107 Commercial Street
Mashpee, MA 02649-
508-477-7090
508-477-7028 (fax)
www.chcofcapecod.org

Welcome to your new medical home! We are excited to offer you high quality, integrated health care services including medical, dental, behavioral health, optometry, pharmacy, and so much more!
Please follow these easy admission steps to become a patient

1. Apply for health insurance if necessary (we must have verification that you have applied for insurance **before** we can schedule you for an appointment). If you need assistance applying for health insurance, we can help. Assistance is available according to the schedule at the end of this sheet.
2. Complete and return (drop off, fax or mail) the registration forms:
   - New Patient Registration
   - Authorization for Treatment and Health Center Services
   - New Patient Nursing Intake
   - Release of information for previous medical records
3. Read and keep the enclosed Patient Information Guide and Notice of Privacy Practices

We will contact you, usually within 5 business days, to help you choose a medical provider and schedule your first appointment. Please call our New Patient line at 508-477-7090 and press 0 for an operator during business hours if you need additional assistance.
Para pacientes que precisam de ajuda para aplicar para o seguro em Mashpee ou precisam de uma orienta-ção para se tornar paciente, por favor ligue para 508-477-7090 ramal 1151.

Sincerely,

Karen Gardner
Chief Executive Officer

Health Insurance Application Assistance
We generally have staff available Monday - Friday, 9 a.m. - 4 p.m. to assist with health insurance applications. It is best to call ahead (508-477-7090) to be sure someone is available to help you. If you have any questions about health insurance applications, please contact our Outreach Coordinator, at 508-477-7090, ext. 1155

Community Health Center of Cape Cod ~ New Patient Registration Form –- please complete in black ink Jun-19

I am registering for the following services: ☐Primary Care *Preferred location for primary:* ☐*Mashpee* ☐*Falmouth* ☐*Bourne*

☐Walk-In only ☐Dental ☐Women's Health/Gyn ☐Addictions Treatment ☐Vision* ☐Behavioral Health*
(*You must be a Primary Care patient at CHC to access these services)
If you receive Primary Care elsewhere, please provide name of your PCP:________________________________

Patient Last Name:	Patient First Name:	SSN:	Date of Birth:	Sex (legal): ☐M ☐F

Title:	Middle Name:	Preferred Name/Nickname:	Maiden Name:	Other names or aliases:

Mailing Address:	City:	State:	Zip Code:
Home Address (if different from Mailing):	City:	State:	Zip Code:

PHONE & EMAIL Please provide number where you prefer to receive calls or text messages & where we may leave a message for you.
Phone (________) ________________________ Patient E-mail: ________________________________
This is my: ☐ Mobile ☐ Home ☐Work ☐ Other ____________________

Marital Status: ☐Single ☐Married ☐Divorced ☐Domestic Partner ☐Separated ☐Widowed

Ethnicity – check one ☐ Hispanic ☐Non-hispanic

Race - Check as many as apply ☐White ☐Black ☐Asian ☐Native Hawaiian ☐Other Pacific Islander ☐ American Indian ☐Alaska Native

Sex assigned at birth: ☐M ☐F	Sexual Orientation:	Pronoun:

Gender Identity: ☐M ☐F ☐Trans M to F ☐Trans F to M ☐Nonbinary/genderqueer ☐Questioning ☐Other ☐Choose not to disclose

Is patient a US VETERAN? ☐Yes ☐No

Country of Birth - ☐US ☐Brazil ☐Cape Verde ☐Jamaica ☐________________

EMERGENCY CONTACT Name:________________________________ Phone Number: (_______)__________________
Relationship to patient:

PARENT/GUARDIANSHIP: please complete for Patients under age 18 and patients with Legal Guardian

Does the patient have a Legal Guardian, other than a parent? ☐Yes ☐No **If Yes, Please attach Guardianship paperwork.**
Name of Parent/Guardian:______________________________ Relationship to Patient ________________________________

