Directions to: **Physiatry and Rehabilitation Medicine**

Our Practice is located at 201 Dates Drive, Cayuga Medical Center Medical Office Building, Suite 201, Ithaca, NY 14850

FROM ITHACA: Take Route 96 N (also known as Cliff St. and Trumansburg Rd.) approximately 2.5 to 3 miles, until you come to a traffic light at the Cayuga Medical Center, turn Right. **Continue to the STOP sign, then make a left. You then proceed through 2 short STOP signs, then take a right. The Hospital Main Entrance is separate from the Medical Office Building Entrance. You will see a glass covered walk way, this is the entrance into the Medical Office Building.**

FROM TRUMANSBURG: Take Route 96 S towards Ithaca until you come to a traffic light at the Cayuga Medical Center entrance, turn Left.
Continue to the STOP sign, then make a left. You then proceed through 2 short STOP signs, then take a right. **The Hospital Main Entrance Is separate from the Medical Office Building Entrance. You will see a glass covered walk way, this is the way into the Medical Office Building.**

If you will be using GPS, enter the following address:

101 Dates Drive

Ithaca, NY

Appointment Scheduled with:_____

Date:_____ Time:_____

Please arrive 15 minutes prior to appointment time.
Thank You for your consideration.

PHYSIATRY & REHABILITATION MEDICINE, PC
Andrew J. Morpurgo, MD and Melissa W. Thibault, MD
201 Dates Drive, Suite #201, Ithaca, NY 14850
Phone: 607-277-4097 Fax: 607-277-4142
Tax ID# 16-1511056

Today's Date: ****USE BLACK INK TO FILL IN FORM****

Name: **Date of Birth:** **Birth Gender:**

ADDRESS (*street, city, state, zipcode)*

PHONE #'S: HOME CELL WORK

E-MAIL ADDRESS:

Do you wish to be enrolled in the patient portal of Practice Fusion, our electronic health record? YES / NO

Sexual Orientation: Gender ID/Pronouns:

Preferred Language if not English: Are you Hispanic or Latino? Race:

Referred to us by: Primary Medical Provider:

Employer: Date stopped work: Due to Injury? YES/NO

Emergency Contact: Phone: Relation:

INSURANCE INFORMATION:

(If this is a workers compensation or no fault case provide your regular insurance information also in case of denial)

Primary Insurance: ID #: Group# :

Subscriber name and date of birth if not self:

Address: Phone #:

Secondary Insurance: ID #: Group# :

Subscriber name and date of birth if not self:

Address: Phone #:

Workers Compensation Insurance Carrier: **Date of Injury:**

Address: Phone #:

Case Manager: Fax #:

WCB #: Case #:

Employer at time of injury and Address (*street, city, state, zipcode)*:

No Fault Insurance Carrier (if motor vehicle related): **Date of Accident:**

Address: Phone #:

Case Manager: Fax #:

Name of Insured: Date of Birth of Insured: Relation:

Policy#: Place of accident (city, state):

Patient: _____ Date of Birth: _____ Date: _____

Questions in this box are for patients ≥ 64 yrs

Advanced Care Plan: It is essential that your wishes regarding medical treatment be established as much as possible prior to incapacity. Advanced directives determine your wishes about future life-sustaining medical treatment including: resuscitation procedures, mechanical ventilation, chemotherapy, radiation therapy, dialysis, simple diagnostic tests, pain control, blood products, medications, and nutrition.

Do you have a living will, advanced directive, or DNR orders? _____

Do you have a surrogate decision maker or health care proxy in the event of your inability to make decisions for yourself and if so, who is it (name and contact information if available)? _____

MEDICATION ALLERGIES (please note reaction):

_____

_____

_____

MEDICATIONS including herbals and supplements (name, route of administration, dose, frequency):

_____

_____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY:

List any major illnesses or injuries: _____

_____

_____

_____

_____

_____

Surgeries or Hospitalizations including year and complications: _____

_____

_____

_____

_____

_____

Patient: _____ **Date of Birth:** _____ **Date:** _____

Family History: Please list below medical conditions of blood-related family members and/or what they died from

_____

_____

_____

Do you exercise regularly? If yes, explain: _____

Smoking: How many packs per day? _____ How many years? _____

Smoking is dangerous to your health. Would you like information about health consequences or how to quit ? _____

Alcohol: Type: _____ Amount: _____

If female, are you now pregnant? _____

What is the highest grade in school or degree you obtained: _____

Who lives with you and in what setting (house, apartment, assisted living)? _____

REVIEW OF SYSTEMS: Are you currently, or have you had major problems with (circle):

Constitutional: Fever Weight loss Excessive fatigue Night sweats

Eyes: Wear glasses Infections Injuries Glaucoma Cataracts

Ear, Nose, Throat, Mouth: Hearing loss Hearing Aids Ringing in ears Vertigo/Spinning Nosebleeds
Inability to smell Sinus problems Sinus headaches Sore throat Mouth sores

