

North Country Adult Medicine

Patient Name: _____

DOB: _____

NEW PATIENT HEALTH HISTORY

Reason for Visit: _____ Previous Primary Care Provider: _____

How did you hear about North Country Adult Medicine?

☐ Friend/family ☐ Another Doctor ☐ Google/internet ☐ Insurance directory ☐ Facebook ☐ Other: _____

BRING ALL MEDICATIONS TO YOUR FIRST VISIT including as-needed meds, inhalers, creams, vitamins, supplements, and anything you may ever want us to refill.

Medical History

Please check all that apply.

- | | |
|--|---|
| ☐ Abnormal Pap smears | ☐ Acid reflux / GERD |
| ☐ Alcohol use disorder | ☐ Anemia |
| ☐ Anxiety | ☐ Arthritis |
| ☐ Asbestosis | ☐ Asthma |
| ☐ Atrial fibrillation | ☐ Autoimmune disease Type: _____ |
| ☐ Bipolar disorder | ☐ Blood clot (DVT/PE) |
| ☐ Borderline diabetes (prediabetes) | ☐ Cancer Type: _____ |
| ☐ Chronic bronchitis | ☐ Congestive heart failure |
| ☐ COPD | ☐ Dementia |
| ☐ Depression | ☐ Diabetes |
| ☐ Diverticulosis | ☐ Erectile dysfunction |
| ☐ Glaucoma | ☐ Gout |
| ☐ Heart attack / angina | ☐ High blood pressure |
| ☐ High cholesterol | ☐ Inflammatory bowel disease |
| ☐ Irritable bowel syndrome (IBS) | ☐ Kidney disease |
| ☐ Liver disease | ☐ Memory problems / mild cognitive impairment |
| ☐ Migraines | ☐ Osteoporosis |
| ☐ Panic attacks / panic disorder | ☐ Poor circulation (PAD) |
| ☐ Pre-osteoporosis (osteopenia) | ☐ Prostate disorder |
| ☐ Seizures | ☐ Sleep apnea |
| ☐ Stomach ulcers | ☐ Stroke / TIA (mini-stroke) |
| ☐ Substance use disorder | ☐ Thyroid disease — ☐ Low ☐ High |

Other medical conditions: _____

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Preventive Care

Annual physical/wellness	Date: _____	Pap/cervical screening	Date: _____	Mammogram	Date: _____
Colonoscopy	Date: _____	Cologuard/stool DNA	Date: _____	Other stool test (FIT/FOBT)	Date: _____
Routine bloodwork	Date: _____	Eye exam	Date: _____	Bone density/DEXA	Date: _____

Most Recent Immunizations

Flu Date: _____ ☐ N/A	COVID Date: _____ ☐ N/A	RSV Date: _____ ☐ N/A
Pneumonia Date: _____ ☐ N/A	Shingrix Date: _____ ☐ N/A	Tdap / Td Date: _____ ☐ N/A

Specialists / Other Clinicians

List specialists you currently see. Include medications they prescribe so we know which clinician is responsible for those prescriptions.

Specialty	Provider Name	Reason You See Them	Medications They Prescribe

Pharmacy

Preferred Local Pharmacy: _____

Mail-Order Pharmacy (if applicable): _____

Home Medical Equipment

☐ Oxygen ☐ CPAP/BiPAP ☐ Glucose meter/CGM ☐ Ostomy supplies ☐ Other: _____

Workers' Compensation

Ever had an injury/condition covered by Workers' Compensation? ☐ Yes ☐ No

Claim/condition still active? ☐ Yes ☐ No

Condition/body part: _____ Treating provider: _____

Any medications currently covered by Workers' Compensation? ☐ Yes ☐ No

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Allergies

☐ No known allergies List medication, latex, contrast dye, food, or other significant allergies.

Allergy	Reaction

Surgeries / Procedures

Approx. Year	Surgery / Procedure

Hospitalizations

Do not include admissions for surgeries listed above.

