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 8:00am- 5:00pm Monday through Friday. We also have office hours at our Olean clinic on Monday evenings from 5:00pm - 8:00pm.

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
- Women's Health (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.

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 8:00am and 5:00pm Monday through 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:

☐ **UPC Olean**
135 N Union St, Olean, NY 14760
P: (716) 375-7500
F:(716) 701-6853

☐ **UPC Cuba**
132 W Main St, Cuba, NY 14727
P: (716) 375-7500
F: (716) 701-6853

☐ **UPC Houghton**
9864 Luckey Dr, Houghton, NY 14744
P: (716) 375-7500
F: (716) 701-6853

☐ **UPC Salamanca**
445 Broad St, Salamanca, NY 14779
P: (716) 375-7500
F: (716) 701-6853

☐ **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
☐ OB/GYN
☐ Radiology Report(s)
☐ Medication Record
☐ Progress Notes
☐ Lab Result(s)
☐ Pathology Result(s)
☐ 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

Demographics:

Patient Name: ______________________ **DOB:** __________

Mailing Address: ______________________ **Apt:** __________

City: ______________________ **State:** ________ **Zip code:** __________

Home Phone: ____________ **Cell Phone:** ____________ **Work Phone:** ____________

Email Address: ______________________ **Portal Access:** Yes☐ No☐

Authorization:

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:**	☐No Restrictions ☐Restrict Substance Use	☐Restrict Sexual Health Info ☐Restrict Mental Health Info
Contact Name: ____________		**Relationship:** ____________	
Contact Phone: ____________	**Release:**	☐No Restrictions ☐Restrict Substance Use	☐Restrict Sexual Health Info ☐Restrict Mental Health Info
Contact Name: ____________		**Relationship:** ____________	
Contact Phone: ____________	**Release:**	☐No Restrictions ☐Restrict Substance Use	☐Restrict Sexual Health Info ☐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)

☐ Anemia	☐ Depression	☐ Hypertension
☐ Arthritis	☐ Diabetes	☐ Kidney Disease
☐ Asthma	☐ Emphysema	☐ Myocardial Infarction
☐ Cancer	☐ Endocrine Problems	☐ Peptic Ulcer Disease
☐ COPD	☐ GERD	☐ Seizures
☐ Clotting Disorder	☐ Glaucoma	☐ Stroke
☐ Congestive Heart Failure	☐ Hepatitis	☐ Ulcerative Colitis
☐ Crohn's Disease	☐ HIV/ AIDS	☐ Other_________________________

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

☐ Adrenal Gland Surgery	☐ Colon Surgery	☐ Kidney Surgery
☐ Appendectomy	☐ Coronary Artery Bypass Graft	☐ Neck Surgery
☐ Bariatric Surgery	☐ Esophagus Surgery	☐ Prostate Surgery
☐ Bladder Surgery	☐ Gastric Bypass Surgery	☐ Small Intestine Surgery
☐ Breast Surgery	☐ Hemorrhoid Surgery	☐ Spine Surgery
☐ Cesarean Section	☐ Hernia Repair	☐ Stomach Surgery
☐ Cholecystectomy	☐ Hysterectomy	☐ 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.

☐ Cancer/Polyps___________________________ Colon, Rectum, Anal, Stomach, Breast, Prostate, Uterus, Ovaries, Thyroid, Lung, Blood, Lymphoma Other ___________________________________	☐ Anemia_______________________ ☐ Diabetes______________________ ☐ Blood Clots___________________ ☐ Heart Disease _________________ ☐ Stroke________________________	☐ High Blood Pressure______________________ ☐ Anesthesia Reaction ______________________ ☐ Bleeding Problems_______________________ ☐ Hepatitis_______________________________ ☐ Other__________________________________

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) _________