Parent/Guardian Phone Number: (______)________________________ Parent/Guardian SSN:________________________

PATIENT EMPLOYER:	PATIENT OCCUPATION:

PATIENT EMPLOYMENT STATUS: Are you a seasonal or migrant worker? ☐ Yes ☐ No
☐Full-time ☐Not employed ☐Part-time ☐Retired ☐Active Military ☐Self-employed ☐Student FT ☐Student PT

Is Patient visually impaired? ☐Yes ☐ No Is Patient hearing impaired? ☐Yes ☐ No

Primary Language if not English:____ Interpreter needed? ☐Yes ☐ No

How did you hear about us?: ☐ Friend ☐Employer ☐ Social Service Agency ☐Hospital ☐Doctor ☐Newspaper

☐TV ☐Radio ☐Online search ☐Online ad ☐CHC postcard ☐CHC brochure ☐Other ______________________

What is your housing situation today?

Do you receive housing assistance (voucher/public housing, etc) ☐Yes ☐ No

☐ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
☐ I have housing today, but I am worried about losing housing in the future
☐ I have housing (check one): ☐Rent ☐Own ☐Live with family ☐Group home ☐Nursing Home

For grant reporting purposes only. No personally identifiable information is ever reported. This section helps us to receive funding
How many people are in your household: ______________ What is the annual income for your household:____________________

MEDICAL INS ID# ______________________________
Primary

MEDICAL INS ID# ______________________________
Secondary if applicable

Insurance (check all that apply): ☐ No Insurance ☐Applied
☐Mass Health (C3) ☐HSN ☐Medicare ☐Harvard Pilgrim
☐BC/BS ☐ Tufts ☐Tricare ☐United Health ☐Veterans
☐Other:___________________________________

ACO Affiliation: ______________________________

Are you a member of Indian Health Services? ☐Yes ☐No

Subscriber info (if insurance subscriber is not the patient):
Name________________________ Date of Birth__________

Dental Insurance ________________ID #________________
Dental Insurance ________________ID #________________

Vision Insurance________________ ID #________________
Vision Insurance________________ ID #________________

SIGNATURE (Patient or Parent/Guardian): Date:

Date received by CHC:	*Office/PCP assigned:*	*CHC Staff initials accepting packet/date:*

COMMUNITY HEALTH CENTER of Cape Cod

NEW PATIENT INTAKE FORM JUN-19

Name *(Last, First, M.I.)*:	Date of Birth:	Date Completed:

MEDICATIONS

Please list any medications that you are currently taking. *Place a checkmark next to any that needs refills.*

☐	☐
☐	☐
☐	☐

Please list any allergies to medications or any other allergies:

Please check here if you do not have any medication allergies ☐ Please check here if you are not on any medications ☐

RECENT HISTORY

Name of Previous Physician:	Phone:

Question	Yes	No
Have you been seen in the ER in the last 10 days?	☐ Yes	☐ No
Have you been an inpatient at a hospital, rehab, detox or nursing facility in the last 21 days?	☐ Yes	☐ No
Do you have any URGENT medical needs that require you to be seen immediately?	☐ Yes	☐ No
Please explain briefly:		
Who is your health care proxy? (Please provide us with a copy of the document):		
Do you have an advance directive document? (Please provide us with a copy)	☐ Yes	☐ No
Have you seen a specialist recently? (i.e. Neurologist, Orthopedist, Cardiologist, Behavioral Health, etc.)	☐ Yes	☐ No
Do you have thoughts of hurting yourself or others?	☐ Yes	☐ No
Would you like to see a counselor?	☐ Yes	☐ No
For pediatric patients: is the patient in need of immunizations or a time-sensitive physical?	☐ Yes	☐ No
Do you need an antibiotic prior to dental treatment? (eg joint replacement, artificial heart valve)	☐ Yes	☐ No
Have you ever had any complications following dental treatment?	☐ Yes	☐ No
If yes, please explain:		

Please check any of the following that you need assistance with:

