The Mary Rose Clinic

CONFIDENTIAL PATIENT INTAKE INFORMATION

Updated on:_____ **Do you have Insurance? Yes / No**

Patient Name:_____
First *Middle* *Last*

Birth Date _____ SS#_____ Male Female

Street _____

City_____State_____Zip:_____

Contact Information:

Home:_____Cell:_____Work:_____

Alternate Phone:_____ Email Address:_____

Emergency Contact Name:_____Phone:_____

Employed? Yes No

Do you speak English? Yes No

Consent of Treatment Form

I hereby voluntarily consent to medical examinations, treatment, and procedures which are deemed necessary in the opinion of my health care providers, including HIV tests, laboratory tests, and x-rays.
I understand that my medical information is strictly confidential and is protected and no guarantees or warrantees have been made to me concerning the results of examinations, treatments or procedures.
My signature acknowledges that I have been given the opportunity to ask questions about this consent form and the opportunity to refuse services.

_____ _____
Patient Signature Date

The Mary Rose Clinic

CONFIDENTIAL PATIENT INTAKE INFORMATION

Patient Name:_____
First *Middle* *Last*

Nicotine/Tobacco Use: _____ Never Used _____ No use last 6 months _____ Current Use
If Current, How Long (years)? _____ How Much? _____ Packs per Day/Week

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HEALTH HISTORY Nn

Please circle all conditions that you have or have had in the past.

ADD/ADHD	Fibromyalgia	Obsessive Compulsive
Allergic Rhinitis	Gall Bladder dysfunction	Ovarian Disease
Anxiety	Gastro Esophageal Reflux	Pancreatitis
Arthritis	Glaucoma	Peptic Ulcer
Asthma	Heart Disease	Pregnant
Cancer	Hepatitis	Psoriasis
Chronic Fatigue	Herpes/Cold Sores	Seizure Disorder
Chronic Sinusitis	High Cholesterol	Shingles
Colitis	Hypertension	Skin conditions
Depression	Hyperthyroidism	Smoker
Diabetes	Hypothyroidism	Stroke
Eczema	Irritable Bowel	Thrush
Endometriosis	Kidney Problems	Urinary Tract Infections
Esophagitis	Liver Disease	Vascular Disease
Fibrocystic Breast Cancer	Menopause	Yeast Infections
Fibroid Tumors	Multiple Sclerosis	

Other:_____

Past Surgeries: _____

Past Hospitalizations:_____

I understand that the Mary Rose Clinic **CANNOT** treat for

DISABILITY CLAIMS
WORKERS COMPENSATION CLAIMS
NO-FAULT INJURY CLAIMS
OR ANY OTHER LEGAL ISSUES

_____

PRINT NAME SIGNATURE DATE

Other Treatments or Pertinent Tests: _____

Is there any special need or concern you have or would like us to be aware of?

_____

_____

_____

Where would you have gone if you had not come to the Mary Rose Center clinic?

_____

PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS YOU ARE TAKING

Med/ Supplement	**Dosage**	**Purpose**

PLEASE LIST ALL ALLERGIES: Drugs etc.

_____

_____

_____

_____

We will NOT confirm your existence as a patient in this clinic or correspond with any family member or other person you have not specifically authorized. If you have another family member or caregiver with whom you wish for us to correspond, you will need to list them below.	
Name:	Relationship:
If you are a female age 40 or over we can offer you information on where to get a free clinical breast exam, mammogram, and Pap smear from the Cancer Services program. Are you interested in the information? YES____ NO____	
If you are a male or female age 50 or over we can offer you information on where to get a FIT kit which is used to provide colorectal cancer screening from the Cancer Services Program. Are you interested in the information? YES____ NO____	

Patient Signature: _____ **Date:**_____

The Mary Rose Clinic

Authorization for Release of Information

Patient Name: _____ Birth Date: _____

I authorize The Mary Rose Clinic to release protected health information, if necessary, about the above-named patient to the people named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

I understand that The Mary Rose Clinic Doctor may need to discuss my medical condition and may need to share my medical records with any physician, physician extender, nurse, therapist or other health care provider who is involved in my care.

Messages (for appointment reminders, lab or x-ray results) may be left on my telephone answering machine at my home. **Yes_____ No___.**

Messages (for appointment reminders, lab or x-ray results) may be left on my telephone voice mail at my work. **Yes____ No____.**

I do not currently have a telephone answering machine at home and/or voice mail at work, but if I were to get one, messages may be left on it. **Yes___ No____.**

Messages for appointment reminders may be left with others in my home. **Yes____ No____**

If necessary, The Doctor may talk with my spouse or significant other about my medical condition. **Yes____ No_____ The name of this person is**

_____.

If necessary, The Doctor may talk with my parents or with my caretaker about my medical condition. **Yes____ No____ The name of my parents or caretaker are:**

_____.

The Doctor **MAY NOT** discuss my medical condition with:

_____

Rights of the Patient

I understand that I have the right to change this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending written notification to: The Mary Rose Clinic Coordinator. I understand that any change in this authorization is effective from the date signed going forward.
I understand that information used or disclosed as a result of this authorization may be subject 4to re-disclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature of Patient, Parent or Guardian Date

the mary rose clinic

HealtheConnections

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow **The Mary Rose Clinic** to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get 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. To learn more visit HealtheConnections website at http://healtheconnections.org/ .

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent *even* in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in 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.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

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

☐ 2. I **DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for **The Mary Rose Clinic** to access my electronic health information through HealtheConnections.

☐ 3. I **DENY CONSENT** for **The Mary Rose Clinic** to access my electronic health information through HealtheConnections for any purpose, ***even** in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

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 the Information acce d through HealtheConnections and the co. nt 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 Provider Organization and/or Health Plan listed 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 the Provider Organization at 315-280-0855; 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.