UR Medicine Geriatrics Group

Thank you for choosing to become part of UR Medicine Geriatric Group. We are looking forward to bringing you something that's very hard to find these days: high-quality medical care, delivered right to your door, lessening the inconvenience of traveling out.

Our medical practice, comprised of physicians, nurse practitioners and physician's assistants who specialize in caring for the elderly, is affiliated with the University of Rochester Medical Center and Highland Hospital.

We have partnered with senior living communities in the Rochester Metro area to provide residents like yourself, personalized medical care in the privacy and comfort of your own living area. When you need to see a doctor, you won't need to worry about arranging transportation or going out in bad weather conditions, because we come to see you!

Our caregivers will visit you for both routine scheduled visits and any unexpected needs or problems that may arise on a specific day of the week. Having your health care practitioner see you in your home is convenient, and ensures that you and your family members have enough time to discuss your care with your doctor in a relaxed environment. We also have on-call providers available to you to address any concern, at any time of the day or night.

In the event you or your loved one chooses to transfer from our services, you must arrange for a primary care provider within the community to care for you. In the interim we will cover your care for 30 days after transferring of services.

Steps to make certain for a smooth transition into becoming our patient:

Within the pages to follow is our "New Patient Registration Packet."
This is a brief summary for you to provide us with your previous medical, social and family history. We ask that you complete these forms to the best of you and your families' knowledge. It is very important that all documents are signed by the patient or Power of Attorney/Health Care Proxy where indicated.

*It is also crucial to include a **copy** of your **insurance information.**

*New patient appointments are scheduled within a 2-3 week time frame after receiving the proper completion of the registration documents, processing the paperwork and receiving your prior medical records. Our caregivers prefer to review your prior health history to become familiar with your background before meeting. Your current primary physician should continue to cover your medical needs until our staff has made your initial appointment, at which time we would then assume medical care on the appointment date in which we have set up.

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Monroe Community Hospital
435 East Henrietta Road ● Rochester, New York 14620 ● Phone 585-760-5466 ● Fax 585-424-4184

Please use the following guidelines to help you along the registration pathway:

Page 1:

☐ Complete patient name, date of birth, social security number and facility address.

☐ **Please supply us with a copy of your insurance card information**.

☐ Indicate whether you will be handling your financial affairs or specify a responsible party to forward these on to.

☐ Designate an emergency contact person on your behalf.

☐ **We also recommend a copy of the Power of attorney and Health Care Proxy paperwork if accessible.**

☐ Please sign and date.

Page 2:

☐ Appoint an individual, if desired, for the involvement in care discussion form for any loved one whom you might want us to share any pertinent information with; including appointment dates, lab draws and so forth.

☐ Provide contact information for this individual.

☐ Please sign and date.

Pages 2-6:

☐ Please provide a brief description of your previous and current health, family and social history, to the best completion of your knowledge.

Page 7:

The authorization for release of medical and behavioral information forms must be completed and signed in order for us to obtain previous medical records.

☐ Provide your current primary care physician's information with the doctor's name, address and phone number to reach him/her in obtaining your medical records on the right hand side within the box. The review of your prior medical records is important to ensuring high-quality medical care. We encourage you/your family to help with this process.

☐ Compete, sign and date pages.

Page 8:

☐ If you are a participant in the Excellus Blue Cross/Blue Shield or MVP (Preferred Care) program, please sign this last form to update the change of your primary care physician for billing purposes.

We are focused on providing excellent primary medical care for the elderly with excellent support for their families. Our office is staffed with many medical professionals to answer all of your questions and concerns Monday – Friday, 8:30 a.m. until 4:00 p.m. Our team of medical providers is available through an on call service 24 hours a day/7 days a week for medical emergencies during non-office hours.

We thank you again and look forward to providing you with the very best care.

