



Welcome to Outer Cape Health Services

We are grateful for your choosing us as your healthcare provider.

As a Patient-Centered Medical Home, OCHS provides evidence-based health care that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient's unique needs, culture, values, and preferences. The medical home practice actively supports patients in learning to manage and organize their own care at the level the patient chooses. Recognizing that patients and families are core members of the care team, OCHS works to ensure that our patients are fully informed partners in establishing care plans, with a focus on prevention, wellness, and quality health care.

This New Patient Admissions Packet must be completed and returned to us prior to your first appointment being scheduled. ***Please complete all forms in black ink only to ensure readability when scanned.***

This packet includes the following:

- 1) **Notice of Privacy Practices:** Please review this notice carefully.
- 2) **Patient Registration Form:** Please complete all portions of this form. Note that as a Federally Qualified Health Center, we are required to collect demographic information regarding the patients we serve. The information you provide is confidential.
- 3) **Health History Questionnaire:** A summary of your medical history, medications, allergies, health habits and family health history. Please record all medication you are on; including any over-the-counter medication and supplements you take.
- 4) **Treatment, Payment and Data Agreement:** Needs to be signed prior to seeing a clinician.
- 5) **Authorization for Request of Protected Health Information:** To ensure continuity of care, we must receive any medical records from your previous Primary Care Provider (PCP). It is your responsibility to complete the Authorization form in order to grant us permission to request records from your previous practice.

Please review the following Patient Responsibilities:

- ❖ Insurance: We do not accept all insurance plans. If you have insurance for which we do not file, you are responsible for payment at time of service. You may submit your receipt to your insurance company yourself for reimbursement, although we cannot guarantee what reimbursement will be made, if any, by your insurance plan.
- ❖ We accept cash, check and credit card payments.
- ❖ If you have an insurance plan that requires assignment of a PCP, it is your responsibility to contact your insurance company to inform them of your new PCP.
- ❖ Co-payments: Any co-pay that is required by your insurance company is due at the time of visit.
- ❖ Prescriptions: We require 48 hours' notice to process all prescription refill requests. If you request a refill on a Friday, it may not be available until Monday.
- ❖ Controlled Substances will not be refilled at the first visit.

Please arrive 15 minutes prior to your appointment.

Thank you for choosing Outer Cape Health Services!



NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED WITH OTHERS AND HOW YOU CAN GET ACCESS TO IT. PLEASE REVIEW IT CAREFULLY.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use your health information in the following ways:

To treat you - Outer Cape Health Services uses a secure medical record. Access to your medical records and other information maintained by Outer Cape Health Services is restricted to clinicians and staff who need the information for treatment, payment or health care operations purposes, or other allowable purposes as described by this Notice.

In some cases, clinicians at other health care organizations may be able to electronically access your health information created or maintained by Outer Cape Health Services, through a secure network for the transmission of health information such as the Massachusetts Health Information Highway ("The Hiway"). All clinicians are required to protect the confidentiality of your information.

Outer Cape Health Services is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of Outer Cape Health Services, OCHIN supplies information technology and related services to Outer Cape Health Services and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by Outer Cape Health Services with other OCHIN participants when necessary for health care operation purposes of the organized health care arrangement.

Care Everywhere – Clinicians involved in a patient's care who use the Epic/OCHIN system can share information securely.

Information shared via Care Everywhere may include sensitive health information such as drug and alcohol abuse treatment or referral, mental health diagnosis and treatment, genetic testing, sexually transmitted illness diagnosis and treatment, and HIV/AIDS diagnosis and treatment. Patients may opt out from their information being shared via Care Everywhere.

To run our organization - We can use and share your health information to run our practice, improve your care and contact you when necessary. For example: We use health information about you to manage your treatment and services.

To bill for our services - We can use and share your health information to bill and collect payment from health plans or entities. For example: We give information about you to your health insurance plan so it will pay for your services.

Contact you - We may use your health information to contact you with information about treatment and follow-up care instructions or with information about services we provide. For example, we may contact you about scheduled or cancelled appointments, registration or insurance updates, billing or payment matters, pre-procedure assessment, satisfaction surveys or test results.

