**Generations Family Health NPs**
*Caring for Families, Generations Strong.*
1617 N. James St. Suite 700 • Rome, NY 13440
Phone: 315-338-2840 • www.generationsfnp.com

## Welcome to Generations Family Health NPs

**Dear New Patient,**

Welcome to Generations Family Health NPs! Thank you for choosing us to partner with you in your healthcare. We are honored to provide you and your family with personalized, comprehensive care that focuses on wellness, prevention, and building long-term relationships.

Continuity and coordination are essential in meeting your healthcare needs. Our nurse practitioners, nurses, and office staff work together in a team approach to support your care every step of the way.

We ask that your New Patient Packet be submitted **before your appointment** so we can review your medical history, verify insurance, and prepare your chart in advance. This allows us to spend more of your appointment time focusing on your care and less on paperwork.

**Before your first visit:**

- If required by your insurance plan, please notify them of your new primary care provider.
- Contact your previous healthcare providers to request that a copy of your medical records be sent to us (an Authorization for Release of PHI is included in this packet for your convenience).
- Bring your health insurance card, a photo ID, and a complete list of your current medications.

We look forward to caring for you and your family — not just for today, but for generations to come.

Sincerely,

**The Providers and Staff of Generations Family Health NPs**

**Generations Family Health NPs**

# Patient Demographics

## Patient Information

- Last Name: _____ First Name: _____ MI: _____
- Date of Birth: ____ / ____ / _____ SS#: _____
- Gender Identity: □ Male □ Female □ Transgender Male □ Transgender Female □ Other: _____
- Marital Status: □ Single □ Married □ Legally Separated □ Divorced □ Widowed □ Partner
- Address: _____ City: _____ State: _____ Zip: _____
- Home Phone: _____ Cell Phone: _____
- Email: _____
- Race: □ White □ Black/African American □ Native Hawaiian □ Asian □ Other Pacific Islander □ American Indian/Alaska Native □ Other: _____
- Ethnicity: □ Hispanic/Latino □ Non-Hispanic/Latino
- Primary Language: _____ Interpreter Needed? □ Yes □ No

## Emergency Contact

- Name: _____ Relationship: _____
  Phone: _____

## Insurance Information

- Primary Insurance: _____ Subscriber: _____
  ID#: _____ Group#: _____
  Subscriber DOB: ___/___/_____ Relation to Patient: _____
- Secondary Insurance: _____ Subscriber: _____
  ID#: _____ Group#: _____
  Subscriber DOB: ___/___/_____ Relation to Patient: _____

## Pharmacy Information

- Preferred Pharmacy: _____ Phone: _____
  Address: _____

## Patient's Employer (if applicable)

- Employer's Name: _____ Work #: _____
  Employer's Address: _____
  _____
  Occupation: _____

**Generations Family Health NPs**
**Patient Name: _____ DOB: ____ / ____ / _____**

## Parent / Guardian Information (*MUST BE COMPLETED* if patient under 18)

*Mother*

- Name: _____ DOB: ___/___/_____
- Relationship: □ Biological □ Step-parent □ Other _____ Marital Status: S M D W
- Address (if different): _____
- Phone: _____ Email: _____
- Occupation: _____
- Employers Name: _____

*Father*

- Name: _____ DOB: ___/___/_____
- Relationship: □ Biological □ Step-parent □ Other _____ Marital Status: S M D W
- Address (if different): _____
- Phone: _____ Email: _____
- Occupation: _____
- Employers Name: _____

*Other Legal Guardian/Health Care Proxy/Power of Attorney*** (if applicable)*

- Name: _____ DOB: ___/___/_____
- Relationship: □ Biological □ Step-parent □ Other _____ Marital Status: S M D W
- Address (if different): _____
- Phone: _____ Email: _____
- Occupation: _____
- Employers Name & Address: _____
  _____