☐ Reading/Writing	☐ Housing	☐ Health Insurance	☐ Language/Interpreter	☐ Transportation

HEALTH ISSUES

☐ AIDS/HIV	☐ Excessive Bleeding	☐ Rheumatic Fever	☐ Pregnancy, Due Date:
☐ Anxiety	☐ Fainting	☐ Radiation Treatment	☐ Rheumatic Fever
☐ Ability to sleep	☐ Growths	☐ Liver Disease	☐ Sexually Transmitted Infection
☐ Arthritis	☐ Hay Fever	☐ Pacemaker	☐ Sinus Problems
☐ Asthma/Emphysema	☐ Heart Disease/ Heart Attack	☐ Ulcers	☐ Stroke
☐ Artificial Joints	☐ Heart Murmur	☐ Glaucoma	☐ Thyroid disease
☐ Blood disease	☐ Hepatitis	☐ Throat	☐ Tuberculosis
☐ Cancer	☐ High Blood Pressure	☐ Rheumatism	☐ Tumors
☐ Depression	☐ Jaundice	☐ Lungs	☐ Vision problems
☐ Diabetes	☐ Kidney Disease	☐ Stomach Problems	☐ Other
☐ Dizziness	☐ Respiratory Problems	☐ Head injuries	
☐ Epilepsy	☐ Alcohol / Drug Dependency (past or present)	☐ Mental Disorders	

Signature:________________________________ **Date:**____________________

Dear Patient, Please complete separate Request for Release of Protected Health Information forms for each provider who has medical records for you, including your previous primary care provider and any specialist you have seen. Additional forms can be downloaded from chcofcapecod.org or picked up any of our office locations. Thank you!

CHC COMMUNITY HEALTH CENTER of Cape Cod

REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION

107 Commercial Street, Mashpee MA 02649
Phone (508) 477-7090 Fax (508) 477-7028

Patient Last Name:	Patient First Name:	Middle Initial:	Date of Birth:

Patient Mailing Address:	Patient Phone:

I authorize CHC of Cape Cod to:

❑ **Send my CHC medical records to** ☒ **Request my medical records from** ❑ **Share (send and receive) records with**

Name/Facility:	Phone:	Fax:

Street:	City:	State:	Zip

Medical records include information pertaining to my identity, prognosis, diagnosis, or treatment
Information to be released:

☒ My Entire Record

Under Massachusetts state law we cannot release certain information unless you give us special permission to release it.
By initialing each item I agree to its release:
___HIV/AIDS information (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST WITH SPECIFIC DATES)
___Details of Domestic Violence Victims' Counseling
___Details of Sexual Assault Counseling
___Details of Mental Health Diagnosis and/or treatment provided by a Mental Health Provider (I understand that my permission may not be required to release my mental health records for payment purposes)
___Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon written request

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 ❑other____________________

I understand that by law, I do not need to consent to the release of/request for this information to receive care or payment for care or to be eligible for enrollment or any benefits. However, I choose to do so willingly and voluntarily for the purpose specified above. My signature acknowledges my receipt and understanding of CHC of Cape Cod Notice of Privacy Practices. I understand that I have the right to request a copy of my records as provided by CFR 164.524. I understand that I have a right to receive a copy of this form after I have signed it. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact the Health Information Manager.

I understand that I may revoke this authorization in writing. Upon revocation, information will not be released except to the extent that we have already taken action in response to this authorization.
I also release Community Health Center of Cape Cod from all legal responsibilities and liabilities that may arise from the release of the information.

Signature of Patient/personal representative:____ **Date:**____________________

If signed by anyone other than patient, print name and select relationship and/or reason and legal authority to do so

Name:____
Patient is: ❑minor ❑incompetent ❑deceased ❑Parent/legal guardian ❑Legal authority (proof attached)

Signature of witness:____ **Date:**____________________

A facsimile or copy of this document is as valid as the original

Dear Patient, Please complete separate Request for Release of Protected Health Information forms for each provider who has medical records for you, including your previous primary care provider and any specialist you have seen. Additional forms can be downloaded from chcofcapecod.org or picked up any of our office locations. Thank you!

