

Family Medicine



www.NYhealth.com



Dear _____

Welcome and thank you for choosing New York Health. For many years, our Physicians have been providing premium comprehensive healthcare for our patients in state-of-the-art medical centers using the latest treatment therapies. Always on the cutting edge of technology and medicine, our physicians make certain that our patients are treated with dignity, comfort, and the utmost respect.

You presently have a new patient appointment scheduled with:

Dr. _____ **Date:** _____ **Time:** _____

Location: _____ **Phone:** _____

We ask that you please arrive 15 minutes prior to your scheduled appointment time for registration. Enclosed are forms for you to complete and bring with you. Kindly also bring any records pertaining to your diagnosis as well as your photo ID and insurance cards. If you have insurance that requires a referral, please obtain it **prior** to your appointment. If your insurance requires a copay, please remember that this is due at the time of your appointment.

Please feel free to contact our **New Patient Navigators at 631-758-7003** or visit our website, www.NYHealth.com, to answer any other questions you might have and to learn more about us.

Thank you for trusting New York Health with your care.

We look forward to seeing you.



PATIENT INFORMATION SHEET

MD Name/Location: _____ **Date:** _____

Name: _____ Date of Birth: _____

Sex: Male _____ Female: _____ Social Security # (optional) _____

Address: _____

(Street) (Apt. #) (City) (State/Zip)

Are you currently a resident in:

In-patient rehabilitation center _____ YES _____ NO Skilled Nursing Facility _____ YES _____ NO

Nursing home _____ YES _____ NO

Ethnicity / Race (optional): _____ Pref. Language: _____

Telephone: Home #: _____ Marital Status: S__ M__ D__ W__

Cell #: _____ Work #: _____ Email: _____

Referring MD Name & Phone #: _____ Family Doctor & Phone #: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Occupation: _____ Full Time: _____ Part Time: _____

Patient's Employer: _____ Employer Phone #: _____

Employer Address: _____

Primary Insurance: _____ ID# _____ Group# _____

Subscriber Name: _____ DOB: _____ Relationship: _____

Subscriber Employer & Address: _____

Secondary Insurance: _____ ID# _____ Group# _____

Subscriber Name: _____ DOB: _____ Relationship: _____

Subscriber Employer & Address: _____

Do you have the following Advanced Directives (Check all that apply):

Living Will Durable Power of Attorney Health Care Proxy DNR

Assignment of Benefits:

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including, Medicare, Private Insurance and any other Health Plan to: New York Health

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance* I hereby authorize said assignee to release all information necessary to secure payment.

**In the event this account is assigned to the collection, I agree to pay all costs of collection, including reasonable attorney fees.*

PLEASE NOTE THAT THE ATTACHED NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT FORM (page 10) AND PATIENT RECORD OF DISCLOSURES FORM (page 9) MUST BE COMPLETED AS REQUIRED UNDER HIPAA GUIDELINES LAW

Patient's Signature: _____

Today's Date: _____

Subscriber's Signature: _____

Today's Date: _____



MEDICAL HISTORY

NOTE: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Last Name: _____ First Name: _____ Today's Date: _____
 Date of Birth: _____ What was the date of your last physical exam: _____
 Primary Care Physician: _____ Next of Kin: _____
 What is your chief complaint (Reason for visit?): _____

THESE ARE MANDATORY FIELDS ----- YOU WILL NOT BE EXAMINED UNTIL THIS FORM IS FILLED OUT ENTIRELY

When was your LAST Colonoscopy: _____ Where? _____ Never _____
 When was your LAST Mammography: _____ Where? _____ Never _____
 When was your LAST PSA/Lab Exam: _____ Where? _____ Never _____
 When was your LAST Flu Shot: _____ When was your LAST Pneumococcal Vaccine: _____
 Do you Smoke? _____ Packs Per Day? _____ When did you quit smoking? _____
 Do you want assistance with Smoke Cessation? YES NO Alcohol use? YES NO
 Have you ever been exposed to toxic substances IE: Asbestos or chemicals? YES NO

DO YOU OR ANY OF YOUR IMMEDIATE FAMILY HAVE THE FOLLOWING?

