



Welcome

Independent  
Living

## UR Medicine Geriatrics Group

Thank you for choosing to become part of UR Medicine Geriatrics Group. We look forward to bringing you something that's very hard to find these days: high-quality medical care delivered where you live, letting you avoid the inconvenience of traveling out.

Our medical practice specializes in caring for the elderly and comprises physicians, nurse practitioners, and physician assistants and is affiliated with UR Medicine and Highland Hospital.

We have partnered with senior living communities throughout the Rochester area to provide residents with personalized medical care in the privacy and comfort of their own living area. Our providers are available for you 24 hours a day, 365 days a year.

When you need us, we'll be there.  
We're just a phone call away.

(585) 276-0830.



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# Welcome to UR Medicine Geriatrics Group

Our caregivers will visit for both routine scheduled visits and any unexpected needs or problems that may arise. Having your health care practitioner see you in your home environment 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.

## Ensuring a Smooth Transition to URMGG

Together we can make your transition to being our patient as smooth as possible. Please complete the forms on the next several pages to the best of your knowledge. These forms comprise our New Patient Packet and provide us with a brief summary of your previous medical, social, and family history. Please remember:

- 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 and POA/HCP form.

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 we have scheduled.

## Please Do Not Hesitate to Contact Us With Any Questions

UR Medicine Geriatrics Group  
Division of Geriatrics & Aging

Phone: (585) 276-0830

Fax: (585) 424-4184

1870 S. Winton Road, Suite 100  
Rochester, NY 14618



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# Facilities

UR Medicine Geriatrics Group brings integrated care programs to patients at partner assisted living facilities and nursing homes throughout the area. Below is a

complete list of all the facilities where our geriatricians provide primary geriatric care.

## Assisted Living and Independent Facilities

- Baywinde Kidd Castle Way, Webster
- Bridges of Mendon Rush-Mendon Rd., Mendon
- Brookdale Pittsford Sully's Trail, Pittsford
- Clark Meadows Clark Meadows, Canandaigua
- Cloverwood Sinclair Dr., Pittsford
- Cobbs Hill Manor Monroe Ave., Rochester
- Creekstone Ranney Dr., Fairport
- Elderwood at Fairport Chardonnay Dr., Fairport
- Fairport Baptist Home Nine Mile Point Rd., Fairport
- Ferris Hills Ferris Hills, Canandaigua
- Glenmere Sinclair Dr., Pittsford
- GrandeVie Five Mile Line Rd., Penfield
- GrandeVie- Villagewood & Caring House Five Mile Line Rd., Penfield
- Heather Heights West Jefferson Rd., Pittsford
- Heathwood Elderwood Court, Penfield
- Highlands at Pittsford Hahnemann Trail, Pittsford
- Horizons - DePaul NY Route 21, Canandaigua
- Landing of Brighton Westfall Road, Rochester
- Legacy at the Fairways High Street, Victor
- Linden Knoll Linden Ave., Rochester
- Morgan Estates Morgan View Rd., Geneseo
- Northfield Nine Mile Point Rd., Fairport
- Parkside Main St., East Rochester
- Quail Summit Parrish Street, Canandaigua
- River Edge Mt. Hope Ave., Rochester
- Rochester Presbyterian Home Thurston Rd., Rochester
- St. Johns Johnsarbor Dr., Rochester
- Woodcrest Commons West Henrietta Rd., Henrietta

## Skilled Nursing Facilities

- Aaron Manor St. Camillus Way, Fairport
- The Brook Nursing Home Saint Paul St., Rochester
- Brightonian Elmwood Ave., Rochester
- Crest Manor Pitts-Palmyra Rd., Fairport
- Elm Manor N. Main St., Canandaigua
- Fairport Baptist Home Nine Mile Point Rd., Fairport
- Friendly Home East Ave., Brighton
- Highlands Living Center Hahnemann Trail, Pittsford
- Hurlbut E. Henrietta Rd., Rochester
- Monroe Community Hospital E. Henrietta Rd., Rochester
- M.M. Ewing 350 Parrish St., Canandaigua
- Penfield Place Penfield Rd., Penfield
- Shore Winds Beach Ave., Rochester
- Wedgewood Church St., Spencerport
- Woodside Manor S. Clinton Ave., Rochester



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# Guidelines to Help You Along the Registration Pathway

## Page 5: Ethnicity & Race Form

- ☐ Please share your ethnicity and race to help us to know our patients better and improve health care for all.