CHC Community Health Center of Cape Cod	**REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION** 107 Commercial Street, Mashpee MA 02649 Phone (508) 477-7090 Fax (508) 477-7028		
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Patient is: ❑minor ❑incompetent ❑deceased ❑Parent/legal guardian ❑Legal authority (proof attached)

Signature of witness:____ **Date:**____________________

Notice of Privacy Practices for Patients

Please read and keep

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

Community Health Center of Cape Cod (CHC) strongly believes in safeguarding the privacy of our patients' protected health information (PHI). PHI is information which:

- Identifies you (or can reasonably be used to identify you) and
- Relates to your physical or mental health condition, the provision of health care to you or the payment for that care.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. This Notice of Privacy Practices describes how we may collect, use and disclose your PHI, and your rights concerning your PHI.

Understanding Your Personal Health Information

Every time you visit the Health Center and are seen by a provider or receive other services a record is made of that visit. This medical record usually contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. The medical records for the Health Center are stored on paper or on computer.

Medical information may also be used and stored by other departments in the Health Center in the regular course of business. This information may be stored on paper or on computer. The Health Center also may receive information about your health from providers or facilities not part of CHC and store such information with your CHC medical record. All of this information is considered confidential and is subject to the protections mentioned in this privacy notice.

Your medical information is used for many purposes, including:

- Planning your care and treatment
- Communication among the health care providers who take care of you
- Proving that services billed to your insurance company were actually provided
- Helping to improve the quality of care provided to Health Center patients
- Assisting public health officials in improving the health of the public
- Providing a legal record of the care and treatment you received

Understanding what is in your PHI and how it is used helps you to:

- Ensure its accuracy and completeness
- Understand who, what, where, why, and how others may access your PHI
- Make informed decisions about authorizing disclosures to others
- Better understand the PHI rights detailed below

Your Individual rights

Your PHI is the property of the Health Center, but you or your legally recognized representative have the right to:

- Obtain a paper copy of this notice upon request

- Request a restriction on some uses and disclosures of the information contained in your medical record
- Obtain a copy of your medical record
- Request to make an amendment to your medical record
- Receive an accounting or list of disclosures of your medical record
- Request that we provide your health information to you in an alternative way or at an alternative location in a confidential manner
- Revoke your authorization to use or disclose medical information except in cases where information has already been used or disclosed upon your previous authorization

The Health Center is required to:

- Protect the privacy of your medical information
- Provide you with a notice about our legal duties and privacy practices in regard to the information we collect and keep about you
- Follow the terms of this notice
- Let you know if we cannot agree to a requested restriction on the use or disclosure of your medical information
- Let you know if we cannot agree to a requested amendment to your medical information
- Agree to reasonable requests to communicate medical information by alternative means or at alternative locations than we usually use

The Health Center has the right to change the practices we follow. Should this happen we will let you know by having revised privacy notices posted and available at the Health Center.

We will not use or disclose your medical information except as described in this notice.

Examples of uses of medical information for treatment, payment, and health care operations

We will use your medical information for treatment
For example: Each time you visit the Health Center a record is made of the symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. All of the health care providers at CHC who take care of you are allowed to look at this information every time you return to the clinic for a visit or service.

We will use your medical information for payment
For example: When a bill is sent to an insurance company charging them for a visit it usually includes your name, other identifying information such as your date of birth and address, and information about the reason for your visit, the treatment given, and any supplies used.

We will use your medical information for regular health care operations
For example: The Health Center contracts with financial companies to audit the billing and payment processes. As part of auditing the billing and payment processes the contractor may need to review medical information related to the bill they are auditing. In all situations where a contractor or business associate receives access to protected health information, the Health Center requires the contracted person or company to protect the privacy of the medical information received. The Health Center may contact you to provide appointment reminders or information about health related benefits or services that may be of interest to you.