Cardiovascular: Chest pain/Angina Date of last EKG: _____ High blood pressure Irregular pulse
Heart murmur High cholesterol Swelling in Hands/Feet Leg pain while walking

Respiratory: Asthma Chronic cough COPD/Emphysema Shortness of breath Bronchitis Pneumonia
Lung Cancer Bloody sputum

Gastrointestinal: Indigestion Nausea Vomiting Blood in vomit Liver disease Jaundice
Abdominal pain Diarrhea Constipation Stool incontinence Bleeding ulcer Gastritis Colon cancer

Genitourinary: Urinary tract infections Painful urination Blood in urine Difficulty starting or stopping urine
Incontinence Kidney stones Prostate cancer Endometriosis Uterine/Cervical cancer

Musculoskeletal: Broken bones (list) _____
Arm Weakness Leg Weakness Back pain Neck pain Arm Pain Leg pain
Joint pain/swelling Arthritis (where) _____

Integumentary: Skin disease Skin cancer Breast pain, tenderness, swelling Nipple discharge
Date and result of last mammogram _____

Neurological: Fainting spells Seizures (date of last) _____ Memory problems Disorientation
Difficulty speaking Poor concentration Double vision Face weakness Poor coordination

Psychiatric: Anxiety Depression Other psychiatric disorder(s) _____

Endocrine: Diabetes mellitus Thyroid disease Increased appetite Excessive thirst Excessive urination
Hormone problems

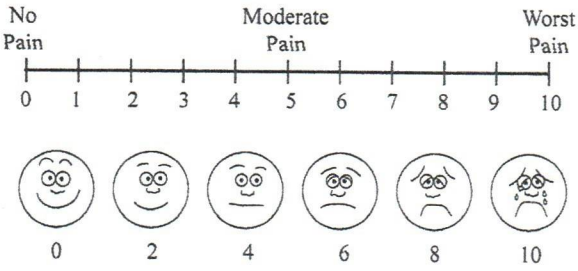
Hematologic/Lymphatic: Anemia Hemophilia Bleeding tendencies Swollen glands/lymph nodes
Blood transfusion

Allergic/Immunologic: Food allergies Inhalant/Nasal allergies Immunologic disorders

Patient: _____ Date of Birth: _____ Date: _____

Reason for today's visit? _____

Faces Pain Scale: Please circle the number that best matches your usual pain



PATIENT AUTHORIZATIONS:

Insurance

I hereby authorize my insurance benefits to be paid directly to the physician, realizing that I am responsible to pay non-covered services. I hereby authorize the release of pertinent medical information to insurance carriers.

Signature_____ Date_____

Treatment

I hereby agree to be treated by Dr. Morpurgo / Dr. Thibault. I understand that I will notify him/her if I obtain narcotic medication from any other doctor or care provider. I agree that we, Dr. Morpurgo / Dr. Thibault and myself, will be committed to my returning to work (if applicable and/or when such is reasonable) in some capacity and that the road to wellness requires effort on my part.

Signature_____ Date_____

Accuracy

I hereby certify that, to the best of my knowledge, all of the information I have provided on these forms is accurate and complete.

Signature_____ Date_____

Telemedicine

I consent to telemedicine visits, communicating with Dr. Morpurgo/Dr. Thibault via a secure communication platform. I have the option to refuse the delivery of health care services via telemedicine at any time without it affecting my right to future care or treatment and without risking the loss of withdrawl of any program benefits to which I am otherwise entitled. All the same privacy and confidentiality rules apply. I will still be responsible for copayments or coinsurances that apply to any telemedicine visit. I shall have access to all medical information resulting from the telemedicine services as provided by applicable law for client access to his or her medical records.

Signature_____ Date_____

Cancellation and No Show Policy

I understand that if I miss a scheduled, confirmed appointment, and do not call 24 hours prior to the appointment, I will be billed a fee of $30 or notified that I may not be seen by anyone in this office for subsequent visits.

Signature_____ Date_____

Cayuga Area Plan, Inc.
Cayuga Area Preferred, Inc.

Clinical Integration Privacy Notice & Consent Form

We are pleased to be part of the Cayuga Area Preferred ("CAP") Clinical Integration Program. Clinical Integration is intended to improve the safety, efficiency, and quality of health care by allowing all health care providers participating in the CAP Clinical Integration Program to have access to and share data in your medical record in order to provide care to you and for purposes of improving the quality of care in the community. To learn more about Clinical Integration please talk to your physician. You can also call CAP at (607)252-3694.

