Outer Cape
HEALTH SERVICES

Welcome to Outer Cape Health Services

We are grateful for your choosing us as your healthcare provider.

This New Patient Admissions Packet must be completed and returned to us prior to your first appointment being scheduled. This packet includes the following:

1) **Notice of Privacy Practices:** Please review this notice carefully.
2) **Patient Registration Form:** Please complete all portions of this form. Note that as a Federally Qualified Health Center, we are required to collect demographic information regarding the patients we serve. The information you provide is confidential.
3) **Health History Questionnaire:** A summary of your medical history, medications, allergies, health habits and family health history. Please record all medication you are on, including any over-the-counter medication and supplements you take.
4) **Treatment, Payment and Data Agreement:** Needs to be signed prior to seeing a clinician.
5) **Authorization for Request of Protected Health Information:** It is your responsibility to request your medical record(s) from your previous Primary Care Provider (PCP). You will find the request at the end of this packet. Please send this to your previous PCP and not to Outer Cape Health Services.

Please review the following Patient Responsibilities:

- Insurance: We do not accept all insurance plans. If you have an insurance for which we do not file, you are responsible for payment at time of service. You may submit your receipt to your insurance company yourself for reimbursement, although we cannot guarantee what reimbursement will be made, if any, by your insurance plan.
- We accept cash, check and credit card payments.
- If you have an insurance plan that requires assignment of a PCP, it is your responsibility to contact your insurance company of your new PCP
- Co-payments: Any co-pay that is required by your insurance company is due at time of visit.
- Prescriptions: We require 48 hours' notice to process all prescription refill requests. If you request a refill on a Friday, it may not be available until Monday.
- Controlled Substances will not be refilled at the first visit.

Please arrive 20 minutes prior to your appointment.

Thank you for choosing Outer Cape Health Services!

Patient Registration Form

Outer Cape HEALTH SERVICES

Patient Information (Please print clearly)

Legal Name* Last First Middle Initial

Name used:

Legal Sex (please check one)* ◯ Female ◯ Male

Pronouns:

**While Outer Cape Health Services recognizes a number of genders / sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.*

Date of Birth (mm/dd/yyyy) _____ / _____ / _____

Social Security #

Contact Information

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone

Ok to leave voicemail? ◯ Yes ◯ No

Cell Phone

Ok to leave voicemail? ◯ Yes ◯ No

Work Phone

Ok to leave voicemail? ◯ Yes ◯ No

Best number to use to leave results & messages?

❑ Home ❑ Cell ❑ Work ❑ Other:

Mailing Address City State Zip Code

Address (if different from above) City State Zip Code

Email address

Would you like to register for the Patient Portal? ◯ Yes ◯ No

Occupation Employer/School Name

Are you covered under school or employer's insurance? ◯ Yes ◯ No

Emergency Contact's Name Phone Number Relationship to you

If you are under 18, the Department of Public Health requires that you provide parent/guardian contact information.

Parent/Guardian Name Phone Number Relationship to you

Preferred Pharmacy

Pharmacy Name_____ **Address** _____

Insurance Information

Medical	Plan Name	Subscriber #	Insured Name
Secondary	Plan Name	Subscriber #	Insured Name
Vision	Plan Name	Subscriber #	Insured Name
Dental	Plan Name	Subscriber #	Insured Name

Permission to Speak/Share Information

I authorize disclosure of my healthcare information to the individuals listed below. I understand that this authorization is voluntary I understand that one disclosed by Outer Cape Health Services to such person(s), we can no longer ensure that the confidentiality of the information. I understand that this authorization will remain in effect until Outer Cape Health Services receives written notice from me to cancel it.

Name	Relationship	Phone Number

Demographic Information

This information is for demographic purposes only and will not affect your care. As a Federally Qualified Health Center, Outer Cape Health is required to collect demographic information regarding the patients we serve. The information you provide is confidential.

1) What is your annual income?

$ _____

❑ No income

How many people (including you) does your income support?

