Welcome to Mosaic Health. Your health is our #1 priority!

SERVICES
We offer the following services: primary medical care, primary dental care, counseling services, lab testing, sliding fee scale, and help with insurance.

CENTERS AND HOURS

<table>
<thead>
<tr>
<th>Location</th>
<th>Address/Location</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ilion (Medical only)</td>
<td>55 Central Plaza Ste B Ilion, NY 13357 (315)444-1900</td>
<td>Monday-Friday 8:30am-5pm</td>
</tr>
<tr>
<td>Mt. Morris (Dental only)</td>
<td>1 Murray Hill Drive Building 1, Room 140 Mt. Morris, NY 14510 (585)243-7840</td>
<td>Monday-Friday 8am-4:30pm Closed for lunch 12:30-1:00</td>
</tr>
<tr>
<td>Lyons (Dental only)</td>
<td>1519 Nye Rd Lyons, NY 14489 (315)871-3178</td>
<td>Monday-Friday 8:30am-5pm Closed for lunch 12:30-1:00</td>
</tr>
<tr>
<td>Rushville (Medical and Dental)</td>
<td>2 Rubin Drive Rushville, NY 14544 (585)554-4400</td>
<td>Monday-Thursday 8:00am-7:00pm Friday 8:00am-5:00pm</td>
</tr>
<tr>
<td>Utica (Medical only)</td>
<td>1651 Oneida St Utica, NY 13501 (315)793-7600</td>
<td>Monday-Thursday 8:00am-7:00pm Friday 8:00am-5:00pm</td>
</tr>
<tr>
<td>Utica Dental (Dental only)</td>
<td>3 Parkside Court Building 1 Utica, NY 13501 (315)927-0000</td>
<td>Monday-Thursday 8:00am-7:00pm Friday 8:00am-5:00pm</td>
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AFTER HOURS
If you have a medical or dental emergency when the health center is closed, you may call the on-call provider. You will be given advice on what to do. This service is not for medication refills, appointments, or billing issues. To reach the on-call provider, call your center’s main number and follow the options.

PAYMENT FOR SERVICES RECEIVED
Payment should be made at the time of service. We accept cash, checks, credit cards, and most insurance. If you have a question about if we take your insurance, please call your insurance company. We do not accept Worker’s Compensation. We have a sliding fee scale we offer to our patients that is based on family size and income. We also offer payment plans to our patients who need help paying any overdue or future charges.

FUTURE VISITS-IT IS IMPORTANT TO KEEP YOUR APPOINTMENTS
Remember to bring your medications to every visit. If your job, insurance, address, phone number, or email change, you need to let us know. If you know you cannot make it to your appointment, you must cancel at least one day ahead of time.
Patient’s Name (Last, First, Middle Initial): ________________________________________________

Previous Name (if applicable) __________________Preferred Name (if applicable) ________________

Home Address: ___________________________________________ Apt # _________________________
City: ____________________________ State: ________________ Zip Code: _______________________
County of Residence: ______________________________

Home Phone #: ________________________ Cell Phone #: _________________________

Appointment Reminders by: Phone or Text (circle one)

Please complete the following if your mailing address is different than your home address:

Mailing Address: ___________________________________________ Apt # _______________________
City: ____________________________ State: _________________ Zip Code: _________________

Date of Birth: _________________ Social Security #: _______________________

Marital Status (circle one): Single Married Separated Divorced Widowed Partner

Sex at Birth (circle one): Male Female

What is your gender identity? (please circle one)
Male Transgender Male
Female Transgender Female
Genderqueer Choose to not disclose
Other (please specify) __________________

What is your sexual orientation? (please circle one)
Straight Lesbian
Gay Bi-Sexual
Do not know Choose to not disclose

Other (please describe) __________________
**Are you employed? (circle one)** Not Employed/Full Time/Part Time/Self Employed/Retired/Active Military

Employer Name: ________________________________________________________________

Employer Address: ______________________________________________________________

City: _____________________ State: ___________ Zip Code: _________ Phone #: _________________

**MINORS**

Patients under 18 years of age must be with a parent or legal guardian in order to receive routine treatment. Legal guardians must show proof of guardianship. If a parent or legal guardian is not able to bring the minor child to the appointment, we must have written or verbal permission for someone else to bring the minor child to the appointment. All minors need to be accompanied by someone over 18 years of age. Please note that some circumstances do not require parent or guardian permission.