## Page 6: Registration Document Form

- ☐ 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.
- ☐ Designate an emergency contact.
- ☐ We also recommend a copy of the Power of Attorney and Health Care Proxy paperwork.
- ☐ Sign and date.

## Page 7: Involvement in Care Discussion Form

- ☐ Use this form to appoint an individual with whom you would like us to share information, including appointment dates, lab draws, etc.
- ☐ Provide contact information for this individual.
- ☐ Sign and date.

## Pages 8: Telehealth Consent Form

- ☐ Complete this form if you wish to be able to visit your health care team using video calls and similar.

## Pages 9-10: Health History Form

- ☐ To the best of your knowledge, provide a brief description of your previous and current health, family, and social history.

## Page 11: Authorization for Release of Medical & Behavioral Information Form

The authorization for release of medical and behavioral information form 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 obtain your medical records. 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.
- ☐ Sign and date.

## Page 12: Change In Primary Care Provider Form

- ☐ 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.

## Page 13-14: Questions About Health Care Costs

- ☐ This tip sheet addresses many common questions about health care costs to help you better understand potential expenses while receiving care at UR Medicine.

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 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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# Ethnicity & Race Form

DATE \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_  
FIRST MIDDLE LAST

BIRTH DATE \_\_\_\_\_ MEDICAL RECORD NUMBER \_\_\_\_\_  
OFFICE USE ONLY

We are asking our patients to share their ethnicity and race. This will help us to know our patients better and improve health care for everyone. Personal information will remain private and confidential.

**Ethnicity:** Your ethnicity refers to your background heritage, culture, religion, ancestry or sometimes the

country where you were born. For New York State reporting, we are specifically collecting whether or not your ethnicity is Hispanic, Latino, or of Spanish Origin.

**Race:** Your race is the group(s) that you relate to as having similar features, traits, or birthplace.

## What is your ETHNICITY?

☐ **Hispanic or Latino or Spanish Origin** (If checked, please select up to 4 choices below):

- |  |   |   |   |   |
|--|---|---|---|---|
| <input type="checkbox"/> Andalusian        | <input type="checkbox"/> Central American | <input type="checkbox"/> Dominican        | <input type="checkbox"/> Mexican American | <input type="checkbox"/> South American |
| <input type="checkbox"/> Argentinean       | <input type="checkbox"/> Central American | <input type="checkbox"/> Ecuadorian       | <input type="checkbox"/> Indian           | <input type="checkbox"/> South American |
| <input type="checkbox"/> Asturian          | <input type="checkbox"/> Indian           | <input type="checkbox"/> Gallego          | <input type="checkbox"/> Mexicano         | <input type="checkbox"/> Indian         |
| <input type="checkbox"/> Balearic Islander | <input type="checkbox"/> Chicano          | <input type="checkbox"/> Guatemalan       | <input type="checkbox"/> Nicaraguan       | <input type="checkbox"/> Spaniard       |
| <input type="checkbox"/> Bolivian          | <input type="checkbox"/> Chilean          | <input type="checkbox"/> Honduran         | <input type="checkbox"/> Panamanian       | <input type="checkbox"/> Spanish Basque |
| <input type="checkbox"/> Canal Zone        | <input type="checkbox"/> Colombian        | <input type="checkbox"/> La Raza          | <input type="checkbox"/> Paraguayan       | <input type="checkbox"/> Uruguayan      |
| <input type="checkbox"/> Canarian          | <input type="checkbox"/> Costa Rican      | <input type="checkbox"/> Latin American   | <input type="checkbox"/> Peruvian         | <input type="checkbox"/> Valencian      |
| <input type="checkbox"/> Castillian        | <input type="checkbox"/> Criollo          | <input type="checkbox"/> Mexican          | <input type="checkbox"/> Puerto Rican     | <input type="checkbox"/> Venezuelan     |
| <input type="checkbox"/> Catalanian        | <input type="checkbox"/> Cuban            | <input type="checkbox"/> Mexican American | <input type="checkbox"/> Salvadoran       |   |

☐ **Not Hispanic or Latino or Spanish Origin**

☐ **Patient Refused**

## What is your RACE? (You may select up to 4 Races)

☐ **American Indian or Alaska Native**

☐ **Asian** (If checked, please specify from the choices below):