DISEASE	YOU	RELATION	DISEASE	YOU	RELATION
CANCER			GI (STOMACH PROBLEMS)		
HYPERTENSION / HIGH BLOOD PRESSURE			ARTHRITIS		
HIGH CHOLESTEROL			OSTEOPOROSIS		
INFECTIOUS DISEASES			DIABETES		
LIVER DISEASE			HEART DISEASE		
LUNG DISEASE			HEART ATTACK		
KIDNEY DISEASE (CHRONIC)			CONGESTIVE HEART FAILURE		
ACUTE KIDNEY FAILURE			STROKE / CVA / TIA		
KIDNEY STONES			SEIZURES		
URINARY PROBLEMS			PACEMAKER / ICD		
ENDOCRINE (THYROID)			ASTHMA / COPD		
PERIPHERAL VASCULAR DISEASE			EMPHYSEMA		
ANEMIA BLOOD DISORDER			GOUT		
BLOOD CLOTS			MENTAL / PSYCHIATRIC ILLNESSES		
BLEEDING PROBLEM			BACK PAIN		
SKIN DISORDERS					

DO YOU HAVE ANY MEDICATION ALLERGIES? _____
 DO YOU HAVE ANY FOOD ALLERGIES? _____
 DO YOU HAVE A LATEX ALLERGY? _____
 Preferred Pharmacy (name, address, phone) _____

PLEASE LIST ANY INFECTIOUS DISEASES YOU HAVE OR ARE BEING TREATED FOR:



CONTINUED MEDICAL HISTORY

REVIEW OF SYMPTOMS: NO SYMPTOMS AT THIS TIME _____

SYMPTOMS	YES	NO	SYMPTOMS	YES	NO	SYMPTOMS	YES	NO
CONSTITUTIONAL			RESPIRATORY			MUSCULOSKELETAL		
WEIGHT LOSS			SHORTNESS OF BREATH			JOINT ACHES		
WEIGHT GAIN			COUGH			JOINT SWELLING		
FEVER			WHEEZING			MUSCLE ACHES		
CHILLS			DIFFICULTY BREATHING			MUSCLE SWELLING		
FATIGUE			LUNG DISEASE			PAIN KILLER USE		
SWEATING			GASTROINTESTINAL			NEUROLOGIC		
DIZZINESS			BLOOD IN STOOL			CONFUSION		
SWOLLEN GLANDS			CONSTIPATION			LIGHTHEADEDNESS		
PREGNANT			DIARRHEA			SEVERE HEADACHES		
HEENT			NAUSEA			NUMBNESS IN FEET		
DECREASED VISION			VOMITING			HEMATOLOGIC		
BLURRY VISION			POOR APPETITE			BLEED EASILY		
DIABETIC RETINA DISEASE			GENITOURINARY			BLEEDING DISORDERS		
BLEEDING BEHIND EYES			BURNING IN URINE			BLOOD CLOTS		
OTHER _____			BLOOD IN URINE			EASY BRUISING		
CARDIOVASCULAR			FREQUENT URINATION			ENDOCRINE		
CHEST PAIN			UTI'S			EXCESS THIRST		
PALPITATIONS			KIDNEY STONES			COLD INTOLERANCE		
EDEMA/LEG SWELLING			SKIN			HEAT INTOLERANCE		
FAINTING			ITCHY SKIN			OTHER SYMPTOMS		
LEAKY HEART VALVES			RASES ON BODY			<u>DESCRIBE:</u>		
			DRY SKIN					

HAVE YOU BEEN OUT OF THE COUNTRY RECENTLY? _____ WHERE? _____ When? _____

PAST SURGERIES	WHERE	PAST SURGERIES	WHERE

OTHER PHYSICIANS THAT CARE FOR YOU	YOUR LAST VISIT THERE	REASON FOR VISIT

YOUR SIGNATURE IS REQUIRED: _____

DATE: _____

THANK YOU FOR YOUR HELP WITH THIS DATA COLLECTION. THIS INFORMATION IS INVALUABLE TO US AND HELPS US TO GET TO KNOW YOU BETTER. ALL OF THE INFORMATION IS CONFIDENTIAL AND WILL BE TREATED THAT WAY AT ALL TIMES. IF YOU HAVE



ANY QUESTIONS REGARDING THIS INFORMATION OR NEED ANY HELP IN CLARIFYING THIS FORM FEEL FREE TO CALL.

