111 Wilbur Peck Court
Greenwich, CT 06830
(203) 717-1760

Initial: _____

WELCOME LETTER

Patient Name: _____

You have a First-Time Appointment at Family Care Health Centers (FCHC) on_____ at _____
(Date) (Time)

Our Mission is to be your **primary care medical home** by providing you with the best quality comprehensive care. Included in this package is information on your rights as our patient and what you can do to help us provide you with all the services you need.

Please help our efficiency with the following list:

1. You must **make an appointment in advance** of arrival and will not be seen without an appointment. (COVID-19)

2. Please bring all your medications bottles with you for the first appointment, especially those prescribed by other physicians.

2. Please complete the medical health questions on the next pages.

3. Please bring the following information for your First Appointment
   - Photo ID
   - Current Insurance Card and/or Proof of income (to qualify for our sliding fee scale policy)
   - Any prior medical records

4. Please allow us to dedicate sufficient time to each patient. Sometimes, doctors & nurse practitioners fall behind schedule. We apologize if this causes inconvenience, so we ask for your understanding. Some medical conditions can become very complicated and time consuming. We will try to provide regular updates during times of delay.

6. Medication Refills
   - Please call pharmacy first, to confirm refills are available. The pharmacy will contact us to confirm the request.
   - If no refills at the pharmacy, please request medication refills at the time of your visit.
   - If you need a refill before your next visit, please allow 24 hours' notice for our staff to pull your chart…review your list…and call your pharmacy.
   - Please call during office hours for refills. We cannot authorize refills "after hours" without your chart.

7. Hours of Operation
   - Our office is open Monday through Friday from 9:00am to 5:00pm. Our call center operator receives calls from 9:00am to 5pm.
   - 24-Hour Answering Service and On-Call Providers

8. Test Results
   a. "Normal" Results. By policy, we will review these results at your next visit.
   b. "Abnormal" Results. By policy, we will contact you by phone. If we are not confident that we can provide you the results confidentially, we sometimes send you a letter, or sometimes we will ask you to return to the office to review the results in person.
   c. Online 24-hour Access to Patient Portal

9. Co-Pays/Fees
   a. **Medical**: Patients are expected to pay co-pays/fees before they are seen by the health care provider
   b. **Dental**: Patients are expected to pay their copays/fees at the end of their appointments since we will not know the exact amount that would be owed until the dentist has finished.
   c. Patients are responsible for any payments not covered by their insurance.

10. Confirming/Cancelling Appointments
    a. Must confirm scheduled appointments by 12 pm the day prior to appointment.
    b. Our system will cancel your appointment if you arrive 10 minutes late.
    c. If you cancel (within 24 hours) or miss your scheduled appointment 3 or more times, you may lose access to scheduling appointments in advance, and will be asked to schedule same day appointments.

111 Wilbur Peck Court
Greenwich, CT 06830
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Initial: _____

PATIENT INTAKE INFORMATION FORM[1]

Date: _____ /_____/_____

Last Name: First Name: Middle Initial:

Date of Birth: Social Security Number: _____-_____-_____

Gender: ☐ Male ☐Female ☐TG / M → F ☐TG / F → M

Primary Phone # (____)_____
☐Cell ☐Home ☐Work
OK to leave message: ☐Yes ☐No OK to Text: ☐Yes ☐No

Secondary Phone # (____)_____
☐Cell ☐Home ☐Work
OK to leave message: ☐Yes ☐No OK to Text: ☐Yes ☐No

Email Address: _____@_____ ☐ OK to send Email

Physical Address:

City: State: Zip Code:

Mailing Address: (if different from above):
☐ Check here if you DO NOT authorize mailings from Family Centers Inc.

Primary Medical Provider (if not Family Centers Health Care)_____
Address: _____ Phone__(____)_____

PHARMACY : _____ ADDRESS: _____

Occupation (if employed): _____ ☐ Full Time ☐ Part Time ☐ N/A

School (if student) _____ ☐ Full Time ☐ Part Time

Annual Household Income: $_____ Number of people in the household: _____

Signature: _____ Date: _____/_____/_____

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Primary Phone # _____☐Cell ☐Home ☐Work OK to leave message:☐Yes ☐No

Secondary Phone # _____ ☐Cell ☐Home ☐Work OK to leave message:☐Yes ☐No

Ethnicity: (Choose One)
☐ Hispanic ☐ Non-Hispanic

Race: (choose all that apply)
☐ White/Caucasian
☐ Black/African American
☐ Asian
☐ Native Hawaiian
☐ American Indian or Alaskan Native
☐ Other Pacific Islander