How else can we share your information? - We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information: <https://www.hhs.gov/hipaa/for-professionals/privacy/index.html>

Help with public health and safety issues, such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence.
- Preventing or reducing a serious threat to anyone's health or safety

Do research - We can use or share your information for health research.

Comply with the law - If state or federal law requires it, we will share your information.

Example: Massachusetts Immunization Information Systems (“MIIS”) is a statewide system to track immunizations given to you and your family. The goal is to ensure everyone in the state is up to date with their vaccinations and that records are available when you need them, such as when a child enters school, in an emergency or when you change your healthcare clinician. You can choose to opt out of the program, but your information will continue to be maintained in the MIIS database. Opting out only means that you will need to keep track of your child’s immunization records if you change doctors or get immunized at another health facility.

Respond to Organ and Tissue donation requests - We share information about you with organ procurement organizations.

Work with a medical examiner or funeral director - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address worker’s compensation, law enforcement and other government requests

- For workers’ compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions - We can share health information about you to a court or administrative order, or in response to a subpoena (unless stricter state standards apply which prevent such disclosures).

We will generally ask for your written consent or a judge’s order before we share certain sensitive information about you such as:

- Alcohol and Substance Use Records - See the NOTICE OF ADDITIONAL PROTECTIONS OF SUBSTANCE USE DISORDER RECORDS attached at the end of this Notice.
- AIDS, ARC or HIV related information, including but not limited to status or testing results, regardless of whether the test results are positive or negative.
- Sexually Transmitted Diseases
- Genetic Testing Results
- Consent for Abortion
- Victim’s Counseling for Domestic Violence or Sexual Assault
- Certain psychotherapy documentation
- Communications with Mental Health Providers and Social Workers

- **Certain federal and state funding programs.** We are a Business Associate to several federal and state agencies, and as such, if you are a client of one or more of these agencies, your de-identified information may be shared with these agencies as permitted by law upon the agencies’ request.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We will follow the duties and privacy practices described in this Notice and give you a copy.
- We will not share or use your information other than as described in this Notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

As a member of Community Care Cooperative (C3) Accountable Care Organization (ACO), we are committed to safeguarding your privacy and ensuring that your personal information is handled with care and respect. **As part of our efforts to provide comprehensive and inclusive care, we collect demographic information, including race, ethnicity, preferred language, disability, gender identity, and sexual orientation.** This information helps us better understand and meet the diverse needs of our community. Access to demographic data is restricted to authorized personnel only.

Physical safeguards, such as secure filing systems and restricted access areas, are in place to prevent unauthorized access. Our electronic health record (EHR) systems are equipped with robust security measures to protect against unauthorized access, including encryption, user authentication, and audit trails. **Demographic information is used to tailor our services and programs to better meet your individual needs and preferences. Demographic information will never be used to discriminate against or stigmatize any individual or group. We will not disclose your demographic information to any third parties without your explicit consent, except as required by law.**

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of your responsibilities to help you.

Get an electronic copy of your medical record - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record - You can ask us to correct information about you that you think is incorrect or incomplete. Ask us how to do this.

We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications - You can ask us to contact you in a specific way for example, (home or office phone) or to send mail to a different address.

We will say “yes” to all reasonable requests.

Ask us to limit what we share -

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out of pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we have shared information -

- You can ask for a list (accounting) of the times we have shared your health information in the past 6 years prior to the date you ask, who we shared it with and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures that you have asked us to make.

Get a copy of the Privacy Notice - You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. **Choose someone to act for you**- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights have been violated. You can complain if you feel we have violated your rights by contacting the location where you received care, or by contacting the Outer Cape Health Services Privacy Officer at 508-905-2820. A complaint can also be filed with:

- US Department of Health and Human Services Office for Civil Rights, 200 Independence Avenue, SW, Washington DC 20201, 1-877-696-6775 or www.hhs.gov/ocr/privacy/hipaa/complaints.
- The Office of National Coordinator for Health Care Information Technology at <https://www.healthit.gov/topic/information-blocking>
- C3 members can file a grievance with Community Care Cooperative (C3), Member Advocates – Grievance, 75 Federal Street, 7th floor, Boston, MA 02110 or at 866-676-9226 (TTY 711)

Outer Cape Health Services will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. Please let us know if you have a clear preference for how we share information in the situations described below.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share information when needed to lesson a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission or an attestation (if legally required):

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

If you do not wish to be contacted about fundraising, please contact the Outer Cape Health Services Privacy Officer at 508.905.2820.

