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. ***Please complete all forms in black ink only to ensure readability when scanned.***

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!

Outer Cape HEALTH SERVICES

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities

This notice describes how medical information about you may be used and shared with others and how you can get access to it. Please review it carefully.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use your health information in the following ways.

1) To treat you

We can use your health information to and provide it to others who are treating you.

Example: *A doctor treating you for an injury asks another doctor about your overall health condition.*

Outer Cape Health Services uses a secure medical record. Access to your medical records and other information maintained by Outer Cape Health Services is restricted to clinicians and staff who need the information for treatment, payment or health care operations purposes, or other allowable purposes as described by this Notice.

In some cases, clinicians at other health care organizations may be able to electronically access your health information created or maintained by Outer Cape Health Services, through a secure network for the transmission of health information such as the Massachusetts Health Information Highway ("The Hiway"). All of these clinicians are required to take steps to protect the confidentiality of your information.

2) To run our organization

We can use and share your health information to run our practice, improve your care and contact you when necessary.

Example: We use health information about you to assess the quality of care we provide.

3) To bill for our services

We can use and share your health information to bill and collect payment for health plans or entities, including individuals, such as family members who are responsible for paying for your health care.

Example: We give information about you to your health insurance company so it will pay for our services.

How else can we share your information?

We are allowed or required to share your information in other ways, usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information. For more information: www.hhs.gov.privacy,hipaa

Help with public health and safety issues

Such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medication
- Reporting abuse, neglect or domestic violence.

Do research

We can use or share your information for health research.

Comply with the law

If state or federal law requires it, we will share your information. This includes the Department of Health and Human Services if it wants to see that we are complying with federal privacy laws.

Example: *Massachusetts Immunization Information Systems ("MIIS") is a statewide system to track immunizations given to you and your family. The goal is to ensure everyone in the state's up-to-date with their vaccinations and that records are available when you need them, such as when a child enters school, in an emergency or when you change your healthcare provider. You can choose to opt out of the program, but your information will continue tobe maintained in the MIIS database. Opting out only means that you will need to keep track of your child's immunization records in the event that you change doctors or get immunized at another health facility.*

Respond to organ and tissue donation requests

We share information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We share information when an individual dies.

Address worker's compensation, law enforcement and other government requests

- Workers compensation claims
- Law enforcement purposes with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security and presidential protective services.

Response to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs.
- We will follow the duties and privacy practices described in this Notice and give you a copy.
- We will not share or use your information other than as described in this Notice unless you tell us we can. If you change your mind at any time, you must let us know in writing.

YOUR RIGHTS

This section explains your rights and some or our responsibilities to help you.

Get an electronic copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how we can help you do that. We will provide a copy within 30-days of your request. We may charge a reasonable cost-based fee in accordance with state and federal law.

Ask us to correct your medical record

You can ask us to correct information about you that you think is incorrect. Ask us how we can help you do that. We may say “no” to your request, but we’ll tell you why in writing within 60 days. If we say “no”, you still have the right to have your disagreement noted in your file.

Request confidential communications

You can ask us to contact you in a specific way (phone or cell phone) and all reasonable requests will be approved.

Ask us to limit what we share

- You can ask for us not to share or use certain health information. We are not required to agree with your request and we may say “no” if it would affect your care.
- If you pay out of pocket for your health care, you can ask us not to share that information with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we have shared information

- You can ask for a list (accounting) of the times we’ve shared your health information in the past 6 years prior to the date you ask, who we shared it with and why.
- We will make all disclosures except for those about treatment, payment, health care operations and any other disclosures that you have asked us to make.

  We will provide one accounting a year for free, but will charge a reasonable cost-based fee if you make another within 12 months.

Get a copy of the Privacy Notice

You can ask for a paper copy of this Notice, even if you have agreed to get it electronically.

File a complaint if you feel your rights have been violated

- You can complain, if you feel we have violated your rights by contacting the location where you received care, or by contacting the Outer Cape Health Services Privacy Officer at 508-905-2800.
- You can file a complaint with the US Department of Health and Human Services Office for Civil Rights, 200 Independence Avenue, SW, Washington DC 20201, 1-877-696-6775 or www.hhs.gov/ocr/privacy/hipaa/complaints
- Outer Cape Health Services will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information you can tell us your choices about what we share. Please let us know if you have a clear preference for how we share information in the situations described below.

- Share information with your family, close friends or others involved in your care.
- Share information in a disaster relief situation

If you are not present, unable to communicate or in an emergency situation, we may exercise judgment to determine whether to disclose information to others involved in your care. We may also share information when needed to lesson a serious and imminent threat to health or safety.

Federal and state law require your specific written authorization for the disclosure of this information: psychotherapy notes, as defined by laws; communication with certain behavioral health professionals; communications between domestic violation victims and their domestic violence counselor(s); and between sexual assault victims and their sexual assault counselor(s); and information related to substance abuse treatment, HIV testing or results ; treatment of sexually transmitted diseases, and genetic testing. As well as marketing and the sale of your information.

In the case of fundraising, if you do not wish to be contacted, please call our Development Office at 508-905-2800.

RIGHT TO CHANGE TERMS OF THIS NOTICE

We may change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, at Outer Cape Health Services and on our website. **Effective Date of this Notice is November 1, 2018**.

Patient Registration Form

Outer Cape HEALTH SERVICES

Patient Information (Please print clearly in BLACK ink only)

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

Outer Cape
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. ***Please complete in BLACK ink only.***

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

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)	

To the practice sending records, please send **only** the following:

- Health maintenance sheet
- Immunization record
- Last CPE
- Last 3 office visit notes
- Labs for current and previous year
- All pathology reports
- Last PAP report and any abnormal reports
- Last colonoscopy and any abnormal reports
- Last mammogram and any abnormal reports
- Last chest x-ray and any abnormal reports
- All MRI's, CT's, interventional radiology studies
- All consults in the past 2 years with exception, of all cardiology, oncology, neuropsychiatry and pain consults
- All cardiology testing in the last 2 years
- All neurology testing (EMG, EEG) or pulmonary testing in the past 2 years
- Hospital discharge summaries
- All mental health records for the past 2 years

*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