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Welcome to UR Medicine Geriatrics Group

Registration Documents

Patient Name & Address:

Name: _____ **Date of Birth**: _____ ☐ **Male** ☐**Female**

Address: _____ **City:** _____ **Sate/Zip:** _____

Phone #: _____ **Social Security Number:** _____

Name Prefers to be called: _____ **Facility Name:** _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse's Name: _____ **Spouse's Contact #:** _____

Insurance Information

Please supply us with a copy of your Insurance Card

Insurance Name	Subscriber	Relationship To Subscriber	Member ID	Copay

Responsible Party (Send bills to):

Name: _____**Home #:** _____**Work #:** _____

Address: _____**City:** _____**State/Zip:** _____

Are you Power Of Attorney: ☐**Yes** ☐**No (If yes, please supply us with a copy of the paperwork)**

Contact in Case Of Emergency

Name: _____ **Relationship:** _____ **Home#:** _____

Address: _____ **State/Zip:** _____

Authorization of Medical Information Release and Payment Responsibility

I authorize the release of any medical information necessary to process this claim and request payment of benefits either to myself or to the party who accepts assignment. I acknowledge responsibility for payment of fee for all services rendered, regardless of any insurance coverage.

Medicare will only pay for services, which it determines to be medically necessary. Under section 1862(a) (1) of the Medicare law it states that if the services is not necessary under Medicare program standards, payment will be denied. I have been notified that Medicare is likely to deny payment for my early physical, which Medicare considers preventative care and may not cover. If Medicare denies payment. I agree to be personally and fully responsible for payment.

Please sign below to indicate consent to the statements above:

Signature: _____ **Date:** _____

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Involvement in Care Discussion Form

UR Medicine Geriatrics may discuss protected health information, including lab/test results and payment issues with the following people:

Name	Relationship	Phone Number

Communication Requests: _____ **Days:** _____

Phone me using the following Number: _____

Y **N**

☐ ☐ May phone me at work

☐ ☐ May leave messages on answering machine

☐ ☐ Other: _____

This will remain in effect until notified differently by the above patient.

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE AND RETURN TO THE ABOVE ADDRESS FOR MD REVIEW. FAILURE TO RETURN A COMPLETE PACKET COULD DELAY TRANSFER OF MEDICAL CARE.

PRESENT HEALTH

Describe general health compared to others the same age: ☐excellent ☐good ☐ fair ☐poor

Have you fallen within the past year: ☐ yes ☐ no

Have you recently (within the last year) lost interest or pleasure in doing activities: ☐yes ☐ no

Have you recently (within the last year) felt down, depressed and/or hopeless: ☐ yes ☐ no

General health over the past 5 years: _____

_____

Weight: changes in past 6 month's _____ past year_____

Describe typical day/hobbies: _____

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FUNCTIONAL STATUS

Are you able to?
(I = independently, A = with assistance, D = dependent on others for help)

Get dressed	☐I ☐A ☐D	Drive	☐I ☐A ☐D
Baths	☐I ☐A ☐D	Use Phone	☐I ☐A ☐D
Use toilet	☐I ☐A ☐D	Manage Money	☐I ☐A ☐D
Eat	☐I ☐A ☐ D	Prepare Meals	☐I ☐A ☐D
Walk	☐I ☐A ☐D	Telephone	☐I ☐A ☐D
Getting up from Chair	☐I ☐A ☐D	Shop	☐I ☐A ☐D

Do you use? ☐ walker ☐ cane ☐ commode ☐ raised toilet seat ☐ hospital bed ☐ wheelchair
Other assistive devices: _____

HEALTH HISTORY

Medical Problems

Date	Diagnosis/Condition

Date	Diagnosis/Condition

Surgeries

Date	Procedure

Date	Procedure

Current Medications (also include non-prescription drugs and vitamins) **Preferred Pharmacy:**_____

Medication	Dosage/How many times daily

Medication	Dose/How many times daily

Allergies (medications, environmental, food and latex)

Allergies	Reaction

Allergies	Reaction

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SOCIALHISTORY

Education: _____ Occupation: _____
Religion: _____ Children/G. Children: _____
Does someone else depend on you as care giver? _____

