



UNIVERSAL PRIMARY CARE

SOUTHERN TIER COMMUNITY HEALTH CENTER NETWORK •(716) 375-7500 •WWW.UPCHEALTH.NET

135 N. UNION ST
OLEAN, N.Y. 14760

132 WEST MAIN ST
CUBA, N.Y. 14727

9864 LUCKEY DR
HOUGHTON, N.Y. 14744

445 BROAD ST
SALAMANCA, N.Y. 14779

159 INTERSTATE PKWY
BRADFORD, P.A. 16701

Welcome to Universal Primary Care

Thank you for choosing Universal Primary Care to meet your healthcare needs. Our office hours are 8:00 AM-5:00 PM Monday-Friday. We also have office hours on Monday evenings from 5:00 PM-8:00 PM.

UPC is a nationally recognized “Patient-Centered Medical Home,” providing patient-centered primary care as an excellent model for how primary care should be modeled and provided to patients throughout their lifetime. This model of care puts you, as the patient, at the center of your care, working with your health care team to create a personalized plan for reaching your health care goals.

Our Patient-Centered Medical Home practice is a partnership with you. You are cared for with respect, dignity, and compassion at UPC. We are hopeful of building solid and trusting relationships with you and your family. UPC is committed and responsible for helping you manage your healthcare needs, or we appropriately refer your care to other qualified specialists or community health facilities.

Our health professionals work together to provide high levels of care, access and communication, care coordination, and integration and are committed to providing quality care and safety. Having your care managed by a primary care provider ensures you receive the safest and complete healthcare throughout your lifetime.

UPC provides:

- Pediatric and adolescent care (with sensitivity to teen concerns)
- Adult and Elder Medicine
- OB/GYN
- Behavioral Health Services & Counseling
- Care Management & Education classes
- Dental
- Telehealth services

Enclosed, you will find new patient paperwork. Please fill out the documents in their entirety and bring them to your initial appointment. Please remember to bring your insurance card, driver’s license or photo identification, and all medications or supplements in their original bottles. Please arrive 15 minutes early for all appointments.

If applicable, please call your insurance company to list your new primary care provider (if your new provider is a nurse practitioner, physician’s assistant, or resident, you may need to list the collaborating provider instead.)

We accept patients regardless of the insurance they have. We participate with most major insurers, including Medicare, Medicaid, and uninsured patients. If you are uninsured or underinsured, please ask us about our sliding fee scale, which allows us to reduce fees a patient may have to pay.

Below is a detailed list of all Universal Primary Care Physicians and collaborating providers:

- Dr. AnnMarie Zimmermann, MD (Olean UPC)- **Primary Care/OB/GYN**
- Dr. Christina Roosa, DO (Olean UPC)- **Primary Care/OB/GYN**
- Julie Elsigan, PA (Cuba UPC) -**Primary Care**
- Ann Anderson, PA (Olean UPC) - **Primary Care**
- Dr. Roop Kaur, MD (Olean UPC) – **Primary Care**
- Dr. Sarmad Baloch, MD (Olean UPC)- **Primary Care**
- Dr. Robert Haas, MD (Salamanca UPC)- **Primary Care/OB/GYN**
- Elizabeth Kelterborn, NP (Olean UPC) – **Primary Care**
- Dr. David Brubaker, MD (Houghton UPC) – **Primary Care**
- Marzella Harrison, PA (Houghton UPC)– **Primary Care**
- Karol Pohlman Rejman, FNP (Houghton UPC)- **Primary Care**
- Dr. Matthew Heckman, MD (Bradford UPC) – **Primary Care**
- Dr. Kaitlin Hanmer, MD (Olean UPC) – **OB/GYN Specialist**
- Dr. Leo Cusumano, MD (Cuba UPC) – **Pediatrics**
- Dr. Sarah Renna, MD (Olean UPC) – **Primary Care/OB/GYN**
- Kim Hahn, NP (Olean UPC) – **Primary Care**
- Francesca Parry, FNP (Olean/Bradford UPC) – **Primary Care**
- Dr. Ravi Purushuttam, MD (Cuba/Houghton UPC) -**Primary Care**
- Dr. Brooke Pancio, MD (Olean – UPC) – **Primary Care**
- University of Buffalo Resident Physicians (Olean UPC)

UPC's other specialized providers include:

- Cindy Mack, Certified Nurse Midwife (Olean UPC)-**OB/GYN**
- Katie Sekulovski, Certified Nurse Midwife (Olean UPC)-**OB/GYN**
- Heather Greenawalt, LCSW-R (Olean UPC)-**Behavioral Health**
- Gabrielle Fancher, LMHC (Olean UPC) – **Behavioral Health**
- Dion Jacobs, DDS-**Dental-Houghton**

If you have any questions or concerns, you can reach our office at 716-375-7500. If you cannot keep your appointment and would like to reschedule, please give us 24 hours of advanced notice by calling 716-375-7500 between the hours of 8:00 AM and 5:00 PM Monday- Friday. For urgent medical problems after hours, please call 716-375-7500. Follow the prompts, and you will be connected to the on-call provider. For more practice information, please visit our website at: <http://www.upchealth.net>



UNIVERSAL PRIMARY CARE

Southern Tier Community Health Center Network

• (716)375-7500

• www.upchealth.net

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ DOB: _____

Please indicate which location records should be released to:

<input type="checkbox"/> UPC Olean 135 N Union St, Olean, NY 14760 P: (716) 375-7500 F:(716) 701-6853	<input type="checkbox"/> UPC Cuba 132 W Main St, Cuba, NY 14727 P: (716) 375-7500 F: (716) 701-6853	<input type="checkbox"/> UPC Houghton 9864 Luckey Dr, Houghton, NY 14744 P: (716) 375-7500 F: (716) 701-6853
<input type="checkbox"/> UPC Salamanca 445 Broad St, Salamanca, NY 14779 P: (716) 375-7500 F: (716) 701-6853	<input type="checkbox"/> UPC Bradford 159 Interstate Pkwy, Bradford, PA 16701 P: (716) 375-7500 F: (716) 701-6853	

Release from: _____ Phone: _____
Fax: _____

Are records being released to transfer care to a new provider? Yes No

Records to be Released: Entire Record Progress Notes
 OB/GYN Lab Result(s)
 Radiology Report(s) Pathology Result(s)
 Medication Record Dental Record
 Other: _____

Disclosure: I understand that I can revoke this authorization by providing written notice to the office at the address listed above or in a manner described in the Notice of Privacy Practices. I also understand that revocation will not be valid if the information has been released by relying upon this authorization. The Physician's office listed above may not condition treatment or payment on signing this authorization unless allowed by law. I understand that I am waiving my rights to privacy by releasing my medical information to the parties listed above, and this information may be re-disclosed by the receiving party. With this, I authorize the entity listed above to release the said information.

Additional Releases: I understand that this release is only for medical or dental information. A separate release is required for behavioral health, substance use, and HIV treatment records.

Expiration: This release can be revoked at any time at the request of the patient or will expire one year from the signature date.

Signature of patient OR parent/authorized legal representative authorized by law _____
Today's Date

Print name of patient or parent/legal representative authorized by law

External Prescription History

I authorize Universal Primary Care and its affiliated providers to view my external prescription history via the Rx Hub service. I understand that prescription history from multiple affiliated and unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my medical provider and medical staff here, and it may include prescriptions back in time several years.

My signature below certifies that I have read and understand the scope of my consent, and that I authorize the access.

Notice of Privacy Practices, Patient Bill of rights, Patient Responsibilities and Conduct.

I hereby acknowledge that I received or have been offered a copy of the Notice of Privacy Practices, Patient Bill of rights, Patient Responsibilities and Conduct.

I may request an additional copy at any time.

My signature below certifies that I have read and understand the Notice of Privacy Practices, Patient Bill of rights, Patient Responsibilities and Conduct.

Physician to Physician / HealtheLink

I authorize my health information to be exchanged electronically to providers and healthcare entities involved in my care.

My signature below certifies that I have read and agree to the use of Physician to Physician.

Consent for Care

I am requesting and authorizing Universal Primary Care Physicians and personnel to provide me with medical care. No guarantees have been made regarding the outcome of this care.

I consent to HIPAA compliant automated phone calls, text messages, and voice calls for appointments and reminders, health checkups, lab test results, notifications about prescriptions, pre-operative instructions, post-discharge follow up calls, home healthcare instructions, hospital pre-registration instructions, and the provision of medical treatment. I understand I can **opt-out** of automated communications by letting the front office staff know so they can update my chart not to receive automated messages, calls, and voicemails.