- |                                       |                                     |                                     |                                      |                                     |
|---------------------------------------|-------------------------------------|-------------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Chinese    | <input type="checkbox"/> Japanese   | <input type="checkbox"/> Maldivian   | <input type="checkbox"/> Sri Lankan |
| <input type="checkbox"/> Bangladeshi  | <input type="checkbox"/> Filipino   | <input type="checkbox"/> Korean     | <input type="checkbox"/> Nepalese    | <input type="checkbox"/> Thai       |
| <input type="checkbox"/> Bhutanese    | <input type="checkbox"/> Hmong      | <input type="checkbox"/> Laotian    | <input type="checkbox"/> Okinawan    | <input type="checkbox"/> Taiwanese  |
| <input type="checkbox"/> Burmese      | <input type="checkbox"/> Indonesian | <input type="checkbox"/> Madagascar | <input type="checkbox"/> Pakistani   | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Cambodian    | <input type="checkbox"/> Iwo Jiman  | <input type="checkbox"/> Malaysian  | <input type="checkbox"/> Singaporean |                                     |

☐ **Black or African-American**

☐ **Native Hawaiian or Pacific Islander** (If checked, please specify from the choices below):

- |                                       |   |  |                                     |   |
|---------------------------------------|---|--|-------------------------------------|---|
| <input type="checkbox"/> Carolinian   | <input type="checkbox"/> Chamorro         | <input type="checkbox"/> Micronesian     | <input type="checkbox"/> Palauan    | <input type="checkbox"/> Samoan           |
| <input type="checkbox"/> Chamorro     | <input type="checkbox"/> Kiribati         | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Papua New  | <input type="checkbox"/> Solomon Islander |
| <input type="checkbox"/> Chuukese     | <input type="checkbox"/> Kosraean         | <input type="checkbox"/> New Hebrides    | <input type="checkbox"/> Guinean    | <input type="checkbox"/> Tahitian         |
| <input type="checkbox"/> Fijian       | <input type="checkbox"/> Mariana Islander | <input type="checkbox"/> Other Pacific   | <input type="checkbox"/> Pohnpeian  | <input type="checkbox"/> Tokelauan        |
| <input type="checkbox"/> Guamanian    | <input type="checkbox"/> Marshallese      | <input type="checkbox"/> Islander        | <input type="checkbox"/> Polynesian | <input type="checkbox"/> Tongan           |
| <input type="checkbox"/> Guamanian or | <input type="checkbox"/> Melanesian       | <input type="checkbox"/> Pakistani       | <input type="checkbox"/> Saipanese  | <input type="checkbox"/> Yapese           |

☐ **White**

☐ **Other**

☐ **Patient Refused**



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# Registration Form

## PATIENT'S INFORMATION

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ MALE/FEMALE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/ZIP \_\_\_\_\_

PHONE # \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

NAME YOU PREFER 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
1.				
2.				
3.				

## 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 \_\_\_\_\_ CITY \_\_\_\_\_ 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 that it determines to be medically necessary. Under section 1862(a) (1) of the Medicare law it states that if the service 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 Group 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 ADDRESS ON PAGE 2 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: Past 6 months \_\_\_\_\_ Past year \_\_\_\_\_

Describe typical day/hobbies: \_\_\_\_\_



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# Telehealth Consent

SH 419TELE MR

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This consent is for all telehealth services provided for the following condition(s):

1. I understand that my health care provider wishes me to engage in a telehealth appointment/consultation to evaluate my health condition.
2. My health care provider has explained to me that either video conferencing technology and/or electronic transmission of my health information such as radiologic images, photos and sounds will be used during this appointment/ consultation and it will not be the same as a direct patient / health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand that there are risks associated with use of this technology such as interruptions, technical difficulties, and inability to obtain information sufficient for decision making about my health problem and that all possible precautions will be taken to minimize these risks. In addition, my health care provider or I can discontinue the telehealth visit if it is felt that the information obtained through the telemedicine connection is not adequate for diagnostic decision-making or for implementing management of my health problem. In that event, we will endeavor to facilitate access to a site where adequate care can be provided, such as a doctor's office or other source of in-person care.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the appointment/ consultation and thus will have the right to request the following:
  - (a) Omitting specific details of my medical history / physical examination that are personally sensitive;
  - (b) Asking non-medical personnel to leave the telemedicine examination room; and/ or
  - (c) Terminating the consultation at any time.
5. The alternatives to a telehealth appointment/consultation have been explained to me. In choosing to participate in a telehealth appointment/consultation, I understand that some parts of the visit, such as the physical exam, may be conducted by individuals at my location at the direction of the consulting health care provider, as indicated.
6. In an **emergent** consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
7. I understand that depending on factors such as my location, my health insurance, and the services I am receiving, billing may occur from both my health care provider and the facility at which I am presenting for my appointment. If my health insurance is Medicaid and I am receiving telepsychiatry services in a location that is licensed by the New York State Office of Mental Health, I understand that billing will only occur from the facility at which I am presenting.
8. I have had a direct conversation with my health care provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify that:

- I have read or had this form read and/or had this form explained to me
- I fully understand its contents including the risks and benefits of the telehealth appointment / consultation
- I have been given ample opportunity to ask questions and that all questions have been answered to my satisfaction.
- I consent to this telehealth appointment / consultation.
- I have been provided with the University of Rochester Medical Center and Affiliates Notice of Privacy Practices.

Patient/Parent/Guardian Signature

Date

Time

TO BE COMPLETED BY STAFF

No signature was obtained due to:

- ☐ Impractical, verbal consent given
- ☐ Patient's condition/capacity
- ☐ No representative

Staff Signature

Date

Time



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# Functional Status & Health History

## 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
Bathe	I	A	D	Use the 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
Get Up from a Chair	I	A	D	Shop	I	A	D

Do you use? ☐ walker ☐ cane ☐ commode ☐ raised toilet seat ☐ hospital bed ☐ walker

Other assistive devices? \_\_\_\_\_

## HEALTH HISTORY

### Medical Problems

Date	Diagnosis/Condition

Date	Diagnosis/Condition

### Surgeries

Date	Procedure

Date	Procedure

### Current Medications

Medication	Dose/Times Per Day

Medication	Dose/Times Per Day

### Allergies

Allergy	Reaction

Allergy	Reaction



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## SOCIAL HISTORY

Education: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Religion: \_\_\_\_\_ Children/Grand Children: \_\_\_\_\_  
Does someone else depend on you as a caregiver? \_\_\_\_\_

## FAMILY HISTORY

Mother: Age of death: \_\_\_\_\_ Cause of death: \_\_\_\_\_  
Father: Age of death: \_\_\_\_\_ Cause of death: \_\_\_\_\_  
Siblings: Age of death: \_\_\_\_\_ Cause of death: \_\_\_\_\_  
Siblings: Age of death: \_\_\_\_\_ 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)

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Poor Vision     | <input type="checkbox"/> Headache        | <input type="checkbox"/> Numbness         | <input type="checkbox"/> Weakness              |
| <input type="checkbox"/> Poor Hearing    | <input type="checkbox"/> Earache         | <input type="checkbox"/> Pain             | <input type="checkbox"/> Neck Pain             |
| <input type="checkbox"/> Low Back Pain   | <input type="checkbox"/> Leg Pain        | <input type="checkbox"/> Dizzy Spells     | <input type="checkbox"/> Faints                |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Passing Out     | <input type="checkbox"/> Broken Bones     | <input type="checkbox"/> Joint Injury          |
| <input type="checkbox"/> Tremor          | <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Change of Smells | <input type="checkbox"/> Falling               |
| <input type="checkbox"/> Memory Loss     | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Sinusitis        | <input type="checkbox"/> Unusual Movements     |
| <input type="checkbox"/> Visual Spots    | <input type="checkbox"/> Nausea          | <input type="checkbox"/> Vomiting         | <input type="checkbox"/> Loss of Urine Control |
| <input type="checkbox"/> Irregular Pulse | <input type="checkbox"/> Double Vision   | <input type="checkbox"/> Cold Numb Feet   | <input type="checkbox"/> Loss of Bowel Control |
| <input type="checkbox"/> Ulcers          | <input type="checkbox"/> Heart Murmur    | <input type="checkbox"/> Depression       | <input type="checkbox"/> Insomnia              |
| <input type="checkbox"/> Snoring         | <input type="checkbox"/> Pacemaker       | <input type="checkbox"/> Thyroid Disease  | <input type="checkbox"/> Chiropractic Care     |
| <input type="checkbox"/> 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 Form? 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

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/ZIP \_\_\_\_\_  
PHONE # \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
DATE OF REQUEST: \_\_\_\_\_ DATE NEEDED: \_\_\_\_\_