FAMILY HISTORY

Parents – Age of death – Illnesses/Cause of death:
Mother: _____ Father: _____
Siblings – Age – Illnesses/Cause of death:
_____ _____
_____ _____

HABITS

Alcohol intake: _____ Have you used street drugs? _____
Smoking history: _____ Do you exercise regularly? _____

IMMUNIZATION STATUS (note most recent date)

Tetanus, diphtheria _____ TB _____ Influenza _____ Pneumovax _____

REVIEW OF SYSTEMS (Please place an "X" on the space next to any of these symptoms you are currently having)

☐ Poor vision	☐ Headache	☐ Numbness	☐ Weakness
☐ Poor hearing	☐ Earache	☐ Pain	☐ Neck Pain
☐ Low Back Pain	☐ Leg Pain	☐ Dizzy Spells	☐ Faints
☐ Chronic Fatigue	☐ Passing Out	☐ Broken Bones	☐ Joint Injury
☐ Tremor	☐ Arthritis	☐ Change of Smells	☐ Falling
☐ Memory Loss	☐ Ringing in Ears	☐ Sinusitis	☐ Unusual Movements
☐ Visual Spots	☐ Nausea	☐ Vomiting	☐ Loss of Urine Control
☐ Irregular Pulse	☐ Double Vision	☐ Cold Numb Feet	☐ Loss of Bowel Control
☐ Ulcers	☐ Heart Murmur	☐ Depression	☐ Insomnia
☐ Snoring	☐ Pacemaker	☐ Thyroid Disease	☐ Chiropractic Care
☐ Apnea			

ADVANCE DIRECTIVES

Do you have a Health Care Proxy? ☐Y ☐N Name: _____

Do you have a Living Will? ☐Y ☐N

Do you have a MOLST? ☐Y ☐N

Please provide copies of the above documents if available.

Person Completing this Form: _____ Relationship: _____

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Authorization for Release of Medical & Behavioral Information

Patient's Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

SS#: _____ Patient's Phone: _____

Date of Request: _____ Date Needed: _____

☐ **I authorize UR Medicine Geriatrics Group to obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone#/Fax# (Include Area Code)

Purpose for this request: ☐Health Care ☐Insurance Coverage ☐Personal ☐ Other

Type of Records Requested:

☐ Inpatient: date(s) _____ ☐ Outpatient: date(s) _____

Specific Information (Select one or more, as applicable)

☐ Operative Report ☐ History & Physical ☐ Discharge Summary ☐ Laboratory Tests

☐ X-Ray Reports ☐ Physical Therapy ☐ Other: _____

☐ Treatment Summary (Includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)

☐ Entire Copy of the inpatient/outpatient record checked above

AUTHORIZATION VALID FOR: (Check one)

☐ This request only

☐ One year from the date of this authorization OR _____(insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.

☐ This request is for Medical Records of any future treatment of the type described above until: _____

I understand that:

- My right to healthcare treatment is not conditioned on this authorization
- I may cancel this authorization at any time by submitting a ***written request*** to the address provided at the top of the form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed
- Release of HIV-related information requires additional authorization.
- There may be a charge for the requested records.

Signature of Patient or Representative: _____ Date: _____

Relationship to Patient (if requester is not the patient): _____

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CHANGE IN PRIMARY CARE PROVIDER FORM

Insurance Company:

☐	**Blue Choice**	**Fax # 238-3692**	**Attn: Member Services**
☐	**MVP (Preferred Care)**	**Fax # 327-2227**	**Attn: Member Services**

Patient's Name: _____

Address: _____

_____

Phone Number: _____

Contract #: _____

Date of Birth: _____

I would like to change my Doctor From: _____

To: _____

Effective as of: _____

Reason: _____

_____

Signature: _____ **Date:** _____

Provider ID #: _____ **(Office use/MVP only)**

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