mosaic health
Better happens together.

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

Ilion *(Medical only)*	55 Central Plaza Ste B Ilion, NY 13357 (315)444-1900	Monday-Friday 8:30am-5pm
Mt. Morris *(Dental only)*	1 Murray Hill Drive Building 1, Room 140 Mt. Morris, NY 14510 (585)243-7840	Monday-Friday 8am-4:30pm Closed for lunch 12:30-1:00
Lyons *(Dental only)*	1519 Nye Rd Lyons, NY 14489 (315)871-3178	Monday-Friday 8:30am-5pm Closed for lunch 12:30-1:00
Rushville *(Medical and Dental)*	2 Rubin Drive Rushville, NY 14544 (585)554-4400	Monday-Thursday 8:00am-7:00pm Friday 8:00am-5:00pm
Utica *(Medical only)*	1651 Oneida St Utica, NY 13501 (315)793-7600	Monday-Thursday 8:00am-7:00pm Friday 8:00am-5:00pm
Utica Dental *(Dental only)*	3 Parkside Court Building 1 Utica, NY 13501 (315)927-0000	Monday-Thursday 8:00am-7:00pm Friday 8:00am-5:00pm

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.

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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) _____

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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: _____

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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: _____

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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:

Total Number of people in your household, including yourself: _____

Total Household income: (Please check the amount that best describes the total income in your household)

Less than $11,000 ___ $11,001- $15,000 ___ $15,001- $20,000 ___ $20,001- $25,000 ___
$25,001- $30,000 ___ $30,001-$35,000 ___ $35,001- $40,000 ___ $40,001- $45,000 ___
$45,001- $50,000 ___ $50,001- $55,000 ___ $55,001-$60,000 ___ $60,001-$65,000 ___
$65,001- $70,000 ___ $70,001- $75,000 ___ Greater than $75,000 ___

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
Decline 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