Marital Status:
☐ Single
☐ Married
(Spouse Name_____)
☐ Separated
☐ Widowed
☐ Divorced

Type of Residence where you live:
☐ Home, own
☐ Rent
☐ Friends / Family
☐ Transitional
☐ Homeless
☐ Shelter
☐ Other: _____

Public Housing ☐Yes ☐No
Section 8 ☐Yes ☐No

Do you think of yourself as:
☐Straight or Heterosexual
☐Lesbian, Gay or Homosexual
☐Bisexual
☐Something Else
☐Don't Know

Primary Language if other than English:
_____
Do you need a Translator: ☐ Yes ☐ No

Do you need any sign language services? ☐ Yes ☐ No

Do you need any auditory assistance? ☐ Yes ☐ No

Are you a veteran of one of the United States Uniformed Services? ☐ Yes ☐ No

How did you hear about us?
☐Friend/Family member
☐Media
☐Internet
☐ Family Centers Event/Outreach
☐ Referred by other Agency:
Agency Name_____
☐Other:
Who referred you? _____
_____

PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST TO MAKE A COPY

111 Wilbur Peck Court
Greenwich, CT 06830
(203) 717-1760

Initial: _____

PATIENT FINANCIAL INFORMATION FORM[2]

***INSURANCE COVERAGE: ☐NONE ☐MEDICAID ☐MEDICARE ☐PRIVATE INSURANCE ☐OTHER_____**

PRIMARY MEDICAL INSURANCE :		Policy / ID #		Group #
Last Name of Insured:		First:		M.I.
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other:				
Date of Birth:	SSN:		Gender: ☐ M ☐ F	
Physical Address:	City:	State:	Zip Code:	
Home Phone:	Work Phone:	Cell Phone:		
SECONDARY MEDICAL INSURANCE :		Policy / ID #		Group #
Last Name of Insured:		First:		M.I.
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other:				
Date of Birth:	SSN:		Gender: ☐ M ☐ F	
Physical Address:	City:	State:	Zip Code:	
Home Phone:	Work Phone:	Cell Phone:		
DENTAL INSURANCE :		Policy / ID #		Group #
Last Name of Insured:		First:		M.I.
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other:				
Date of Birth:	SSN:		Gender: ☐ M ☐ F	
Physical Address:	City:	State:	Zip Code:	
Home Phone:	Work Phone:	Cell Phone:		

CONSENT TO TREAT / BILLING

1. I _____ (patient name) give permission for **Family Centers Health Care** to give me medical/dental/mental health treatments.
2. Authorization to pay benefits to **Family Centers Health Care**:
   - I authorize the release of medical, dental, Mental Health, or other information necessary to process health insurance claims.
   - I also request payment of benefits to myself or to Family Centers, when they accept assignment.
   - My signature here indicates the information provided above is true and correct.
   - I am responsible for any payments not covered by insurance.
   - By signing below, you are authorizing Family Centers Inc. to bill your insurance and you take full responsibility of unpaid amounts.
3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical/dental/mental health treatments with my provider.
   - If I miss or cancel within 24 hours (Friday's by 12pm for Monday's appointments) 3 or more times, I may be unable to schedule any further appointments in advance.

_____ _____ _____

Print Name | Patient/ Parent or Guardian (for children under 18) Signature | Date

*You may qualify for a sliding scale discount regardless of insurance coverage. Ask to set up an appointment with the Financial Counselor.

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Initial: _____

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name	Date of Birth:	Medical Record #:

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Family Centers providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Family Centers at 203-869-4848. As long as this consent is in force (has not been revoked) Family Centers may provider health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient (or person authorized to sign for Patient)

_____Date: _____

I have been offered a copy of this consent form (patient's initials) _____

111 Wilbur Peck Court
Greenwich, CT 06830
(203) 717-1760

Initial: _____

Client's Rights and Responsibilities

The client and the provider have a responsibility to each other to assure that the best possible service is provided and appropriately used.

Each Client Has the Right to the Following:

- Considerate and respectful service.
- Service provided by qualified personnel.
- A reasonable response to his/her request for service and reasonable continuity of care.
- Service without discrimination as to race, religion, sex, gender identity/expression, national origin, sexual orientation, ancestry, age, familial status, physical or mental disability or handicap, or ability to pay.
- To participate in the development of his/her treatment plan.
- To accept or reject any treatment plan.
- Family Centers Inc.'s policies such as eligibility for service, regulations, hours of service and fee information.
- Assistance in locating the appropriate service when continuity cannot be provided
- To examine and receive an explanation of his/her bill for service, regardless of the payment source.
- To receive a copy of the Client's Rights and Responsibilities at the time service begins.
- To the name, title and professional credentials of any person providing or supervising his/her service.
- To review their case record in accordance with Family Centers Inc.'s policy.