My signature below certifies that I request and authorize medical care from UPC physicians and their clinical teams.

Assignment of Benefits

I hereby request and give my authorization for payment of insurance benefits to be made directly to Universal Primary Care for services rendered. I understand that my signature authorizes release of medical information necessary to pay my claim. I understand that I am financially responsible for all charges whether they are covered by insurance. I also agree that a photocopy of this agreement shall be as valid as the original. For Medicare, I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

I understand that any copays, co-insurance, and deductibles are due at the time of service. I understand that if I have no insurance coverage, I agree to pay the balance in full at the time services are provided, unless previous payment arrangements were made with the office. I understand I am responsible in knowing the benefits of the insurance plan I have purchased, and I will personally be responsible to resolve any claim processing disputes with my insurance carrier.

My signature below is authorization for the release of information necessary to process insurance claims, obtain authorizations or pre-certifications for treatment, process insurance applications, and to obtain prescriptions. For Medicare/ Medical Assistance: I also authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers as needed for a Medicare Claim. I understand that payment for these services will be from Federal and State funds and that any false claims, statements, or documents or concealment of material may be prosecuted under applicable Federal or State laws.

I am voluntarily requesting family planning and reproductive health care services; services must be provided solely on a voluntary basis. I understand that receipt of family planning services is not a prerequisite to receiving any other services rendered at Universal Primary Care. **(Family Planning Services ONLY)**

I consent to automated messages regarding billing collections. I understand I can opt-out of automated billing communications by letting the front office staff know so they can update my chart not to receive automated messages, calls, and voicemails.

My signature authorizes insurance and/or self-pay payment in accordance with the above statements.

Patient Responsibility Waiver / Independent Ancillary Providers and Laboratories

It is important for you to know that some independent ancillary providers and independent laboratories may be actively involved during diagnosis and treatment and these services are not included in the bill from Universal Primary Care. Instead, you may receive a separate bill directly from these independent ancillary providers and laboratories performing these services (e.g., x-rays, MRIs, ultrasounds, blood work, urinalysis, and all other pathology specimen examinations). It is also important for you to know that some of these ancillary providers and laboratories may or may not participate with your health insurance. You should always check with your physician at Universal Primary Care to determine whether any services will be performed by independent ancillary providers or laboratories, and which plans these independent providers and laboratories participate with. If you are not familiar with your insurance coverage and benefits, we encourage you to call your insurance and become more familiar with it. It is your responsibility to fully understand your healthcare coverage and patient responsibilities for services. I understand that I may receive independent ancillary services and laboratory services (e.g., x-rays, MRIs, ultrasounds, blood work, urinalysis, and all other pathology specimen examinations) while a patient of Universal Primary Care and it is my responsibility to check with my physician to determine if these independent ancillary providers or independent laboratories are participating with my insurance. I also understand that it is my responsibility to know my healthcare coverage and any patient responsibilities I may have for ancillary and laboratory services being provided and that I will receive a separate bill for these services.

My signature below acknowledges I understand the Patient Responsibility Waiver/ Independent Ancillary terms and conditions

Print Name of Patient _____

DOB _____

Signature of Patient or Legal Guardian _____ Today's

Date ____/____/____

HIPAA Privacy Authorization

Patient Name: _____ **DOB:** _____

Mailing Address: _____ **Apt:** _____

City: _____ **State:** _____ **Zip code:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____ **Portal Access:** Yes No

I, _____, grant the individual(s) named below permission to access my protected health information with the purpose of treatment, care, and scheduling as described in accordance with New York State Law and the Privacy Rule of the Health Insurance portability and Accountability Act of 1996 (HIPAA) And understand and acknowledge the following:

- I consent to HIPAA compliant automated phone calls, text messages, and voice calls for appointments and reminders, health checkups, lab test results, notifications about prescriptions, pre-operative instructions, post-discharge follow up calls, home healthcare instructions, hospital pre-registration instructions, and the provision of medical treatment. I understand I can opt-out of automated communications by letting the front office staff know so they can update my chart not to receive automated messages, calls, and voicemails.
- I understand that I have the right to refuse authorization of consent to share information except in the case where this information is used for treatment, payment, or eligibility for benefits.
- I understand that Universal Primary Care is not liable if disclosed information is redisclosed by patient authorized parties and that this redisclosure may no longer be protected by federal or state law.
- I understand that I have the right to revoke my authorization at any time. Revoking consent must be submitted in writing to Universal Primary Care. Upon receipt of notice UPC will not share any future information with identified recipient but cannot be held liable for information shared prior to revocation date.