## I authorize UR Medicine Geriatrics Group to obtain information from:

NAME OF PROVIDER or FACILITY \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/ZIP \_\_\_\_\_  
PHONE #/FAX # (Include Area Code) \_\_\_\_\_

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

**Type of Records Requested:** ☐ Inpatient: dates \_\_\_\_\_ ☐ Outpatient: dates \_\_\_\_\_

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)  
☐ Copy of the entire 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 health care 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 redisclosed.
- Release of HIV-related information requires additional authorization.
- There may be a charge for the requested records.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient (if requestor 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 \_\_\_\_\_ CITY \_\_\_\_\_ STATE/ZIP \_\_\_\_\_

PHONE # \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

CONTRACT # \_\_\_\_\_

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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# Questions About Health Care Costs

**This tip sheet addresses many common questions about health care costs to help you better understand potential expenses while receiving care at UR Medicine.**

Thank you for entrusting your care to UR Medicine. We are committed to providing you with excellent service in all aspects of your care, including answering your questions about your health care costs. With more patients moving to newer high deductible and co-insurance plans, we find many patients have questions about medical expenses.

As part of our service excellence pledge to you, we are providing this tip sheet to make you aware of some of the ways you can better understand your potential expenses while receiving care at UR Medicine.

- **Become aware of your insurance plan's "network tiers"**

Today, many insurance plans sort hospitals and other care providers into "in-network" and "out-of-network" tiers. Typically, "in-network" care is less expensive than "out-of-network" care. Before you receive care, it's a good idea to contact your insurance company to help you understand how your health care providers' status in a particular tier may affect your health care costs.

- **UR Medicine care providers & hospitals**

Most UR Medicine care providers and hospitals accept most insurance plans (see list on reverse side or visit [insurance.urmc.edu](https://insurance.urmc.edu)). To find out if your care provider is part of the UR Medicine network, visit [urmc.rochester.edu/people/](https://urmc.rochester.edu/people/). You can also view the specific locations where your UR Medicine care provider works at [urmc.rochester.edu/people/](https://urmc.rochester.edu/people/). UR Medical Faculty have admitting privileges to Strong Memorial Hospital, Highland Hospital or both.

- **Separate charges for some services**

UR Medicine will send one combined bill for the health care services you received. The UR Medicine logo will be at the top of the Statement of Services. The bill will separate charges related to: [1] Hospital facility fees. These are fees which includes such items as exam/surgery rooms, medicine given, x-rays taken, tests, etc. [2] Physician Fees. These fees are for a provider who was involved in your care in-person or reviewing images/tests, etc.

- **Referrals and insurance plans**

When your care provider sends you to the hospital or arranges a procedure or test, ask your insurance company if those providers are "in network" for your plan. On our website, you can view a list of UR Medicine lab locations ([urmc.rochester.edu/urm-labs/service-centers.aspx](https://urmc.rochester.edu/urm-labs/service-centers.aspx)) and imaging locations ([urmc.rochester.edu/imaging/locations.aspx](https://urmc.rochester.edu/imaging/locations.aspx)).

- **Anticipated costs at UR Medicine**

You may contact our Health Care CostEstimator team at 585-758-7801 to receive an estimated cost for services or procedures provided at UR Medicine hospitals or by our providers.

- **Financial assistance is available**

UR Medicine also offers a Financial Assistance program for individuals who cannot afford the health care they need.

For more information, visit: [financialassistance.urmc.edu](https://financialassistance.urmc.edu) or call 585-784-8889.



**Geriatrics Group**

**Part of Highland Hospital**

# Insurance Carriers

Below is a list of the insurance carriers that UR Medicine care providers and hospitals serve as participating providers. Each carrier may offer several different plans. UR Medicine doctors and hospitals routinely care for patients served by a variety of health plans and the participation status with each plan is unique. While a specific health plan may not be listed here, your UR Medicine provider may participate. Please contact your insurance carrier to learn if your particular plan is accepted by UR Medicine, and the services you require are covered under your plan.