It is the Client's Responsibility to:

- Accept or refuse any service.
- Direct grievances, concerns and recommendations for change to assigned staff member/supervisor and/or Program Director
- Keep all scheduled appointments or give 24 hour notice of cancellation.
- To inform clinician of changes in financial circumstances which may affect the fee.

In Order to Protect Your Privacy:

The Clinical Staff of Family Centers Inc. are required by law and professional ethics to maintain client confidentiality. This is done within the context of standard agency practice. Your records are confidential and will not be released or discussed with anyone outside of Family Centers Inc. without your written consent except as otherwise provided by law.

Emergency/Crisis:

In the event there is an emergency or crisis outside of the agency's business hours, (Monday - Thursday, 9 AM to 9 PM and Friday, 9 AM - 5 PM) please dial 203-717-1760 or go to your nearest hospital emergency department. In addition, we have an on-call provider 24 hours - 7 days a week.

Minor Child:

The Clinical Staff of Family Centers Inc. are required to discuss and determine parental arrangements and responsibilities for the client's arrival and departure; procedures followed in the event of a medical emergency**;** inform the parent or guardian of the clinic's mandated reporting responsibility according to Section 17a-101 of the CT General Statutes.

The parent or guardian of a minor will sign for the child that they and the child have received and reviewed the Client's Rights and Responsibilities and have been explained these rights in an understandable and age appropriate manner.

I have received and reviewed the Client's Rights and Responsibilities and I have been oriented to the agency's policies and procedures.

Do you have an **Advance Directive**? YES: ____ NO: ____ If no, are you interested in getting information? YES: ☐ NO: ____

_____	_____	_____
Print Name	Patient/ Parent or Guardian (for children under 18) Signature	Date

Staff Signature _____ Date_____

Family Centers Inc. Notice of Privacy Practices (HIPAA)
Effective September 23, 2013
CONSENT AND ACKNOWLEDGMENT FORM

I consent to the use or disclosure of my protected health information by Family Centers Inc. to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. I understand that further information regarding how Family Centers Inc. will use and disclose my information can be found in Family Centers Inc.'s Notice of Privacy Practices.

By signing below, I understand and acknowledge the following:

- I have read and understand this consent; and
- I have received Family Centers Inc.'s Notice of Privacy Practices currently in effect.

_____ _____ _____
Print Name **Patient/ Parent or Guardian (for children under 18) Signature** Date

If signed by the individual's representative, describe the legal authority of the representative to act on behalf of the individual:

_____

Unable to obtain written consent and acknowledgment because:

- ☐ Individual refused
- ☐ Emergency treatment situation
- ☐ Individual not able to sign due to incompetence or other medical reason
- ☐ Other: _____

_____ _____ _____
Print Name **Patient/ Parent or Guardian (for children under 18) Signature** Date

APPOINTMENT CONFIRMATION/CANCELLATION FORM

Family Centers Health Care is committed to providing good quality services to all our patients. Your appointments are very important to FCHC. Every time you scheduled an appointment, we reserved that time especially for you.
Please understand that it is your responsibility to remember your appointment dates and times. If you forget, cancel, or change your appointment without giving us enough notice, we miss the opportunity to offer that appointment to another patient.

- As a courtesy, our appointment confirmation service will contact you by text messages or phone calls. If you do not confirm before 12pm the day prior your appointment, your appointment will be canceled.
- Please be advised that our system will cancel your appointment if there is 10 minutes' late arrival.
- If you miss or cancel (within 24-hour notice) 3 or more times, you may be unable to schedule any further appointments in advance. You will only have access to schedule same day appointments.
- Please call at (203)717-1760 before 12 p.m. the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel Monday appointments, please call our office before 12 p.m. on Friday.
- No calls on Saturday or Sunday.

Best phone number to contact you for appointment reminders: _____
Please sign below to consent to these terms.

_____ _____ _____
Print Name **Patient/ Parent or Guardian (for children under 18) Signature** Date

111 Wilbur Peck Court
Greenwich, CT 06830
(203) 717-1760

Initial: _____

Date: _____

PEDIATRIC MEDICAL HISTORY[1]

Gender: ☐ M ☐ F

Child's Name: _____ Date of Birth: _____
Last First Middle

Birth Weight: _____ Delivery Type _____ Place of Birth: _____

Any complications during pregnancy? ☐ Y ☐ N | N.I.C.U ? ☐ Y ☐ N | Explain: _____

Describe briefly the reason for your visit today?

