Burnt Hills Internal Medicine & Pediatrics
Community Care Physicians
Newborn Registration Form

Patient

Last Name:	First Name:	MI:	Suffix:	Preferred/Nick Name:
Physical Address:		○ Male ○ Female		Date Of Birth:
City:		State:	Zip:	Social Security#:
Primary Contact Phone:		○ Home: ○ Mom Cell: ○ Dad Cell:	○ Other: ○ Mom Work: ○ Dad Work:	
Secondary Phone:		○ Home: ○ Mom Cell: ○ Dad Cell:	○ Other: ○ Mom Work: ○ Dad Work:	
Email:		Primary Care Provider:		
In Case of Emergency, Notify:	Relationship:	Contact Phone #:		Date of Birth:

Parent/Guardian

Circle/ Complete as applicable: Parent Step- Parent Foster Parent Grandparent Aunt Uncle Other:				
Mother's Last Name:	First Name:	Email:		
Physical Address:		○ Male ○ Female		Date of Birth:
City:	State:	Zip:		Mother Maiden Name:
Primary Phone(If different from above):	○ Home ○ Work	○ Work: ○ Other:		Marital Status:
Circle/ Complete as applicable: Parent Step- Parent Foster Parent Grandparent Aunt Uncle Other:				
Father's Last Name:	First Name:	Email:		
Physical Address:		○ Male ○ Female		Date of Birth:
City:		State:	Zip:	
Primary Phone(If different from above):	○ Home ○ Work	○ Work: ○ Other:		Marital Status

Primary

Insurance Name:		Identification #:		Group #:
Address:	City:		State:	Zip:
Policy Holder Name and Address:		Subscriber DOB:		Copay Amount:

Secondary

Insurance Name:		Identification #:		Group #:
Address:	City:		State:	Zip:
Policy Holder Name and Address:		Subscriber DOB:		Copay Amount:

www.communitycare.com

Community Care Physicians

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, ___________________________________, have received a copy of Community Care Physicians
Print Patient Name

Notice of Privacy Practices.

________________________________ Signature of Patient or Guardian

____________ Date of Birth

____________ Date

________________________________ Witness

____________ Date

Hixny

COMMUNITY CARE PHYSICIANS

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.

- o **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.

- o **I DENY CONSENT for Community Care Physicians to access** my electronic health information through Hixny for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through Hixny.

______________________ Print Name of Patient	______________________ Date of Birth
______________________ Signature of Patient or Patient's Legal Representative	______________________ Date
______________________ Print Name of Legal Representative (if applicable)	______________________ Relationship of Legal Representative to Patient (if applicable)

Details about patient information in Hixny and the consent process:

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

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

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

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

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

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

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

5. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Community Care Physicians at: (518) 452-1337; or call Hixny at (518) 783-0518; or call the NYS Department of Health at (877) 690-2211.

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

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

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

9. **Copy of Form**. You are entitled to get a copy of this Consent Form after you sign it**.**

To Enroll in the Patient Portal mycareDOT™, complete this form and give it to the front desk

Patient's Name: ______________________________ Patient's Date of Birth: ____________________

Information for the individual receiving the invite:

Name (if other than the patient): ______________________________

Relationship to Patient: ______________________________

Phone Number: ______________________________

Address: ______________________________

City: ____________________ State: __________ Zip Code: __________

Email Address: ______________________________

If someone other than the patient will be receiving the invite and the patient is an adult, the patient must choose what access they would like the proxy to have (please check one): ☐ Full Access ☐ Read Only

(PLEASE NOTE: If choosing Read Only access the authorized individual will be authorized to access your FollowMyHealth health record ONLY and will NOT be able to communicate with or otherwise engage in transactions with your providers)

Signature of patient or legal guardian: ______________________________

Name of legal guardian (if applicable): ______________________________

By completing this form and submitting it to your doctor's office, you are agreeing to the terms and conditions and allowing the office to invite you to join the patient portal via email invitations. (Please ask the front desk if you would like a copy of the terms and conditions)
You may also receive health and company news and announcements from Community Care Physicians, PC through your portal account. If you do not understand or do not agree to comply with or do not consent to these policies or procedures, please do not complete this form to enroll in the patient portal.
A copy of this form will be scanned into your permanent medical records.