



A Free Clinic for the Uninsured or Underinsured

Mary Rose Clinic

Do you need Health Insurance?

YES! Please have a representative contact me regarding free or low-cost health insurance coverage or about other options available to me if not qualified.

Name: _____ Date: _____

Address: _____ City _____ Zip _____

Cell Phone _____ Home _____ Work _____

Primary Language _____ Household Size _____

How did you hear about us? _____

E-mail address _____

What is the best time to call you? Morning _____ Afternoon _____ Evening _____

Additional Information:

OFFICE USE ONLY

Referred to Navigator _____

Completed Application _____

Projected Start Date _____

Navigator Name _____

Agency Represented _____

Phone Number _____

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 _____

Employed? Yes No

Do you speak English? Yes No

I hereby give my consent for treatment at the Mary Rose Clinic

Signature _____ Date _____

The Mary Rose Clinic

1

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

HEALTH HISTORY

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: _____

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
Oneida Free Medical Health For the Uninsured
Phone #: 315-280-0855
Fax #: 315-367-0031

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Phone number: _____

Purpose of this request - Health Care

Type of records authorized: Medical

Periodic Use Disclosure: I authorize the periodic use/ disclosure of the information described above to The Mary Rose Clinic as often as necessary to fulfill the purpose identified in this document.

My authorization will expire:

- When I am no longer receiving services from The Mary Rose Clinic
- One year from this date
- Other: _____

Signature of Patient or Representative: _____

Date: _____

Patient or Representative has been provided a copy of this authorization. _____
Staff member providing agency

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.

The Doctor may leave messages (for appointment reminders, lab or x-ray results) on my telephone answering machine at my home. Yes _____ No _____.

The Doctor may leave messages (for appointment reminders, lab or x-ray results) 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, The Doctor may leave messages on it. Yes _____ No _____.

The Doctor may leave messages for appointment reminders with others in my home. Yes _____ No _____.

If necessary, The Doctor may talk with my spouse or significant other about my medical condition and / or billing information. The name of this person is _____ Yes _____ No _____.

If necessary, The Doctor may talk with my parents or with my caretaker about my medical condition and / or billing information. The name of my parents or caretaker are: _____ Yes _____ No _____.

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 to 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

HIPAA Authorization 6/16/08 HIPAA Authorization 6/16/08

The Mary Rose Clinic
1081 Northside Shopping Center
Oneida, NY

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 warranties 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

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A Free Clinic for the Uninsured or Underinsured

I understand 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

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 Health Connections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Health Connections 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 Health Connections website at <http://healthconnections.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.

<p>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.</p>
<p><input type="checkbox"/> 1. I GIVE CONSENT for The Mary Rose Clinic to access ALL of my electronic health information through Health Connections to provide health care services (including emergency care).</p>
<p><input type="checkbox"/> 2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY for The Mary Rose Clinic to access my electronic health information through Health Connections.</p>
<p><input type="checkbox"/> 3. I DENY CONSENT for The Mary Rose Clinic to access my electronic health information through Health Connections for any purpose, <i>even in a medical emergency</i>.</p>

If I want to deny consent for all Provider Organizations and Health Plans participating in Health Connections to access my electronic health information through Health Connections, I may do so by visiting Health Connections website at <http://healthconnections.org/> or calling Health Connections 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 accessed through Health Connections and the consent 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 Health Connections. 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 Health Connections. You can obtain an updated list at any time by checking Health Connections website at <http://healthconnections.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 Health Connections 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 Health Connections website at <http://healthconnections.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 Health Connections ceases operation. If Health Connections 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 Health Connections 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.