**If the patient is a minor, please list the parent(s)/guardian(s) name and phone number:**

Mother’s Name: ___________________________ Mother’s Phone #: _______________________

Father’s Name: ___________________________ Father’s Phone #: _________________________

Legal Guardian’s Name: ______________________ Phone #: ______________________________

Emergency Contact: ______________________________________________________________

Relationship to Patient: ____________________________ Phone Number: ___________________

Who will be responsible for paying the bill for services that the patient’s insurance company does not pay or cover? (please circle one) Patient Parent/Guardian Other

**If the responsible party is someone other than the patient, please fill out the following:**

Responsible Party: _____________________________ Responsible Party’s Date of Birth: __________

Responsible Party’s Address: ________________________________________________________

City: _________________________________ State: __________________ Zip Code: __________
Please check if you DO NOT have medical insurance: _____
Please check if you DO NOT have dental insurance: _____

**Primary Insurance**

Insurance Company: ____________________________________________________________

Policy Holder: ___________________________ Policy Holder’s Date of Birth: ______________

ID #: ____________________ Group #: ____________ Medicaid CIN # (AB12345C): ________

**Please complete if you have a SECONDARY Insurance:**

Insurance Company: ____________________________________________________________

Policy Holder: ___________________________ Policy Holder’s Date of Birth: ______________

ID #: ____________________ Group #: ____________ Medicaid CIN # (AB12345C): ________

Email address: ________________________________ Interested in Patient Portal (circle one) Yes  No

**PRESCRIPTIONS**

Please allow 2 business days for refill requests to be completed. A follow-up visit may be scheduled for management of your medications, unless otherwise noted by your provider.

Primary Pharmacy: ___________________________ Address: ______________________________

Secondary Pharmacy (if applicable): _______________________ Address: ____________________

Please sign below authorizing your Mosaic Health provider to access your prescription information. This is so that we can check for possible drug interactions or allergies.

**Patient/Parent or Guardian Signature:** ___________________________ Date: ______________

**Printed Name/Relationship to Patient:** ___________________________________________
We ask that you please answer the following questions so that Mosaic Health can receive Federal grant dollars to serve our patients. We appreciate your cooperation. All information is kept confidential and is used for reporting purposes only.

**INCOME INFORMATION:**

<table>
<thead>
<tr>
<th>Total Number of people in your household, including yourself:</th>
<th>____________</th>
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<table>
<thead>
<tr>
<th>Total Household income: (Please check the amount that best describes the total income in your household)</th>
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<tbody>
<tr>
<td>Less than $11,000</td>
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**What is your race?** (*Circle all that apply*)

*White-Caucasian* | *Black/African American* | *American Indian/Alaska Native* | Decline to specify

*Native Hawaiian* | *Asian* | *Other Pacific Islander*  

**What is your ethnicity?** (*please circle one*)

*Hispanic/Latino* | *Non-Hispanic/Non-Latino* | Declined to specify

**What is your primary language spoken?**

*English* | *Spanish* | *Arabic* | *Burmese* | *Karen* | Declined to specify | *Other (please specify)______________________________*

**Do you need an interpreter?** Yes | No

**Patient Lives:**

*Public Housing* | *Homeless*  

*Seasonal Worker* | *None Apply*  

*Migrant Worker*  

**Are you a Veteran?** (*please circle one*) Yes | No

The information I have provided on this form is true and correct to the best of my knowledge.

I have received Mosaic Health’s Notice of Rights and Responsibilities.

I have received the Mosaic Health’s Notice of Privacy Practices.

__________________________________________ __________________________

Patient/Parent or Guardian Signature  Date

__________________________________________ __________________________

Printed Patient/Parent or Guardian Name  Relationship to Patient

January 2020  

**Patient Documents: NPP**

**Mosaic Health**

Better happens together.