Right to Change Terms of this Notice

We may change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request, at Outer Cape Health Services and on our website.

Contact Us

If you have any questions about this Notice of Privacy Practices, please contact our Privacy Officer at Compliance@OuterCape.org.

NOTICE OF ADDITIONAL PROTECTIONS OF SUBSTANCE USE DISORDER RECORDS

Our HIPAA Notice of Privacy Practice (“HIPAA NPP”) applies to all our patients. If you receive treatment, diagnosis, or referral for treatment in one of our designated Substance Use Disorder Programs (“Part 2 Programs”), the confidentiality of your records in such programs (“Part 2 Records”) are subject to further protections under the federal law and regulations 42 U.S.C. § 290dd-2, 42 U.S.C. 290ee-3, and 42 C.F.R. Part 2 (“Part 2”).

THIS NOTICE SUPPLEMENTS THE HIPAA NPP AND DESCRIBES:

- I. HOW YOUR PART 2 RECORDS MAY BE USED AND DISCLOSED,
- II. YOUR RIGHTS WITH RESPECT TO PART 2 RECORDS, AND
- III. HOW TO FILE A COMPLAINT CONCERNING A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR PART 2 RECORDS, OR OF YOUR RIGHTS CONCERNING YOUR PART 2 RECORDS.

YOU HAVE A RIGHT TO A COPY OF THIS NOTICE (IN PAPER OR ELECTRONIC FORM) AND TO DISCUSS IT WITH PRIVACY OFFICER AT Compliance@OuterCape.org IF YOU HAVE ANY QUESTIONS.

I. USES AND DISCLOSURES

Our Part 2 Programs may use and disclose your Part 2 Records only as described in this section or with your written consent.

(A) Permitted Uses and Disclosure of Part 2 Records Without Consent

- To communicate with other staff within the Part 2 Program who have a need for the information in connection with their duties to provide diagnosis, treatment, or referral for treatment or persons/office with direct administrative control over the Part 2 Program.
- To qualified service organizations providing services to us or on our behalf.
- To law enforcement agencies or officials if you commit, or threaten to commit, a crime in our facilities or against our personnel.
- To report suspected child abuse and neglect consistent with state laws.
- To medical personnel in a medical emergency under certain conditions.
- For research purposes if certain conditions are met.
- To qualified personnel for management and financial audit or program evaluation purposes who agree in writing to comply with the limitations on use and redisclosure.
- To a public health authority, if the information has been properly de-identified.

(B) Permitted Uses and Disclosures that Require Consent

- For treatment, payment, and health care operations purposes.

Our Part 2 Program will request that you provide a single written consent for all future uses or disclosures of your information for treatment, payment, and healthcare operations purposes in order to ensure you receive the highest level of coordinated care. If you do not sign this consent, we may not be able to treat you. This consent shall remain in effect until you revoke it in writing.

- Records that are disclosed to us or to another Part 2 program, covered entity, or business associate pursuant to your written consent for treatment, payment, and health care operations may be further disclosed by us or that Part 2 program, covered entity, or business associate, without your written consent, to the extent the HIPAA regulations permit such disclosure.
- Our Part 2 Program may make uses and disclosures not described in this notice only with your written consent.

(C) Right to Revoke or Withdraw a Consent

You may revoke or withdraw your written consent at any time by submitting a request to the Part 2 Program. We will no longer use or disclose your Part 2 Records after such time, except to the extent we have already acted in reliance upon it.

If you were mandated to treatment through the criminal legal system (including drug court, probation, or parole) and you sign a consent authorizing disclosures to elements of the criminal legal system such as the court, probation officers, parole officers, prosecutors, or other law enforcement, your right to revoke consent may be more limited and should be clearly explained on the consent you sign.