Approx. Year	Reason for Hospitalization

Occupation (current or former): _____ Retired: ☐ Yes ☐ No

Significant occupational exposures? ☐ Yes ☐ No If yes: _____

Relationship status: ☐ Single ☐ Married/Partnered ☐ Divorced/Separated ☐ Widowed

Children: ☐ Yes ☐ No If yes, how many? ____

Travel outside U.S./Canada in past 12 months? ☐ Yes ☐ No Where? _____

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FAMILY HISTORY

Check the conditions that apply to each family member.

Family Member	Diabetes	Heart Attack / Heart Disease	Stroke	Blood Clot	Aortic Aneurysm	Brain Aneurysm	Cancer	Dementia	Kidney Disease	Sudden / Unexplained Death <50
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Aunt(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Uncle(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Aunt(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Uncle(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sibling(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child(ren)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Cancer Details

If you checked Cancer above, list the family member and type of cancer: _____

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SOCIAL HEALTH

Tobacco & Vaping

Cigarettes: ☐ Never ☐ Current ☐ Former Age started: ____ Packs/day: ____ Age quit: ____

Other tobacco: ☐ Cigars ☐ Chewing tobacco ☐ Other: _____

Current vaping: ☐ Yes ☐ No What do you vape? _____

Marijuana & Caffeine

Current marijuana use: ☐ Yes ☐ No Method: ☐ Smoked ☐ Vaped ☐ Edible ☐ Tincture ☐ Other: _____

Typical marijuana frequency/amount: _____

Caffeine type & typical amount/day: _____

Alcohol & Drug Screening

Have you ever used drugs other than those required for medical purposes? ☐ Yes ☐ No

How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2–4 times/month ☐ 2–3 times/week ☐ 4 or more times/week

How many standard drinks containing alcohol do you have on a typical day?

☐ None, I do not drink ☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ 7–9 ☐ 10 or more

How often do you have six or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Sexual Health

Currently sexually active? ☐ Yes ☐ No

Partners in past 12 months: ☐ Men ☐ Women ☐ Both men and women ☐ Another gender ☐ No sexual partners

Number of partners: ____ Sexual contact includes: ☐ Vaginal ☐ Oral ☐ Anal

Condom/barrier use: ☐ Always ☐ Sometimes ☐ Never ☐ Not applicable

Ever diagnosed with an STI? ☐ No ☐ Yes — Type: _____

Would you like to be tested for HIV? ☐ Yes ☐ No

Sexual Orientation and Gender Identity (Optional)

Pronouns: ☐ she/her ☐ he/him ☐ they/them ☐ other: ____ ☐ prefer not to answer

Sex assigned at birth: ☐ Female ☐ Male ☐ Intersex/another designation ☐ Prefer not to answer

Gender identity: ☐ Woman ☐ Man ☐ Nonbinary ☐ Transgender woman ☐ Transgender man

☐ Self-describe: _____ ☐ Prefer not to answer

Sexual orientation: ☐ Straight/heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Asexual

☐ Self-describe: _____ ☐ Prefer not to answer

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Over the last 2 weeks, how often have you been bothered by any of the following problems?

Problem	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Problem	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble Relaxing	☐	☐	☐	☐
Being so restless that it's hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

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HOME SAFETY

What is your current housing situation?

☐ I have housing ☐ I do not have housing (staying with others/hotel/shelter/outside) ☐ I choose not to answer

Are you worried about losing your housing?

☐ Yes ☐ No ☐ I choose not to answer

What is the highest level of school that you have finished?

☐ Less than a high school degree ☐ High school diploma or GED ☐ More than high school ☐ I choose not to answer

What is your current work situation?

☐ Unemployed and seeking work ☐ Part time or temporary work ☐ Full time work ☐ Otherwise unemployed but not seeking work ☐ I choose not to answer

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply

☐ Food ☐ Clothing ☐ Utilities ☐ Child care ☐ Medicine or any health care ☐ Phone ☐ Other ☐ I do not have problems meeting my needs ☐ I choose not to answer

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

☐ Yes — medical appointments/medications ☐ Yes — non-medical meetings/work/daily needs ☐ No ☐ I choose not to answer

How often do you see or talk to people that you care about and feel close to?

