CoveCare Center
1808 Route Six, Carmel, NY 10512
www.CoveCareCenter.org

Health Screening Form

Client's Name: (Last)_____(First)_____ (MI)____

Gender: ☐ Male ☐ Female ☐ Transgender Date of Birth: ____/_____/_____

Date of Last Physical Examination: ____/_____/_____ Height_____ Weight_____

Current Primary Medical Care Provider:

Name _____

Address _____

_____

Telephone Number _____

If you do not have a primary medical care provider, are you interested in getting help to obtain one? ☐ No ☐ Yes

Have the following changed in the last year? If Yes in what way has it changed?

Appetite ☐ No ☐ Yes _____

Weight ☐ No ☐ Yes _____

Sleeping Habits ☐ No ☐ Yes _____

Energy Level ☐ No ☐ Yes _____

Please indicate if you do the following. If yes how often?

Exercise ☐ No ☐ Yes _____

Drink Water ☐ No ☐ Yes _____

Drink Coffee/ Tea ☐ No ☐ Yes _____

Drink Energy Drinks ☐ No ☐ Yes _____

Drink Alcohol (including beer) ☐ No ☐ Yes _____

Use Drugs (including marijuana) ☐ No ☐ Yes _____

Smoke Cigarettes ☐ No ☐ Yes _____

Other Nicotine Products ☐ No ☐ Yes _____

If you use nicotine products please answer below:

Are there nicotine products in the home with younger children? ☐ No ☐ Yes

Are you interested in reducing or quitting nicotine? ☐ No ☐ Yes

Personal Medical History (select all) that apply

High Blood Pressure ☐No ☐Yes

High Cholesterol ☐No ☐Yes

Diabetes ☐No ☐Yes

Heart Attack ☐No ☐Yes

Stroke ☐No ☐Yes

Other Cardiac Condition ☐No ☐Yes

Pulmonary (Emphysema, COPD, Asthma) ☐No ☐Yes

Kidney Disease ☐No ☐Yes

Liver Disease (Cirrhosis, Hepatitis A/B/C) ☐No ☐Yes

Endocrine Condition (High or Low Thyroid, Pituitary Disease, Adrenal Disease) ☐No ☐Yes

Overweight	☐No ☐Yes	Traumatic Brain Injury	☐No ☐Yes
HIV/AIDS	☐No ☐Yes	Cancer	☐No ☐Yes
Tuberculosis	☐No ☐Yes	Mobility Impairment	☐No ☐Yes
Hearing Impairment	☐No ☐Yes	Visual Impairment	☐No ☐Yes

Other_____

Allergies (drugs, food, environmental): _____

Surgery(s) within the last 6 months-include dates:_____

Medication/Supplements (Please list all medications/supplements that you are currently taking. Include prescribed/non-prescribed drugs, vitamins and over- the- counter drugs, amount and frequency):

_____

_____

_____

Client Signature (If under 18 parent/ guardian must sign) _____Date____/____/____

Clinician Signature _____ Date____/____/____

Date Given To Nurse ____/____/____

Evaluation (To be completed by a physician, nurse practitioner, physician's assistant or registered nurse)

Staff Signature and Title _____ _____Date____/____/____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE: _____

I acknowledge that I was provided with a copy of the CoveCare Center's Notice of Privacy Practices.

_____ _____

Client Name (Print) Client Signature

If completed by a client's personal representative, please print and sign your name in the space below

_____ _____

Personal Representative (Print) Personal Representative's Signature
Relationship

For CoveCare Center use only

Complete this section if this form is not signed and dated by the client or client's personal representative.

I have made a good-faith effort to obtain a written acknowledgement of receipt of the CoveCare CenterNotice of Privacy Practices but was unable to for the following reason:

☐ Client refused to sign
☐ Client unable to sign
☐ Other

_____ _____

Employee Name Date

This form should be placed in the client's medical record

Revised 3/29/2019

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PERMISSION TO TREAT A MINOR

Childs Name: _____ DOB: _____

I am the custodial parent/legal guardian of the above named child. I give permission for any of the CoveCare Center professional staff to provide psychotherapeutic treatment to _____.