2) Employment Status

- ❑ Employed full-time
- ❑ Employed part-time
- ❑ Student full-time
- ❑ Student part-time
- ❑ Retired
- ❑ Unemployed
- ❑ Other _____

3) Racial Group(s) (check all that apply)

- ❑ African American / Black
- ❑ Asian
- ❑ Caucasian / White
- ❑ Native American / Alaskan Native / Native Hawaiian
- ❑ Pacific Islander

4.) Ethnicity

- ○ Hispanic/Latino/Latina
- ○ Not Hispanic/ Latino/Latina

5) Preferred Language (choose one)

- ○ English
- ○ Spanish
- ○ French
- ○ Portuguese
- ○ Hebrew
- ○ Other _____

6) Do you think of yourself as:

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

7) Marital Status

- ○ Married
- ○ Partnered
- ○ Single
- ○ Divorced
- ○ Other _____

8.) Veteran Status

- ○ Veteran
- ○ Not a Veteran

9.) What is your gender?

- ○ Female
- ○ Male
- ○ Genderqueer or not exclusively male or female
- ○ Choose not to disclose

10) What was your sex assigned at birth?

- ○ Female
- ○ Male
- ○ Choose not to disclose

11) Do you identify as transgender or transsexual?

- ○ Yes
- ○ No
- ○ Don't know
- ○ Choose not to disclose

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HEALTH SERVICES

ANNUAL HEALTH HISTORY QUESTIONNAIRE

All information you provide is strictly confidential and will become part of your medical record. Please answer the questions to the best of your ability, especially any information that is new or has changed over the past year. You may leave any or all fields blank, but your provider may ask for the information in your office visit.

DEMOGRAPHICS

Last Name _____ First Name _____ Middle Initial _____

Date of Birth (mm/dd/yyyy) _____

Gender ◯ Female ◯ Male ◯ Transgender ◯ Other _____

Marital Status ❑ Single ❑ Married ❑ Partnered ❑ Separated ❑ Divorced ❑ Widowed

Occupation _____

Previous Source of Health Care _____

Date of Last Physical Exam _____

Is a record release signed? ◯ Yes ◯ No

Have you completed a Health Proxy or Living Will form? ◯ Yes ◯ No

MEDICAL CONDITIONS THAT HAVE BEEN DIAGNOSED

Acid Reflux/Heartburn	◯ Yes	◯ No	Kidney Disease	◯ Yes	◯ No
Blood Pressure High	◯ Yes	◯ No	Liver Disease/Hepatitis	◯ Yes	◯ No
Bowel Disease	◯ Yes	◯ No	Lung Disease/Asthma	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Cholesterol Elevated	◯ Yes	◯ No	Thyroid Disease	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No	Other _____		
Heart Disease	◯ Yes	◯ No			

CURRENT HEALTH PROBLEMS

Have you had a recent change in weight?	◯ Yes ◯ No
If yes, was it intentional?	◯ Yes ◯ No
Do you have difficulty sleeping?	◯ Yes ◯ No
Do you have fatigue?	◯ Yes ◯ No
Do you have pain?	◯ Yes ◯ No
Do you get up to urinate at night?	◯ Yes ◯ No
If yes, how many times each night?	_____
Do you have difficulty with urination including pain, burning or blood in your urine?	◯ Yes ◯ No
Have you had kidney or bladder infections in the past year?	◯ Yes ◯ No
Do you have difficulty with your bowels?	◯ Yes ◯ No
Do you have difficulty breathing?	◯ Yes ◯ No
Do you have chest pain or pressure?	◯ Yes ◯ No
Do you have a cough?	◯ Yes ◯ No
Do you have mood changes?	◯ Yes ◯ No
Do you have frequent headaches?	◯ Yes ◯ No

Other _____

SURGERIES AND OTHER HOSPITALIZATIONS

Date	Reason	Name of Hospital

IMMUNIZATIONS

	Date	Name of Facility
Tetanus/Diptheria/Pertussis		
Pneumovax (Pneumonia)		
Zostavax (Shingles)		
Hepatitis B		
Other		

SCREENINGS

	Date	Name of Facility
Mammography		
Pap Test (Female or Male)		
Colonoscopy		
Bone Mass Density		
Anal Colposcopy (HRA)		
Rectal Exam		
Prostate Exam		
Other		

OTHER DOCTORS AND SPECIALISTS

	Date	Name of Facility
Dentist		
Eye Doctor		
Therapist/Counselor		
GYN		
Other		

PRESCRIPTIONS, OVER THE COUNTER MEDICATIONS AND HERBAL PRODUCTS USED

Name	Dose	Frequency

PRESCRIPTIONS, OVER THE COUNTER MEDICATIONS AND HERBAL PRODUCTS, Continued

Name	Dose	Frequency

ALLERGIES TO MEDICATIONS

Medication	Reaction

ALLERGIES TO FOOD AND ENVIRONMENTAL SOURCES

Source	Reaction

HEALTH HABITS AND PERSONAL SAFETY

Exercise

What type of exercise do you do? _____

How many times a week?