☐ Less than once a week ☐ 1 or 2 times a week ☐ 3 to 5 times a week ☐ More than 5 times a week ☐ I choose not to answer

How stressed are you? Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much ☐ I choose not to answer

In the past year have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

☐ Yes ☐ No ☐ I choose not to answer

Are you a refugee?

☐ Yes ☐ No ☐ I choose not to answer

What country are you from?

☐ United States ☐ Country other than the United States _____ ☐ I choose not to answer

Do you feel physically and emotionally safe where you currently live?

☐ Yes ☐ No ☐ Unsure ☐ I choose not to answer

In the past year, have you been afraid of your partner or ex-partner?

☐ Yes ☐ No ☐ Unsure ☐ I have not had a partner in the past year ☐ I choose not to answer

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Signature Pages: Electronic Signature: By typing my name in any following signature field, I understand and agree that my typed name constitutes my electronic signature and has the same force and effect as my handwritten signature.

FINANCIAL POLICY

Payment at Check-In

Copays and any outstanding balance on your account are due at check-in. If a copay due for that day's visit is not paid before you leave the office, a \$25 administrative fee will be added to your account. Deductible and coinsurance amounts that are not known until your insurance claim is processed will be billed afterward. Self-pay charges are due at the time of the visit. Balances are due within 30 days.

Missed Appointments & Late Cancellations

Please give at least 24 hours' notice if you need to cancel or reschedule an appointment. Appointments canceled with less than 24 hours' notice or missed without notice may be subject to a \$25 fee. Three no-show appointments within a rolling 24-month period may result in a warning. Five no-show appointments within a rolling 24-month period may result in dismissal from the practice at the providers' discretion.

Returned Checks

A \$30 fee will be charged for each returned check.

Unpaid Accounts

Accounts that remain unpaid after 120 days may be referred to a collection agency as a last resort. If an account is referred to collections and the practice terminates the patient relationship, North Country Adult Medicine will provide the required transition period for urgent medical care and necessary prescription refills while the patient establishes care elsewhere.

Medical Records

Paper copies of medical records are charged at \$0.25 per page, subject to applicable federal and New York requirements and exceptions.

Forms & Paperwork

North Country Adult Medicine reserves the right to charge a fee for completion of forms. Some forms may require an office visit.

Outside Labs, Imaging & Other Services

When we order laboratory tests, imaging, or other services outside our office, you may receive a separate bill from the organization providing that service. Your insurance plan determines coverage and your share of the cost. Contact your insurer if you have questions about coverage.

I acknowledge that I have read and understand the North Country Adult Medicine Financial Policy.

Patient/Representative Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

North Country Adult Medicine

Patient Name: _____ DOB: _____

General Office Policies

Arriving for appointments: Patients arriving 15 minutes late may need to be rescheduled.

Insurance identification: Bring your current insurance card and photo ID to every appointment.

Prescription refills: Please allow 48 hours for routine refill requests.

Controlled medications: An office visit is required for controlled-medication prescriptions. No exceptions.

Workers' Compensation: North Country Adult Medicine does not treat Workers' Compensation cases.

Forms & paperwork: Some forms may require an office visit. NCAM reserves the right to charge a fee for form completion.

Transferring primary care: If you choose to transfer your primary care to another practice, NCAM generally will not re-establish you for primary care at a later date.

I acknowledge that I have read and understand the General Office Policies.

Patient/Representative Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

Prescription Consent

I give North Country Adult Medicine permission to review my prescription history through my pharmacy.

Patient/Representative Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

Notice of Privacy Practices — Acknowledgment of Receipt

I acknowledge that I have been provided access to North Country Adult Medicine's Notice of Privacy Practices.