_____

Medications: ***Do you take any medication, over the counter & vitamins or supplements? If your answer is "yes" please tell us the name of the medication:*** ☐ ***YES*** ☐ ***NO***

Name of Drug	Dose (include strength & quantity per day)
1.	
2.	
3.	

Date of Last Physical Exam _____/_____/_____

Primary Medical Provider (Previous/Current)_____

Address: _____ **Phone**__(_____)_____

Primary Dental Provider: (if not Family Centers)_____

Address: _____ **Phone**__(_____)_____

Allergy/Drug Allergy: Do you have any allergy or drug allergy? ☐ ***YES*** ☐ ***NO***

If your answer is "yes" please tell us the name of the drug	Side Effect/Reaction:
1.	
2.	
3.	

PRIMARY PHARMACY : _____ **ADDRESS:** _____

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ☐ Abnormal heart rhythm
- ☐ Acid Reflux
- ☐ Aneurysm
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation/Flutter
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Cataracts
- ☐ Chronic Lung Disease/COPD
- ☐ Clotting Disorder
- ☐ Congestive Heart Failure
- ☐ Convulsions
- ☐ Depression
- ☐ Diabetes (insulin? Y/N)
- ☐ Depression
- ☐ Gallstones
- ☐ Gastrointestinal Disease
- ☐ Gout
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Valve Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV or AIDS
- ☐ Kidney Disease
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Mental Illness
- ☐ Prostate Problems
- ☐ Rheumatic fever
- ☐ Sleep Apnea
- ☐ Stroke of TIA
- ☐ TB (Tuberculosis)
- ☐ Thyroid Disease
- ☐ Ulcers

Other: _____

_____ _____ _____
Print Name **Patient/ Parent or Guardian (for children under 18) Signature** Date

111 Wilbur Peck Court
Greenwich, CT 06830
(203) 717-1760

Initial: _____

PEDIATRIC MEDICAL HISTORY[2]

Past Surgical History (surgeries)		Hospitalization	
Date:	Reason:	Date:	Reason:
Date:	Reason:	Date:	Reason:
Date:	Reason:	Date:	Reason:
☐ **No History of Surgeries**		☐ **No History of Hospitalization**	

FAMILY HISTORY ☐ **No Family History – Family Members are Alive and Well**

	Father	Mother	Sibling	Grandparent		Father	Mother	Sibling	Grandparent
Addiction	☐	☐	☐	☐	Heart attack	☐	☐	☐	☐
Auto Immune	☐	☐	☐	☐	Heart disease	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	Heart bypass	☐	☐	☐	☐
Blood Clotting Disorder	☐	☐	☐	☐	Heart rhythm problems	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	High blood pressure	☐	☐	☐	☐
COPD	☐	☐	☐	☐	High cholesterol	☐	☐	☐	☐
Congestive heart failure	☐	☐	☐	☐	Mental illness	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Seizures	☐	☐	☐	☐
Thyroid disorder	☐	☐	☐	☐					

Other: _____

VACCINATION HISTORY ** PLEASE GIVE VACCINE RECORD TO MEDICAL STAFF** Is child up-to-date with vaccinations? ☐ Y ☐ N

SOCIAL HISTORY

Grade in school: _____ Does anyone in the household smoke? ☐ Yes ☐ No

Has the child been exposed to secondhand smoke? ☐ Yes ☐ No | If yes, Amount: _____ Frequency: _____

Smoke detectors in house? ☐ Yes ☐ No Carbon Monoxide detectors in house? ☐ Yes ☐ No

Does anyone in the household use drugs other than prescribed by a medical provider? ☐ Yes ☐ No

Caffeine: ☐ **Yes** ☐ **No** Amount: _____ Frequency: _____

Does the child follow a special diet? ☐ Yes No Explain _____ Exercise? ☐ Yes ☐ No

Travel outside US within past: ☐ 2 weeks ☐ 3 months ☐ year Explain _____ Do you feel safe at home? ☐ Yes ☐ No Explain _____ Is there any history of exposure to domestic violence? ☐ Yes ☐ No

Does the child use a car seat/seat belt regularly? ☐ Yes ☐ No

_____ _____ _____

Print Name **Patient/ Parent or Guardian (for children under 18) Signature** Date

111 Wilbur Peck Court
Greenwich, CT 06830
(203) 717-1760

Initial: _____

PEDIATRIC MEDICAL HISTORY[3]

As the Parent or Legal Guardian, I give permission to the following adult person(s) to escort the patient to:

☐ Dental visits ☐ Medical visits

and make necessary decisions regarding treatment, with the following restriction(s):

Name Relation to Patient

Name Relation to Patient

Name Relation to Patient

I have the legal right to preauthorize this facility to deliver medical treatment to my child without me present. I request and authorize Family Centers Health Care and its personnel to deliver care to my child, with the following restriction(s):

From _____ Through _____
(This consent will be valid for one year from date of signature unless stated differently.)