_____

Signature Date

_____

Print Name Relationship

_____

Witness

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

PSYCKES Consent Form
COVECARE CENTER

The Psychiatric Services and Clinical Enhancement System (PSYCKES) is an administrative database maintained by the New York State Office of Mental Health (OMH). It contains health information from the NYS Medicaid claims database, health information from the clinical records of persons who have received care from State operated psychiatric centers, and health information from other NYS health databases. This administrative data includes identifying information (such as name, date of birth), information about health services that have been paid for by Medicaid, and information about a person's health care history (such as treatment for illnesses or injuries a person has had, test results, and lists of medication a person has taken). For an updated list and more information about the NYS health databases in PSYCKES, visit www.psyckes.org and see "About PSYCKES."

The health information in PSYCKES can help your provider provide you with good care. In this Consent Form, you can choose whether or not to give your provider electronic access to your health information that is in PSYCKES. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent will not be the basis for denial of health services.**

If you check the **"I give consent"** box below, you are saying "Yes, this provider's staff involved in my care may get access to all of my medical information that is in PSYCKES."

If you check the **"I deny consent"** box below, you are saying "No, this provider may not see or be given access to my medical information through PSYCKES," this does not mean your provider is completely barred from accessing your medical information in any way. For example, if the Medicaid program has a quality concern about your healthcare, then under federal and state regulations your provider may be given access to your data to address the quality concern. There are also exceptions to the confidentiality laws that may permit your provider to obtain necessary information directly from another provider for treatment purposes under state and federal laws and regulations.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices:

☐ **I give consent for this provider to access all** of my electronic health information that is in PSYCKES in connection with providing me any health care services.

☐ **I deny consent for this provider to access** my electronic health information that is in PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

Print Name of Patient	Date of Birth of Patient	Patient's Medicaid ID Number

Signature of Patient or Patient's Legal Representative	Date

Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Signature of Witness	Print Name of Witness

Details about patient information in PSYCKES and the consent process:

1. **How Your Information Will be Used.** Your electronic health information will be used **only** to:
    - Provide you with medical treatment and related services
    - Evaluate and improve the quality of medical care provided to all patients.

Note: The choice you make in this Consent Form does not allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information About You Are Included?** If you give consent _____ may access all of your electronic health information available through PSYCKES. This includes information created before and after the date of this Consent Form. The information in PSYCKES includes information from your health records, such as a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:
    - Mental health conditions
    - Alcohol or drug use problems
    - Birth control and abortion (family planning)
    - Genetic (inherited) diseases or tests
    - HIV/AIDS
    - Sexually transmitted diseases

3. **Where Health Information About You in PSYCKES Comes From.** If you received health related services that were paid for by Medicaid, information about those services will be stored in PSYCKES. If you received services from a State operated psychiatric center, health related information taken from your clinical records will also be stored in PSYCKES. However, although the information contained in PSYCKES may come from your clinical record, your PSYCKES record is not the same thing as your complete clinical record. Health information from other databases maintained by NYS is also included in PSYCKES. New health database may be added to PSYCKES as available. For an updated list and more information about the data available in PSYCKES, visit the PSYCKES website at www.psyckes.org and see "About PSYCKES" or ask your treatment provider to print the list for you.

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve on_____'s medical staff who are involved in your medical care; health care providers who are covering or on call for _____'s doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call_____at_____; or call the NYS Office of Mental Health Customer Relations at 800-597-8481.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by_____ _____to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information.

7. **Effective Period.** This Consent Form will remain in effect until 3 years after the last date you received any medical services from _____, or until the day you withdraw your consent, whichever comes first.

8. **Withdrawing Your Consent.** You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to _____. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from this provider or from the PSYCKES website at www.psyckes.com, or by calling _____ _____ at _____. Note: Organizations that access your health information through_____while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

9. **Copy of Form.** You are entitled to receive a copy of this Consent Form after you sign it.

Revised 6.26.2015