Patient/Representative Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

Hospital & Nursing Home Follow-Up Policy

After a hospital or nursing home discharge, please call North Country Adult Medicine the day of or the day after discharge so we can arrange appropriate follow-up. Our goal is to see you within 2–4 days when clinically appropriate.

Patients are expected to participate in medically appropriate post-discharge follow-up. Repeated refusal or failure to complete necessary follow-up may affect our ability to safely continue providing primary care and may result in termination of the patient relationship in accordance with applicable requirements.

I acknowledge that I have read and understand the Hospital & Nursing Home Follow-Up Policy.

Patient/Representative Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

North Country Adult Medicine

Patient Name: _____ DOB: _____

North Country Adult Medicine

HealtheConnections

Authorization for Access to Patient Information

New York State Department of Health **Through a Health Information Exchange Organization**

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow **North Country Adult Medicine** to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network.

HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at <http://healtheconnections.org/>.

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent *even* in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change my decision at any time by completing a new form.

☐ 1. I **GIVE CONSENT** for **North Country Adult Medicine** to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ 2. I **DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for **North Country Adult Medicine** to access my electronic health information through HealtheConnections.

☐ 3. I **DENY CONSENT** for **North Country Adult Medicine** to access my electronic health information through HealtheConnections for any purpose, ***even in a medical emergency.***

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at <http://healtheconnections.org/> or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through HealtheConnections and the consent process: DOH-(6/14)

North Country Adult Medicine

Patient Name: _____ DOB: _____



Remote Patient Monitoring (RPM)

Helping us care for you between office visits

North Country Adult Medicine offers Remote Patient Monitoring (RPM) to eligible Medicare patients. RPM allows our healthcare team to monitor important health information while you are at home and stay connected with you between office visits.

If you participate, you will use a monitoring device that automatically sends your readings to our healthcare team. Our nursing staff reviews your readings, provides regular check-ins, and communicates concerns to your healthcare provider when needed.

Which type of monitoring may be helpful for you?

☐ Blood Pressure

☐ Weight (CHF)

☐ Pulse Oximeter

☐ Glucose

Glucose options: ☐ True Metrix ☐ Dexcom

Your healthcare provider will determine whether RPM is medically appropriate and which device is appropriate. Glucose device options also depend on insurance coverage.

USING YOUR DEVICE

To stay enrolled in our RPM program, your device must transmit readings on at least 2 days every 30 days.

Please use your device regularly as recommended by your healthcare team. If you do not use your device enough to meet program requirements, North Country Adult Medicine may discontinue your RPM enrollment and ask you to return the monitoring device.

How RPM can help

- Monitor your health between visits
- Identify concerning changes earlier
- See how treatment is working
- Support chronic condition management

RPM does not replace regular office visits or emergency medical care.

Medicare coverage

Medicare may cover RPM when Medicare requirements are met and your healthcare provider determines that RPM is medically appropriate for you. Deductibles and/or coinsurance may apply. Secondary insurance may cover some or all of your remaining cost.

Interested in RPM?

- ☐ YES - I am interested.
- ☐ MAYBE - I would like more information.
- ☐ NO - I am not interested at this time.

Participation is voluntary. Choosing not to participate will not affect the care you receive at North Country Adult Medicine.

Patient Name: _____ DOB: _____ Date: _____

North Country Adult Medicine

Patient Name: _____ **DOB:** _____

Introduction to Chronic Care Management

The purpose of this program is to help both you the patient, and us the primary care physicians.

As we age, we tend to have more complicated medical needs, and many times there are questions that you have in between office visits. Medicare recognizes this, and has created this program to compensate primary care offices for the work they do outside of scheduled office visits. By having patients enrolled in this program, we are able to afford to hire an RN to be available to patients for questions outside of office visits.

The following examples are things that our RN is able to provide to patients enrolled in the program.