Duration of workout

Diet

❑ Regular (Unrestricted)

❑ Low Fat

❑ Low Salt

❑ Low Carbohydrate

❑ Vegetarian

❑ Vegan

❑ Gluten Free

❑ Lactose Free

_____ # per day Soda

_____ # per day Sports Drinks

Number of meals average in a day _____

Caffeine

	Number of cups per day
Coffee	_____
Tea	_____

HEALTH HABITS AND PERSONAL SAFETY, Continued

Caffeine, cont'd

Soda _____

Energy Drink _____

Other _____

Alcohol

Do you drink alcohol? ◯Yes ◯No

If yes, how many drinks per day or week? _____

Are you concerned about the amount you drink? ◯Yes ◯No

Have family or friends ever expressed concern about your drinking? ◯Yes ◯No

Tobacco

Have you ever used tobacco? ◯Yes ◯No

If yes, how many years have you used tobacco? _____

If yes, year last used? _____

per day: Cigarettes _____ Cigars _____ Pipe _____ Chew _____

Drugs

Have you ever used recreational or street drugs? ◯Yes ◯No

Have you ever misused prescription or non-prescription drugs? ◯Yes ◯No

Have you ever given yourself drugs with a needle that were not prescribed to you? ◯Yes ◯No

Would you like to meet with a provider to confidentially discuss your drug use? ◯Yes ◯No

Domestic Violence

Have you ever felt unsafe or threatened by someone close to you? ◯Yes ◯No

Have you ever been a victim of verbal, psychological, or physical abuse? ◯Yes ◯No

Mental Health

Have you ever been treated for: depression, anxiety, or other mental health problems? ◯Yes ◯No

Have you ever had a psychiatric hospitalization? ◯Yes ◯No

Have you ever attempted suicide? ◯Yes ◯No

Sexual Health

Are you currently sexually active? ◯Yes ◯No

If yes, currently sexually active with: ◯Men ◯Women ◯Both

Have you ever had a sexually transmitted infection? ◯Yes ◯No

HEALTH HABITS AND PERSONAL SAFETY, Continued

If yes, please list date and type of infection _____

_____

Would you like to speak with a counselor about your risk of HIV/AIDS? ◯ Yes ◯ No

Do you think of yourself as:
- ❑ Straight or heterosexual
- ❑ Lesbian, gay, or homosexual
- ❑ Bisexual ❑ Something else ❑ Don't know