I understand I may revoke this consent at any time.

_____ _____ _____
Print Name **Patient/ Parent or Guardian (for children under 18) Signature** Date

111 Wilbur Peck Court
Greenwich, CT 06830
(203) 717-1760

Initial: _____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED INFORMATION.

I, _____ *the* _____ *of* _____

(Name of Client, Parent/Guardian) *(Relationship, if appropriate)* *(Name of Dependent, if appropriate)*

_____ _____

(D.O.B.) *(Address)*

Authorize: _____ *to disclose/receive information to/from:*

Family Centers Health Care
Wilbur Peck Court, Greenwich CT 06830 Attention: _____
Phone: (203) 717-1760 Fax: (203) 622-2951

Please Fax

The disclosure of information authorized is limited to the following: ***(initial all that apply)***

- ☐ Medical or Dental Information
- ☐ Mental Health Treatment Progress, Developmental Disabilities, Diagnosis & Evaluations
- ☐ Substance Abuse Treatment Progress, Toxicology Results & Evaluations
- ☐ Educational Goals, Progress, PPT & Evaluation Information
- ☐ Employment Information
- ☐ Nutrition Consult
- ☐ Other: _____
- ☐ Eligibility of Benefits
- ☐ Housing Information
- ☐ HIV/AIDS Data
- ☐ Legal Information
- ☐ Social History

It is required for the following purpose(s): _____

RELEASE OF ALCOHOL AND DRUG ABUSE PATIENT REPORTS: This information has been disclosed to you from records protected by Federal confidentiality rules (*42 CFR Part 2*). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by *42 CFR Part 2*. 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 patient.

RELEASE OF HIV-RELATED INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization of the release of medical or other information is NOT sufficient for this purpose (*P.A. 89-246*).

Please note that Family Centers Inc., cannot ensure that protected health information disclosed to a third party will be safeguarded in a manner identical to our agency, and that the possibility of re-disclosure exists.

I understand that this authorization may be revoked by me at any time. If I choose to revoke this authorization, I will do so in writing to Family Centers Inc. Further disclosure of information beyond the scope of this authorization is prohibited without specific written authorization.

Unless otherwise revoked, this consent form expires twelve (12) months from the date of signature.

_____	_____	_____
Name of client(Parent/Guardian)	*Signature*	*Date*

NOTE: Your refusal to sign this form cannot be deemed as reason for terminating services.

111 Wilbur Peck Court
Greenwich, CT 06830
(203) 717-1760

Initial: _____

Family Centers Health Care (FCHC): Primary Care Medical Home
Information Sheet

Mission:
Primary Care Medical Home (PCMH) is an approach to primary care that leverages teamwork and technology to deliver care that is personalized, comprehensive, coordinated and more convenient for patients.

Principles:

- Each patient has an ongoing relationship with their Clinician.
- The Clinician leads a team of individuals who collectively take responsibility for ongoing patient
- care.
- Holistic care where FCHC is responsible for providing all of the patient's health care needs or for
- arranging care with other qualified professionals.
- Quality and safety are hallmarks of the medical home.
- Enhanced access to care is available through scheduling, expanded hours and other options for
- communication between patients and provider staff.
- The Outcome is better care and better health.

Goals:

Personalized and Coordinated Care

- An ongoing relationship with your medical provider
- Good communication with a trusted partnership
- Shared decision-making
- Culturally sensitive care
- Family engagement option
- Oversee and coordinate care across the health system through proactive collaboration
- Coordinate referrals to specialists, providing needed information that is supported by
- electronic medical records
- Electronic orders, prescriptions and reporting
- Offer connections to community services

Comprehensive care

- Whole-person orientation
- Care for acute and chronic conditions
- Preventive care counseling, screening, and education
- Individual health goals set with patient
- Provide self-management through education/support for chronic conditions
- Use of evidence-based best practices

Convenient care

- Same-day appointments
- Patient's time used wisely with team approach
- Leave visit with a plan of care
- Timely follow-up with test results
- Reminders to ensure follow-up on needed services