Health Insurance Carrier	Provider	Facility	Facility	Provider	Facility	Contact Information
	UR Medicine Care Providers	Strong Memorial Hospital	Highland Hospital	UR Medicine Behavioral Health Services Care Providers	UR Medicine Behavioral Health/Strong Memorial Hospital	
Aetna including Medicare	Yes	Yes	Yes	Yes	Yes	<a href="http://aetna.com">aetna.com</a>
Beacon Health Options	Yes	Yes	<b>No</b>	Yes	Yes	<a href="http://beaconhealthoptions.com">beaconhealthoptions.com</a>
BlueCross and BlueShield of Western New York including Medicare Plans	Yes	Yes	Yes	Yes	Yes	<a href="http://bcbswny.com">bcbswny.com</a>
BlueCross BlueShield of Western New York Medicaid Plans	Yes	Yes	Yes	Yes	Yes	<a href="http://mybcbswny.com">mybcbswny.com</a>
CIGNA	Yes	Yes	Yes	<b>No</b>	<b>No</b>	<a href="http://cigna.com">cigna.com</a>
Elderplan	Yes	Yes	Yes	Yes	Yes	<a href="http://elderplan.org">elderplan.org</a>
EmblemHealth (GHI)	Yes	Yes	Yes	Yes	Yes	<a href="http://emblemhealth.com">emblemhealth.com</a>
The Empire Plan	Yes	Yes	Yes	Yes	Yes	<a href="http://empireplanproviders.com">empireplanproviders.com</a>
Excellus BlueCross and BlueShield including Medicare Plans and Medicaid Plans	Yes	Yes	Yes	Yes	Yes	<a href="http://excellusbcbs.com">excellusbcbs.com</a>
Fidelis Care	Yes	Yes	Yes	Yes	Yes	<a href="http://fideliscare.org">fideliscare.org</a>
Fidelis Care Medicare	<b>No</b>	<b>No</b>	<b>No</b>	<b>No</b>	<b>No</b>	<a href="http://fideliscare.org">fideliscare.org</a>
GWH-CIGNA	Yes	Yes	Yes	Yes	<b>No</b>	<a href="http://cigna.com">cigna.com</a>
iCircle Care	Yes	Yes	Yes	Yes	Yes	<a href="http://icirclecarecny.org">icirclecarecny.org</a>
Independent Health including Medicare	Yes	Yes	Yes	Yes	Yes	<a href="http://independenthealth.com">independenthealth.com</a>
Independent Health Medicaid/MediSource Plans	Yes	Yes	Yes	Yes	Yes	<a href="http://independenthealth.com">independenthealth.com</a>
MagnaCare	Yes	Yes	Yes	Yes	<b>No</b>	<a href="http://magnacare.com">magnacare.com</a>
Martin's Point (US Family Health Plan)	Yes	<b>No</b>	<b>No</b>	Yes	<b>No</b>	<a href="http://martinspoint.org">martinspoint.org</a>
Medicaid – New York State*	Yes	Yes	Yes	Yes	Yes	<a href="http://health.ny.gov/health_care/medicaid/">health.ny.gov/health_care/medicaid/</a>
Medicare*	Yes	Yes	Yes	Yes	Yes	<a href="http://medicare.gov">medicare.gov</a>
MultiPlan / PHCS	Yes	Yes	Yes	Yes	<b>No</b>	<a href="http://multiplan.com">multiplan.com</a>
MVP Health Care including Medicare Plans and Medicaid Plans	Yes	Yes	Yes	Yes	Yes	<a href="http://mvphealthcare.com">mvphealthcare.com</a>
OptumHealth Behavioral Solutions / United Behavioral Health	Yes	Yes	<b>No</b>	Yes	Yes	<a href="http://liveandworkwell.com">liveandworkwell.com</a>
POMCO/UMR	Yes	Yes	Yes	Yes	Yes	<a href="http://umr.com">umr.com</a>
TRICARE*	Yes	Yes	Yes	Yes	Yes	<a href="http://tricare.mil">tricare.mil</a>
UnitedHealthcare	Yes	Yes	Yes	Yes	Yes	<a href="http://uhc.com">uhc.com</a>
UnitedHealthcare Community Plan Medicaid Plans	Yes	Yes	Yes	Yes	Yes	<a href="http://uhccommunityplan.com">uhccommunityplan.com</a>
Univera Healthcare including Medicare	Yes	Yes	Yes	Yes	Yes	<a href="http://univerahealthcare.com">univerahealthcare.com</a>
Veterans Affairs Community Care Network (VA CCN)	Yes	Yes	Yes	<b>No</b>	<b>No</b>	<a href="http://va.gov">va.gov</a>
YourCare	Yes	Yes	Yes	Yes	Yes	<a href="http://yourcarehealthplan.com">yourcarehealthplan.com</a>

\*Government-funded plan accepted by UR Medicine