(D) Uses or Disclosures in Legal Proceedings

Your Part 2 Records, or testimony relaying the content of such records, shall not be used or disclosed in any civil, administrative, criminal, or legislative proceedings against you unless you provide specific written consent or a Part 2 compliant court order authorizes such disclosure.

Part 2 Records shall only be used or disclosed based on a court order after notice and an opportunity to be heard is provided to you and/or our Part 2 Program, where required by 42 U.S.C 290dd-2 and 42 CFR Part 2

A court order authorizing use or disclosure must be accompanied by a subpoena or other similar legal mandate compelling disclosure before the record is used or disclosed.

II. Your Rights Related to Your Part 2 Records

As a patient in our Part 2 Program, you have all the rights listed in the HIPAA NPP, including the right to request restrictions of disclosures made with prior consent for purposes of treatment, payment, and health care operations.

You also have the right to an accounting of disclosures of electronic Part 2 Records made with your consent for the past 3 years, including disclosures for treatment, payment, and health care operations when such disclosures are made through an electronic health record.

III. Filing a Complaint

See HIPAA NPP for more information regarding filing a complaint.

The effective date of this Notice is February 16, 2026.

Patient Registration Form

| Patient Information (Please print clearly in BLACK ink only) | | | | |
|--|------|-------|-------------------|-----------------|
| Legal Name* | Last | First | Middle Initial | Preferred Name: |
| Date of Birth (mm/dd/yyyy) _____ / _____ / _____ | | | Social Security # | |

| Sexual Orientation & Gender Identification | | |
|--|---|---|
| Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> Not Recorded on Birth Certificate <input type="checkbox"/> I don't know/am unsure of my sex at birth <input type="checkbox"/> I choose not to answer <input type="checkbox"/> Other _____ | Legal Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Other _____ | Pronouns <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> He/Him/His <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> Patient Name <input type="checkbox"/> I choose not to answer <input type="checkbox"/> My pronouns are not listed |
| Sexual Orientation <input type="checkbox"/> Asexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay <input type="checkbox"/> Straight <input type="checkbox"/> Omnisexual <input type="checkbox"/> Pansexual <input type="checkbox"/> Queer <input type="checkbox"/> I don't know <input type="checkbox"/> I choose not to answer <input type="checkbox"/> Other _____ | Gender Identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Questioning <input type="checkbox"/> Genderqueer or non-binary <input type="checkbox"/> I choose not to answer <input type="checkbox"/> Other _____ | |

| Contact Information | | | |
|--|---|-------|----------|
| Mailing Address | City | State | Zip Code |
| Address (if different from above) | City | State | Zip Code |
| Please circle your primary phone number: | | | |
| Home Phone: | Communication Preferences Check all that apply: <input type="checkbox"/> Mail <input type="checkbox"/> MyChart <input type="checkbox"/> Email <input type="checkbox"/> Phone <i>Appointment reminders default to text msg. Please check if you prefer phone calls.</i> <input type="checkbox"/> | | |
| Cell Phone: | | | |
| Emergency Contact Name: | | | |
| Relationship: | Phone Number: | | |
| Email address | Would you like to sign up for MyChart? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Patient Name _____

Date of Birth _____

| Demographic Information | | |
|---|---|--|
| <p><i>This information is for demographic purposes only and will not affect your care. As a Federally Qualified Health Center, Outer Cape Health is required to collect demographic information regarding the patients we serve. The information you provide is confidential.</i></p> | | |
| <p>Marital Status</p> <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____ | <p>Veteran Status</p> <input type="checkbox"/> Active Duty <input type="checkbox"/> Inactive Duty <input type="checkbox"/> Not a Veteran <input type="checkbox"/> Reservist Veteran | <p>Ethnicity</p> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> I don't know/am not sure of my ethnicity <input type="checkbox"/> I choose not to answer |

| Racial Group(s) (Check all that apply) | | |
|--|---|---|
| <input type="checkbox"/> American Indian or Alaskan Native Please Specify _____ <input type="checkbox"/> Asian Please Specify _____ <input type="checkbox"/> Black or African American | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander Please Specify _____ <input type="checkbox"/> White | <input type="checkbox"/> Other Please Specify _____ <input type="checkbox"/> I choose not to answer <input type="checkbox"/> I do not know/am not sure of my race |