Women's Health

Age at onset of menstruation _____ Age at onset of menopause _____

Date of last period _____ Period every ____ days for ____ days

Bleeding/spotting between periods? ◯ Yes ◯ No

Bleeding/spotting since menopause? ◯ Yes ◯ No

Flow ◯ Light ◯ Moderate ◯ Heavy

Cramping? ◯ Yes ◯ No

Are you currently trying to get pregnant? ◯ Yes ◯ No

If no, what is your birth control method? _____

Are you pregnant? ◯ Yes ◯ No

Are you breastfeeding? ◯ Yes ◯ No

Men's Health

Do you have pain, burning, or discharge from your penis? ◯ Yes ◯ No

Do you have difficulty with erection or ejaculation? ◯ Yes ◯ No

Do you have testicle pain or swelling? ◯ Yes ◯ No

Safety

Are you exposed to hazardous materials or situations at work? ◯ Yes ◯ No

Do you regularly wear a seatbelt? ◯ Yes ◯ No

Are there guns in the house? ◯ Yes ◯ No

FAMILY HEALTH HISTORY

Mother

Father

Siblings

❑ **Adopted** – History Unknown

Children

Thank You for Completing this Form

CLICK HERE TO PRINT

Treatment, Payment and Data Agreement

Print Name: _____ **Date of Birth:** _____

- I hereby give my consent and authorize Outer Cape Health Services to treat any medical or mental health condition providing that the care provider has explained my condition to me, the treatment procedures and alternative methods of treating my condition. The care provider has discussed with me foreseeable risks of the above stated treatment and that there may be undesirable results.
- I understand that Outer Cape Health Services operates a primary care practice that integrates behavioral health services, which means behavioral health staff are part of my medical team and experience, and that being seen by a behavioral health provider through primary care may result in additional charges to my insurance. This may also result in an additional copayment or coinsurance. I acknowledge that in cases of insufficient coverage, I will be held responsible for the remaining balance.
- I have carefully read and fully understand this Informed Consent Form and all of my questions have been adequately answered.
- I authorize examination and treatment for this and all following medical or mental health visits.
- I understand I am personally responsible for all charges and deductibles. Financial assistance is available for those who qualify.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurance submissions.
- I authorize release of all information necessary to secure payments of benefits.
- I understand that Outer Cape Health Services may use data developed for and/or provided by clients to determine general characteristics of the communities it serves and that none of this information will in any way identify individual clients.
- I certify that the above information is true and correct. I have received a copy of Outer Cape's Notice of Privacy Practices (HIPAA) and Patient Rights and Responsibilities.

Patient Signature _____ **Date** _____

General Information: Informed consent will be obtained from all patients accessing medical, behavioral health, and/or research services/activities. Informed consent is not merely a signed document. It is an ongoing process that considers patient needs and preferences, compliance with law and regulation, and patient education.

The patient and/or family, as appropriate, are given information about:

- The patient's condition;
- Proposed treatments, procedures, or research activities;
- Potential benefits and drawbacks of proposed treatments or procedures;
- Problems related to recuperation;
- Alternative treatment(s) or procedure(s);
- The physician or other practitioner primarily responsible for the patient's care;
- Others authorizing or performing procedures or treatments; and
- Any business relationships among individuals treating the patient, or between the organization and any other health facility.

The information in your medical record is confidential and is protected under Massachusetts General Laws Ch. 111, Sec 70. Your written consent will be required for release of information except in the case of a court order.

Authorization for Request of Protected Health Information

Outer Cape HEALTH SERVICES

Patient Name Last	First	Middle Initial	**Patient Date of Birth** (mm/dd/yyyy)

Patient Address Street	City/Town	State	Zip Code

Patient Phone Number

I hereby authorize and request a copy of my medical records be sent by mail or fax to:

Outer Cape Health Services
P.O. Box 598, Harwich Port, MA 02646
Fax: 508-487-6298

For the purpose of: ☐ Personal ☐ Legal ☐ Transferring Care ☐ Other

Requested Information:_____ ❑ All Records

Covering the period from:_____to _____

Former Practice Information

_____
Practice Name

_____
Practice Address

_____
Phone Number Fax Number

Protected under State Law: Please initial below	
Alcohol and/or Drug Abuse Treatment	I DO Authorize. Initial:
HIV/Communicable Disease*	I DO Authorize. Initial:
Genetic Testing	I DO Authorize. Initial:
Mental Health Services	I DO Authorize. Initial:
(Mental Health Services by a clinical nurse specialist, Psychologist, Social Worker, counseling professional or a physician specializing in psychiatry licensed under the provision of Title 32)	

*A separate release authorization is required for each request to release the results of HIV/AIDS testing, M.G. L. c111§ 70F

**Release of information must comply with the federal HIPAA Privacy Act and federal Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR, part 2 regulations. Note to recipient: This contains confidential information. 42 CFR part 2 prohibits you from making any further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse.

I hereby disclose my health information for the purposed noted above. I understand that once such information has been disclosed to the intended recipient, that OCHS cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

If I have questions about disclosure of my health information, I can contact the Outer Cape Health Services Compliance Officer: 508-905-2820 or patientexperience@outercape.org

This authorization is valid for release of Protected Health Information for 180 days from date below **OR** (please indicate):

❑ a one-time disclosure ❑ upon termination from services ❑ until revoked in writing ❑ other

Patient or Legal Representative Name (print) _____

Address: _____

Patient or Legal Representative Signature:_____ Date: _____

Relationship to Patient:_____ Phone Number: _____

A facsimile or copy of this document is valid as the original.
Scan Completed Document to EMR: Consents and Contracts

Revised 10/11/2018