com**, message us through Facebook, patient portal or email us at CVHMPC@me.com. The time made available will be given to another patient. If you cancel your scheduled appointment, please contact us at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

If you do not cancel your appointment at least 24 hours prior and do not show up to your scheduled appointment, you will be charged a fee as follows:

Follow up/Sick Visit = $25.00 Fee

Physical Exam/Specialty Procedure = $50.00 Fee

Version 2020