| Employment | | |
|---|--|---|
| <p>Employment Status</p> <input type="checkbox"/> Employed full-time <input type="checkbox"/> Employed part-time <input type="checkbox"/> Student full-time <input type="checkbox"/> Other: _____ | <p>Occupation</p> <p>Employer/School Name</p> | <p>Are you covered under school or employer's insurance?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No |

| Language | |
|--|---|
| <p>Preferred Spoken Language</p> <input type="checkbox"/> ASL <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Haitian Creole <input type="checkbox"/> Spanish <input type="checkbox"/> Portuguese <input type="checkbox"/> I choose not to answer <input type="checkbox"/> Other _____ | <p>Preferred Written Language</p> <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Haitian Creole <input type="checkbox"/> Spanish <input type="checkbox"/> Portuguese <input type="checkbox"/> I choose not to answer <input type="checkbox"/> Other _____ |

| Preferred Pharmacy |
|--|
| <p>Pharmacy Name _____ Address _____</p> |

Patient Name _____

Date of Birth _____

| Insurance Information | |
|-----------------------|---|
| Medical | Plan Name _____ Subscriber # _____ Subscriber Name _____ DOB: _____ Subscriber Address _____ |
| Secondary | Plan Name _____ Subscriber # _____ Subscriber Name _____ DOB: _____ Subscriber Address _____ |
| Vision | Plan Name _____ Subscriber # _____ Subscriber Name _____ DOB: _____ Subscriber Address _____ |

| Disability | |
|---|--|
| 1. Are you deaf or do you have difficulty hearing? | YES NO I Choose Not to Answer I Don't Know/Am Not Sure |
| 2. Are you blind or do you have difficulty seeing? | YES NO I Choose Not to Answer I Don't Know/Am Not Sure |
| 3. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? | YES NO I Choose Not to Answer I Don't Know/Am Not Sure |
| 4. Do you have difficulty walking or climbing stairs? | YES NO I Choose Not to Answer I Don't Know/Am Not Sure |
| 5. Do you have difficulty dressing or bathing? | YES NO I Choose Not to Answer I Don't Know/Am Not Sure |
| 6. Because of a physical, mental, or emotional condition, do you have difficulty doing errands? | YES NO I Choose Not to Answer I Don't Know/Am Not Sure |

Patient Signature _____

Date: _____

Annual Demographic Form

Patient Name: _____ Date of Birth: _____

All patients must complete this form and will be asked to update it annually. As a federally qualified health center, we are required to obtain the information below. This information is for grant, funding and reporting purposes ONLY. No personally identifiable information is ever reported. The confidentiality of the information reported below is protected by law.

Family Size:

How many people are in your family household? _____ Choose Not To Disclose

Income:

Counting yourself, your spouse and all dependent children (those 18 years or younger who are still claimed as dependent on your federal tax return) what is your gross income (income before taxes) for your family?

\$ _____ **Select one:** Daily Weekly Monthly Annually
 Choose Not To Disclose

Homeless Status

Which best describes your housing/homeless status?

- At risk of homelessness
- Child at risk for homeless
- Currently not homeless, but was in the last 12 months
- Living in a shelter
- Living with others
- Not homeless
- Permanent supportive housing
- Single occupancy hotel
- Street, camp, bridge
- In transitional housing
- Veteran at risk for homeless
- Choose Not To Disclose

Migrant/Seasonal Worker Status

Are you a migrant or seasonal agricultural worker? Seasonal Migrant Neither
 Choose Not To Disclose

Staff Use Only: PCP _____



HEALTH SERVICES

HEALTH HISTORY QUESTIONNAIRE

All information you provide is strictly confidential and will become part of your medical record. Please answer the questions to the best of your ability. You may leave any or all fields blank, but your provider may ask for the information in your office visit. **Please complete in BLACK ink only.**