Legal Guardian: _____	Relationship: _____
Contact Phone: _____	Release: <input type="checkbox"/> No Restrictions <input type="checkbox"/> Restrict Sexual Health Info <input type="checkbox"/> Restrict Substance Use <input type="checkbox"/> Restrict Mental Health Info
Contact Name: _____	Relationship: _____
Contact Phone: _____	Release: <input type="checkbox"/> No Restrictions <input type="checkbox"/> Restrict Sexual Health Info <input type="checkbox"/> Restrict Substance Use <input type="checkbox"/> Restrict Mental Health Info
Contact Name: _____	Relationship: _____
Contact Phone: _____	Release: <input type="checkbox"/> No Restrictions <input type="checkbox"/> Restrict Sexual Health Info <input type="checkbox"/> Restrict Substance Use <input type="checkbox"/> Restrict Mental Health Info

*Note: If restrictions are not identified it will be assumed that all information can be shared with designated recipient.

Signature of Patient or Legal Guardian: _____

Printed Name: _____ **Date:** _____

Relationship to Patient (if applicable): Parent Legal Guardian Power of Attorney Other

Universal Primary Care New Patient Medical History Form

Name: _____ Date of Birth: _____ Today's Date: _____

Reason you are here: _____

Medical History: Have you ever had any of the following conditions? (Check if yes)

<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Myocardial Infarction
<input type="checkbox"/> Cancer	<input type="checkbox"/> Endocrine Problems	<input type="checkbox"/> Peptic Ulcer Disease
<input type="checkbox"/> COPD	<input type="checkbox"/> GERD	<input type="checkbox"/> Seizures
<input type="checkbox"/> Clotting Disorder	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Stroke
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> HIV/ AIDS	<input type="checkbox"/> Other _____

Other. Explain: _____

Surgical History: Have you ever had any of the following surgeries, and what date? (Check if yes)

<input type="checkbox"/> Adrenal Gland Surgery	<input type="checkbox"/> Colon Surgery	<input type="checkbox"/> Kidney Surgery
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Coronary Artery Bypass Graft	<input type="checkbox"/> Neck Surgery
<input type="checkbox"/> Bariatric Surgery	<input type="checkbox"/> Esophagus Surgery	<input type="checkbox"/> Prostate Surgery
<input type="checkbox"/> Bladder Surgery	<input type="checkbox"/> Gastric Bypass Surgery	<input type="checkbox"/> Small Intestine Surgery
<input type="checkbox"/> Breast Surgery	<input type="checkbox"/> Hemorrhoid Surgery	<input type="checkbox"/> Spine Surgery
<input type="checkbox"/> Cesarean Section	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Stomach Surgery
<input type="checkbox"/> Cholecystectomy	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Thyroid Surgery

Other surgeries/dates: _____

Medications: _____

Allergies: _____

Family History: Has anyone in your family had any of the following conditions? (Check if yes); If yes, please indicate who and whether it is on your mother/father's side of the family.

<input type="checkbox"/> Cancer/Polyps _____ Colon, Rectum, Anal, Stomach, Breast, Prostate, Uterus, Ovaries, Thyroid, Lung, Blood, Lymphoma Other _____	<input type="checkbox"/> Anemia _____ <input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Blood Clots _____ <input type="checkbox"/> Heart Disease _____ <input type="checkbox"/> Stroke _____	<input type="checkbox"/> High Blood Pressure _____ <input type="checkbox"/> Anesthesia Reaction _____ <input type="checkbox"/> Bleeding Problems _____ <input type="checkbox"/> Hepatitis _____ <input type="checkbox"/> Other _____
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Social History:

Alcohol use - Never Occasionally Daily Type _____

Tobacco use - Never Previously, but quit Packs Per Day _____ for _____ years

Drugs use - Never Occasionally Daily Type _____

What is your occupation? _____

Marital Status: Single Married Divorced Widowed Separated

Name of spouse or significant other _____

Children: Number of Children _____ Number of grandchildren _____

Women: Number of pregnancies _____, Number of deliveries _____ - Vaginal _____, C-sections _____, Miscarriages _____, VIPs (abortions) _____