1. Calling patients with test results instead of having to log onto the patient portal
2. Speaking to your pharmacy and insurance company on your behalf to figure out why a medication wasn't covered, or getting a prior approval for a medication.
3. Speaking with your specialists to ensure you understand the plan and are up to date on their recommendations.
4. Help get tests scheduled.
5. Help coordinate home care, or durable medical equipment
6. Checking in with you before and after doctor appointments to make sure you understand the plan the doctor discussed with you.
7. Check in with you on a monthly basis or more frequently depending on your needs to make sure you are doing okay.
8. Being on standby in the office to answer any questions you may have, allowing you to get answers to your health questions much faster.

Our goal is to keep your healthcare costs down, make access to care easier, and keep you as healthy as possible.

Patients in this program have LESS hospital and emergency room visits and overall saves Medicare money by KEEPING YOU HEALTHIER.

Your insurance carrier will be billed monthly for this care management service. Medicare deductibles and/or coinsurance may apply. If you have secondary insurance, it may cover some or all of your remaining cost. Only one healthcare practitioner can provide and bill Medicare for Chronic Care Management services for you during a calendar month.

You may stop Chronic Care Management services at any time. Your decision will become effective at the end of the calendar month.

None of the above services replace urgent or emergency care.

Our goal is to keep your healthcare costs down, make access to care easier, and keep you as healthy as possible.

Patient Agreement

I consent to participate in Chronic Care Management (CCM) services as described above.

Patient Name: _____

Signature: _____ **Date:** _____

North Country Adult Medicine

Patient Name: _____ DOB: _____



Care between office visits.

Primary Care Enrollment Agreement

Thank you for being part of our primary care family! We're so grateful for the trust you place in us to support your health and well-being.

Over the years, our team has gone above and beyond to provide services like:

- Coordinating your care with specialists and other healthcare providers.
- Creating personalized care plans to address your unique health needs.
- Keeping in touch between visits to manage your ongoing health concerns.

We've always done these things as part of our commitment to you, without additional reimbursement. Now, Medicare recognizes the value of these extra services and has introduced specific codes (G0556, G0557, and G0558) that reimburse us for the work we're already doing.

We're asking our Medicare patients to participate in this program so Medicare can recognize and support the care coordination services our practice provides between office visits. Here's what this means for you:

- **No changes to your care:** You'll continue receiving the same attentive, personalized care you always have.
- **Covered by Medicare:** Medicare covers Advanced Primary Care Management services. Medicare deductibles and/or coinsurance may apply. If you have secondary insurance, it may cover some or all of your remaining cost.
- **Helps us help you:** Participating in this program ensures we can continue dedicating the time and resources needed to give you the best care possible.
- **One APCM provider:** Only one healthcare provider can provide and be paid by Medicare for APCM services for you during a calendar month.
- **Your choice:** You may stop APCM services at any time.

By signing below, you're simply agreeing to allow Medicare to reimburse us for the care coordination and management services we already provide.

If you have any questions or need more details, please don't hesitate to ask. We're here to help!

Thank you for trusting us to care for you,

North Country Adult Medicine

Patient Agreement

I consent to participate in the Medicare Advanced Primary Care Management (APCM) program as described above.

Patient Name: _____

Patient DOB: _____

Signature: _____

Date: _____

North Country Adult Medicine

Patient Name: _____ DOB: _____



Care between office visits.

APCM - OFFICE USE ONLY

Qualified Medicare Beneficiary: ☐ YES ☐ NO

Number of Chronic Conditions: ☐ 0-1 ☐ 2 or more

CCM patient: ☐ YES ☐ NO

PCP on record:

- ☐ Dr. Neil Cichetti
- ☐ Dr. Joanne Cichetti
- ☐ PA Laura Goldhar
- ☐ PA Camryn Peets

APCM billing level:

G0556 - patients with 0-1 chronic condition

G0557 - patients with 2 or more qualifying chronic conditions

G0558 - patients with 2 or more qualifying chronic conditions who are a Qualified Medicare Beneficiary

For G0557/G0558: qualifying chronic conditions are expected to last at least 12 months or until death and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.