Date Completed: _____

DEMOGRAPHICS

Last Name _____ First Name _____ Middle Initial _____

Date of Birth (mm/dd/yyyy) _____

Primary Care Provider Gender Preference

Male

Female

No Preference

Previous Source of Health Care: (Primary Care Provider Name, Facility, Phone Number)

Date of Last Visit? _____

Have you completed and signed a medical record release form for your primary care provider and specialists, including mental health providers? Yes No

If not, please complete and sign release forms.

| MEDICAL CONDITIONS: Circle any of the following conditions you have had. | | |
|---|------------------------------|---------------------|
| Allergies or Asthma | Cholesterol (high) | High Blood Pressure |
| Acid Reflux/Heartburn | Congestive Heart Failure | Lung Disease |
| Alcoholism | Depression and/or Anxiety | Stroke |
| Anemia | Diabetes | Thyroid Disease |
| Arthritis | Drug or Alcohol Use Disorder | Other (list): |
| Breast lumps/cysts | Heart Disease | |
| Cancer (tumors) | Hepatitis | |

SURGERIES AND OTHER HOSPITALIZATIONS

| Date | Type of surgery / reason | Name of hospital |
|------|--------------------------|------------------|
| | | |
| | | |
| | | |
| | | |

RECENT SCREENINGS (eg, last mammography, pap test, colonoscopy – Please request prior records from the facilities where these were performed)

| |
|--|
| |
| |
| |

OTHER DOCTORS AND SPECIALISTS (Patient Care Team)

| Specialist Type | Specialist/ Facility | Specialist Type | Specialist/ Facility |
|-------------------------|----------------------|-----------------|----------------------|
| Dental | | Gyn/OB | |
| Eye Doctor | | Podiatry | |
| Dermatology | | Other | |
| Psychiatry (prescriber) | | Other | |
| Therapist/Counselor | | Other | |

Smoking Have you ever used tobacco?

- Current smoker Former smoker Never smoke

If yes, how many years have you used tobacco? _____

If yes, year last used? _____

Amount per day: Cigarettes _____ Cigars _____ Vape/Pipe _____ Chew _____

Alcohol How often did you have a drink containing alcohol in the past year?

- Never Monthly or less Two to four times a month
 Two to three times per week Four or more times a week

How many drinks containing alcohol did you have on a typical day when you were drinking in the past year? (1 drink = 12 oz. beer, 4 oz wine, 1.5 oz spirits)

- 0 drinks 1 or 2 3 or 4 5 or 6 7 to 9 10 or more

How often did you have six or more drinks on one occasion in the past year

- Never Less than monthly Monthly Weekly Daily or almost daily

Sexual Health

When you were last tested for sexually transmitted infections (STIs)? _____

Have you had any type of sexual contact since the last time you were tested for STIs?

- Yes No

If you have a concern about sexually transmitted infections that you need addressed more urgently, please contact our Sexual Health staff at 774-538-3350

Drugs

Have you ever used recreational or street drugs?

- Yes No

Have you ever misused prescription or non-prescription drugs?

- Yes No

Have you ever given yourself drugs with a needle that was not prescribed to you?

- Yes No

Would you like to meet with a clinician to confidentially discuss your drug use?

- Yes No

Domestic Violence

Have you ever been a victim of verbal, psychological, or physical abuse?

- Yes No

Have you ever felt unsafe or threatened by someone close to you?

- Yes No

Do you feel safe at home?

- Yes No

Diet List any dietary restrictions: _____

Exercise What type of exercise do you do? _____

How many times a week? _____ Duration of workout _____

Caffeine Number of cups/drinks per day?
 Coffee _____ Soda _____
 Tea _____ Energy Drink _____

Mental Health Have you ever had a psychiatric hospitalization? Yes No

Have you ever attempted suicide? Yes No

Food Security In the past 12 months, have you been worried that food would run out before you had money to buy more.