Health Information Exchange
The Health Center participates in Health Information Exchanges in order to share information securely and electronically with other providers and facilities involved in your care, including:

Massachusetts Immunization System (MIIS) – patients may opt out from MIIS sharing their immunization history with other practices

Massachusetts HIway – CHC uses Direct Messaging to communicate with some providers about your care. If the receiving provider's Direct Message address is a Mass HIway address the patient information will be transmitted securely through the Mass HIway. No data is stored on the Mass HIway. Direct Messaging is a secure, electronic means of communication that replaces methods like mail or fax.

Epic Care Everywhere – Providers involved in a patient's care who use the Epic Electronic Health Record system can share information securely. Patients may opt out from their information being shared via Epic Care Everywhere.

Use or disclosure of medical information without authorization

The Health Center is allowed by federal or state law or regulation to disclose medical information without authorization from the patient or legally recognized representative in the following circumstances:

- In medical emergency situations medical information about a patient may be disclosed to another medical professional or facility taking care of the patient, and as necessary, to a patient's family member
- When a patient is being referred to another provider or facility for medical care, information that the receiving provider or facility needs to take care of the patient may be disclosed to the receiving facility
- Insurance companies paying for services delivered to a patient are able to receive information about the services they are paying for
- Licensing or accrediting agencies receive information about patients in order for them to decide if the Health Center is providing good medical care
- The Health Center is required by state law to report suspected cases of abuse, neglect and domestic violence to state agencies; in such cases patient medical information may be disclosed to the state agency
- When a person dies who has been a patient at the Health Center and the medical examiner is investigating the death the Health Center is required by state law to provide patient medical information to the medical examiner if he or she requests it
- When a person has filed a claim with the Industrial Accident Board the Health Center may disclose patient medical information to the board if they request it
- When information has been requested by a valid court order, the Health Center is required by law to disclose the information requested
- The Health Center is required to report certain illnesses and conditions to state agencies overseeing the public health
- If a health care provider thinks that a patient may harm another person or if a patient has made a threat to harm another person the health care provider may contact law enforcement authorities and disclose information about the patient and the threat(s)
- The Health Center is required by law to provide information to the Food and Drug Administration (FDA) if requested to do so in regard to the quality, safety or effectiveness of products or activities regulated by the FDA
- Employers are entitled by law to receive information related to medical surveillance of the workplace or to evaluate whether or not a person has a work related illness or injury
- The law requires that the Health Center provide information to health oversight agencies if requested to do so
- Certain requests from law enforcement agencies may be responded to
- When there has been a disaster, the Health Center is allowed to share information as necessary to public or private agencies providing disaster relief

Business Associates

We provide some services through contracts with business associates. Examples include but are not limited to, paper shredding copy service to make copies of medical records, and the like. When we use these services, we may disclose your health information to the business associate so that they can perform

the function(s) we have contracted with them to do. To protect your health information however, we require our business associates to appropriately safeguard your information.

Current business associates also include health center controlled networks such as the Massachusetts League of Community Health Centers (MLCHC) and OCHIN. The MLCHC and OCHIN are engaged in quality assessment and improvement activities on behalf of CHC of CC and other network participants to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. MLCHC and OCHIN also work collaboratively with the CHC of CC to work collaboratively in improving the internal and external management of referrals.

Use or disclosure with authorization

Disclosures of information from your medical record other than those included in this privacy notice will be made upon your written authorization or the written authorization of the person legally able to act on your behalf.

For more information or to report a problem

If you have any questions about this notice or want more information you may contact the Compliance Officer at 508-477-7090.

If you think your privacy rights have been violated you can file a complaint with the Compliance Office by mail at Community Health Center of Cape Cod, 107 Commercial Street, Mashpee, MA 02649, or by calling the Compliance Officer at 508-477-4090. These calls will be confidential and will not adversely affect your relationship with CHC.