Providers participating in the Clinical Integration Program are able to access protected health information (PHI) about you collected or accessible from all places where you get health care and from the insurance companies that pay for your health care. This information is only to be used in connection with providing care to you and for purposes of improving the quality of care in the community and is only open to providers participating in the CAP Clinical Integration Program and their staffs. You may decide whether or not to allow CAP participating providers and their staffs to access your protected health information. **Your choice to give or deny consent will not affect your ability to get medical care or health insurance coverage and will not be the basis for denial of health services.**

Furthermore, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have certain rights to privacy regarding protected health information. A description of those rights together with the purposes for which your protected health information may be used or disclosed is set forth in this provider's Notice of Privacy Practices, a copy of which has been provided to you.

If you sign this form, you may request, in writing, restrictions on how your protected health information is used or disclosed to carry out treatment, payment or healthcare operations within the network of providers participating in the CAP Clinical Integration Program. **Please carefully read the information on the back of this form before making your decision.**

By signing this form, you give consent for purposes of providing care to you for all providers participating in the CAP Clinical integration Program and their staffs to access ALL of your protected health information available through a database maintained by CAP and from other sources made available to CAP participating providers, including the electronic medical system of Cayuga Medical Center (together, this information is hereinafter referred to as the "Cap Cayuga Database"). You further acknowledge that you have received this provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of your protected health information.

Print Name of Patient	Date of Birth
Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Cayuga Area Plan, Inc.
Cayuga Area Preferred, Inc.

Details About the CAP Database.

1. How Will Information be Used?
Your electronic health information will be used by providers participating in the CAP Clinical Integration Program **only** to:

- Provide you with medical treatment and related services
- Evaluate and improve the quality of medical care provided to all patients.

2. What Types of Information Are Available?
The CAP Database includes records of participating healthcare providers, facilities, and claims submitted to and/or paid by your health insurance company. This information may be created before and after the date you sign this form and may also include information that relates to sensitive health conditions, such as:

- Alcohol or drug use problems/treatment
- Birth control, pregnancy and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS and Sexually transmitted diseases
- Mental health conditions

3. Who May Access Information About You, If You Give Consent.
Only doctors and other health care providers and their staffs who are involved in your medical care and who participate in the CAP Clinical Integration Program may access your protected health information.

4. Penalties for Improper Access to or Use of Your Information. There are penalties for inappropriate access to or use of your protected health information. If, at any time, you suspect that someone who should not have seen or gotten access to information about you from the CAP Database has done so, call CAP at: (607)252-3694; or call the NYS Department of Health at 877-690-2211.

5. Re-disclosure of Information.
Persons who access information through the CAP Database must comply with all the federal and state privacy laws which restrict re-disclosure about your health information. Access to information in the CAP Database does not change these restrictions.

6. Effective Period. This consent will remain in effect until the day you withdraw your consent or the CAP Clinical Integration Program ceases all operations.

7. Withdrawing Your Consent. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to any provider participating in the CAP Clinical Integration Program. You can get these forms from your healthcare provider or by calling CAP at (607)252-3694.

Cayuga Area Plan, Inc.
Cayuga Area Preferred, Inc.

Health Connections

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 **Cayuga Area Plan, Inc ("CAP") and the physicians, physician practices, and hospitals participating in CAP (see** *http://www.CAPNY.com* **for full list)** to obtain access to my medical records through the health information exchange organization called HealthConnections, and any viewer or portal displaying data supplied by HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealthConnections 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 HealthConnections 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 **Cayuga Area Plan, Inc ("CAP") and the physicians, physician practices, and hospitals participating in the Cayuga Area Physicians Alliance, Inc.** to access ALL of my electronic health information through HealthConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for **Cayuga Area Plan, Inc ("CAP") and the physicians, physician practices, and hospitals participating in the Cayuga Area Physicians Alliance, Inc.** to access my electronic health information through HealthConnections.

☐ **3. I DENY CONSENT** for **Cayuga Area Plan, Inc ("CAP") and the physicians, physician practices, and hospitals participating in the Cayuga Area Physicians Alliance, Inc.** to access my electronic health information through HealthConnections for any purpose, ***even*** *in a medical emergency.*

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

DOH-(1/18)

Details about the information accessed through HealtheConnections **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 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: 607.274.4615 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.

Patient: _____ **Date of Birth:** _____ **Date:** _____

PATIENT HIPPA AWARENESS

With my permission, Physiatry & Rehabilitation Medicine, PC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Physiatry & Rehabilitation Medicine, PC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Physiatry & Rehabilitation Medicine, PC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission Physiatry & Rehabilitation Medicine, PC may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

With my permission Physiatry & Rehabilitation Medicine, PC may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my permission Physiatry & Rehabilitation Medicine, PC may e-mail my home or other designated locations any item that assists the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Physiatry & Rehabilitation Medicine, PC restrict how it uses and discloses my PHI to carry out TPO. However, the practice is not required to agree to my restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Physiatry & Rehabilitation Medicine, PC to use and disclose my PHI for TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature_____ Date_____

Name of person signing if not patient (i.e. parent/legal guardian):_____