******Please provide any Legal paperwork for documentation of a Legal Guardian******

**Generations Family Health NPs**
**Patient Name: _____ DOB: ____ / ____ / _____**

**Previous PCP: _____**

**Dentist: _____**

**Specialists:**

_____

_____

_____

_____

## Acknowledgments

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION/PAYMENT ACKNOWLEDGEMENT: I AUTHORIZE GENERATIONS FAMILY HEALTH NPs, AS DIRECTED BY MY HEALTHCARE PROVIDERS, TO RELEASE MY MEDICAL RECORD INFORMATION INCLUDING THOSE PROTECTED BY FEDERAL AND STATE LAWS, REGARDLESS OF DATES OF SERVICE, TO OTHER HEALTHCARE FACILITIES/PROVIDERS OR THIRD PARTY HEALTH INSURANCE CARRIERS/BENEFIT ADMINISTRATORS, GOVERNMENTAL AGENCIES, MEDICARE/MEDICAID/WORKERS COMP AND NO-FAULT CARRIERS FOR THE PURPOSE OF CONTINUITY OF CARE/DISCUSSING MY CONDITION, INSURANCE CLAIM/PAYMENT ISSUES AND QUALITY ASSURANCE REVIEWS.

ASSIGNMENT OF BENEFITS: I AUTHORIZE PAYMENTS OF THE AUTHORIZED INSURANCE BENEFITS TO BE MADE DIRECTLY TO GENERATIONS FAMILY HEALTH NPs FOR ANY SERVICES RENDERED TO THE ABOVE PATIENT BY A GENERATIONS FAMILY HEALTH NPs PROVIDER AND/OR HIS/HER ASSIGNEES. IF ITEM 9 OF THE CMS-1500 CLAIM FORM IS COMPLETED, THE PROVIDER OR SUPPLIER AGREES TO ACCEPT THE ALLOWABLE/APPROVED AMOUNT AS THE PAYMENT IN FULL.

FINANCIAL RESPONSIBILITY: BY SIGNING BELOW YOU ARE RESPONSIBLE TO PAY ANY DEDUCTIBLE, COPAY, COST SHARE AND NON COVERED SERVICES DETERMINED BY THE INSURANCE CARRIER. YOUR SIGNATURE VERIFIES THAT YOU UNDERSTAND AND AGREE WITH THE ABOVE AND THE AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS AS NECESSARY FOR PAYMENT. (IF SOMEONE OTHER THAN THE PERSON SIGNING IS RESPONSIBLE FOR PAYMENT PLEASE PRESENT PROPER DOCUMENTATION)

BY SIGNING BELOW, I ATTEST THAT THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

I understand that I may revoke any of the above consents in writing at any time, except to the extent that action has already been taken based on this authorization.

**Signature of Patient / Parent / Legal Guardian: _____**

**Printed Name: _____**

**Relationship to Patient: _____**

**Date: ____ /____ /_____**

**Generations Family Health NPs**
**Patient Name: _____ DOB: ____ / ____ / _____**

# Request for Confidential Communication

If there is any one person (i.e; spouse, parent, child, significant other, etc.) you think might ever have a need to discuss your medical condition, treatment (test results, office visit, etc.), office and referral appointments, or your billing/insurance information please list them below. This will prevent us from having to get your written consent each time they call to handle matters on your behalf.

I authorize Generations Family Health NPs to speak to and release the above information to:

Name:_____ Relationship:_____ Phone#:_____
Name:_____ Relationship:_____ Phone#:_____
Name:_____ Relationship:_____ Phone#:_____
Name:_____ Relationship:_____ Phone#:_____

I understand that I may revoke this authorization at any time by giving written notice to Generations Family Health NPs Staff, except to the extent that action has been taken in reliance on this authorization. Patient is responsible to update this form as changes take place.

The information authorized for verbal release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by authorization of the person to whom it pertains or as otherwise permitted by 42 CR Part 2. As a result, by signing below I specifically authorize any such records included in my health information to be discussed.

_____ _____
Signature of Patient, Parent, or Legally Authorized Representative Name (Print)

_____ _____
Relationship to Patient Date

*This form does **not** allow us to release a copy of your medical records to this person.
We will need a separate specific written request from you.*