Yes Sometimes Never

Women's Health Are you pregnant? Yes No

Date of last period _____ Period every _____ days for _____ days

Are you currently trying to get pregnant? Yes No

If no, what is your birth control method? _____

FAMILY MEDICAL HISTORY

Are you **Adopted?** – History Unknown Yes No

| Family Member | Age | Alive? | If Deceased, cause | Age at Death |
|---------------|-----|--------|--------------------|--------------|
| Mother | | | | |
| Father | | | | |
| Siblings(s) | | | | |
| | | | | |
| Children | | | | |
| | | | | |
| Other | | | | |
| | | | | |

Thank You for Completing this Form



Patient Representative Release Authorization

HEALTH SERVICES

By filling out this form and signing below:

I give Outer Cape Health permission to review my health history with my patient representative(s) (listed below). I understand this may include sensitive details, such as:

- Alcohol and/or Drug Abuse Treatment
- HIV/ Communicable Disease
- Genetic Testing
- Mental Health Services

I also give permission to my representative to request a copy of my medical record on my behalf with the understanding that my Patient Representative will complete an Authorization for Request of Protected Information Form. This permission will only expire if I cancel or change it, or upon my death. I can cancel or change it at any time. Changes must be made in writing and sent to Outer Cape Health Services at the address on this form. I understand that changes or cancellations:

- Will not affect information already shared with my representatives
- Will not begin until Outer Cape Health Services receives my written request

If I want to change my representative(s), I must complete a new form. I understand that when I fill out a new form, my old form is no longer valid. My representative(s) can't share information without my permission. If they share without my permission, federal law may not protect those actions

I agree to let Outer Cape Health Services talk to my representative(s). I do not need to sign this form to make sure I get treatment.

My Information (Patient) Name: _____ Date of Birth: _____

Street: _____

City: _____ State: _____ Zip: _____

Patient Representative(s): Please list individuals to be your patient representative. Staff will ask for your name and date of birth before speaking with your representative. Please make sure they have this information.

1. Representative's Name _____ Relationship to Patient: _____

Telephone #: _____

2. Representative's Name _____ Relationship to Patient: _____

Telephone #: _____

3. Representative's Name _____ Relationship to Patient: _____

Telephone #: _____

I understand by signing below I give permission to Outer Cape Health Services to talk to my representative(s) listed above about my health information without restrictions.

Signature of Patient or Legal Representative

Date

If Signed by Legal Representative, Relationship to Patient

Please send this form into the Medical Records Department or bring it in to your clinic:

Outer Cape Health Services

PO BOX2796 Orleans, MA 02653

Fax #: (508) 487-6298

Authorization for Request of Protected Health Information

Please fill out one form per provider
If you need additional request forms, you can find them on our website or in the clinic



| | | | | |
|-----------------------------|--------|-----------|----------------|---|
| Patient Name | Last | First | Middle Initial | Patient Date of Birth (mm/dd/yyyy) |
| Patient Address | Street | City/Town | | State Zip Code |
| Patient Phone Number | | | | |

I hereby authorize and request a copy of my medical records be sent by mail or fax to:

Outer Cape Health Services
P.O. Box 2796, Orleans, MA 02653
Fax: 508-487-6298

For the purpose of: Personal Legal Transferring Care Other

Requested Information: _____ All Records

Covering the period from: _____ to _____

Former Practice Information

_____ Practice Name

_____ Practice Address

_____ Phone Number _____ Fax Number

| Protected under State Law: Please initial below | |
|---|--------------------------------|
| Alcohol and/or Drug Abuse Treatment | I DO Authorize. Initial: _____ |
| HIV/Communicable Disease* | I DO Authorize. Initial: _____ |
| Genetic Testing | I DO Authorize. Initial: _____ |
| Mental Health Services | I DO Authorize. Initial: _____ |
| <small>(Mental Health Services by a clinical nurse specialist, Psychologist, Social Worker, counseling professional or a physician specializing in psychiatry licensed under the provision of Title 32)</small> | |

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 in writing other

Patient or Legal Representative Name (print) _____

Address: _____

Patient or Legal Representative Signature: _____ Date: _____

Relationship to Patient: _____ Phone Number: _____

To the practice sending records, please send **only** the following:

- Health maintenance sheet
- Immunization record
- Last CPE
- Last 3 office visit notes
- Labs for current and previous year
- All pathology reports
- Last PAP report and any abnormal reports
- Last colonoscopy and any abnormal reports
- Last mammogram and any abnormal reports
- Last chest x-ray and any abnormal reports
- All MRI's, CT's, interventional radiology studies
- All consults in the past 2 years with exception, of all cardiology, oncology, neuropsychiatry and pain consults
- All cardiology testing in the last 2 years
- All neurology testing (EMG, EEG) or pulmonary testing in the past 2 years
- Hospital discharge summaries
- All mental health records for the past 2 years

*A separate release authorization is required for each request to release the results of HIV/AIDS testing, M.G. L. c111§ 70F

**Release of information must comply with the federal HIPAA Privacy Act and federal Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR, part 2 regulations. Note to recipient: This contains confidential information. 42 CFR part 2 prohibits you from making any further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse.

I hereby disclose my health information for the purposed noted above. I understand that once such information has been disclosed to the intended recipient, that OCHS cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

If I have questions about disclosure of my health information, I can contact the Outer Cape Health Services Compliance Officer: 508-905-2820 or patientexperience@outercape.org

Please send all requested medical records to:
Outer Cape Health Services
P.O. Box 2796, MA 02653
Fax: 508-487-6298
Phone: 774-209-3232

A facsimile or copy of this document is valid as the original.
Scan Completed Document to EMR: Consents and Contracts

Revised January 2025

Treatment, Payment and Data Agreement



Patient Name: _____ Date of Birth: _____

- I hereby give my consent and authorize Outer Cape Health Services to treat any medical or mental health condition providing that the care provider has explained my condition to me, the treatment procedures and alternative methods of treating my condition. The care provider has discussed with me foreseeable risks of the above stated treatment and that there may be undesirable results.
- I understand that Outer Cape Health Services operates a primary care practice that integrates behavioral health services, which means behavioral health staff are part of my medical team and experience, and that being seen by a behavioral health provider through primary care may result in additional charges to my insurance. This may also result in an additional copayment or coinsurance. I acknowledge that in cases of insufficient coverage, I will be held responsible for the remaining balance.
- I authorize examination and treatment for this and all following medical or mental health visits.
- I have carefully read and fully understand this Informed Consent Form and all of my questions have been adequately answered.
- I understand I am personally responsible for all charges and deductibles. Financial assistance is available for those who qualify.
- I accept full responsibility for payment of services and/or for securing necessary primary care referrals or pre-approvals for medical visits. If applicable, I understand that I have an obligation to obtain a referral for specialist services from my primary care physician (PCP) prior to having services rendered. I acknowledge that if the appropriate referral/authorizations are not on file at the time services are rendered, that I am financially responsible for any charges denied by my health insurance carrier as a result.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurance submissions.
- I authorize release of all information necessary to secure payments of benefits.
- I understand that Outer Cape Health Services may use data developed for and/or provided by clients to determine general characteristics of the communities it serves and that none of this information will in any way identify individual clients.
- I certify that the above information is true and correct. I have received a copy of Outer Cape's Notice of Privacy Practices (HIPAA) and Patient Rights and Responsibilities.

Patient Signature _____ Date _____

General Information: Informed consent will be obtained from all patients accessing medical, behavioral health, and/or research services/activities. Informed consent is not merely a signed document. It is an ongoing process that considers patient needs and preferences, compliance with law and regulation, and patient education.

The patient and/or family, as appropriate, are given information about:

- The patient's condition;
- Proposed treatments, procedures, or research activities
- Potential benefits and drawbacks of proposed treatments or procedures;
- Problems related to recuperation;
- Alternative treatment(s) or procedure(s);
- The physician or other practitioner primarily responsible for the patient's care;
- Others authorizing or performing procedures or treatments; and
- Any business relationships among individuals treating the patient, or between the organization and any other health facility.

Outer Cape Health is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of Outer Cape Health, OCHIN supplies information technology and related services to Outer Cape Health and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by Outer Cape Health with other OCHIN participants when necessary for health care operation purposes of the organized health care arrangement.

The information in your medical record is confidential and is protected under both Federal and Massachusetts laws. Your written consent will be required for release of information except in those certain circumstances where consent is not legally required.