MEDICAL HISTORY - *continued*

The following information is mandatory and of great importance in your continued care and treatment with this facility. This information will assist us in our quest to get you better and make your medical records more accurate. Thank you for your assistance!

Name: _____

Height: _____

Date of Birth: _____

Weight: _____

CHECK ONE: ARE YOU DIABETIC? YES NO



ARE YOU INSULIN DEPENDENT? YES NO

MEDICATION LIST:

NAME	DOSE	ROUTE	HOW OFTEN	WHEN

ALLERGIES:

ALLERGIC TO	REACTION	SEVERITY (MILD OR SEVERE)

PLEASE SEND ALL RESULTS TO:

DOCTORS NAME	ADDRESS	TELEPHONE	FAX
1.			
2.			
3.			
4.			
5.			
6.			



CONSENT FOR RELEASE OF MEDICAL RECORDS

Today's Date: _____

Medical Record #:

Patient Name: _____

Date of Birth: _____

Address: _____
(Street) (Apt. #) (City) (State/Zip)

Authorization is Hereby Given to: _____

to provide New York Health with Access to MY MEDICAL AND/OR HOSPITAL RECORDS:

Phone #: _____

Fax #: _____

1. Records regarding admission and/or treatment for the following dates of service:

From: _____ To: _____

2. The following specified information:

A. Blood work Yes _____ No _____

B. Radiology Yes _____ No _____

C. Pathology Yes _____ No _____

D. All of the above Yes _____ No _____

E. Specifics: _____

Patient Signature: _____

Date: _____

Witness Name: _____

Relation to patient: _____



PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Home Phone: _____ | <input type="checkbox"/> Written Communication: |
| <input type="checkbox"/> OK to leave message with detailed information | <input type="checkbox"/> OK to mail to my home address |
| <input type="checkbox"/> Message with call-back number ONLY | <input type="checkbox"/> OK to mail to my work/office address |
| _____ | <input type="checkbox"/> OK to fax to this number: _____ |
| <input type="checkbox"/> Cell Phone: _____ | <input type="checkbox"/> Work Phone: _____ |
| <input type="checkbox"/> OK to leave a message with detailed information | <input type="checkbox"/> OK to leave a detailed message |
| <input type="checkbox"/> Message with call-back number ONLY | <input type="checkbox"/> Message with call-back number ONLY |

Other (LIST HERE ANY FAMILY MEMBER WE MAY RELEASE MEDICAL INFORMATION TO.)

NAME: _____ RELATIONSHIP: _____ Phone #: _____

NAME: _____ RELATIONSHIP: _____ Phone #: _____

NAME: _____ RELATIONSHIP: _____ Phone #: _____

Patient Signature

Today's Date

Print Name

Date of Birth

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without the prior consent in an emergency.



NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____ Today's Date: _____

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices, which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. If your first date of service with us was due to an emergency, we must try to provide you with our Notice and get your written acknowledgment for the Notice as soon as we can once the emergency has passed.

I have received the Notice of Privacy Practices (*effective date February 14, 2018*).

Patient's (or Legal Representative's) Signature Date

Relationship of Legal Representative

For Office Use Only

To be completed only if acknowledgement is not signed.

1) Was the patient given a copy of the Notice of Privacy Practices? Yes No

2) Please explain why the patient was unable to sign this Acknowledgement and our efforts to try to obtain the patient's signature:



RESPONSIBILITY AND CONSENT STATEMENT

Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. Many insurance companies have fixed allowances or percentages based on your coverage with them, not with our office. It is your responsibility to pay the deductible, co-insurance, and any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.

Patient Name: _____ Patient DOB: _____

Primary Insurance: _____ Address: _____

Policy Number: _____ Group #: _____ Phone: _____

Subscriber: _____ Relationship to Subscriber: _____

Secondary Insurance: _____ Address: _____

Policy Number: _____ Group #: _____ Phone: _____

Subscriber: _____ Relationship to Subscriber: _____

YOUR SIGNATURE IS REQUIRED FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED

Non-Medicare Patient: I authorize the release of all medical information necessary to process my claims and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to Physician/Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Medicare and Medicaid Patient: I request the payment of authorized Medicare benefits to be made to me or on my behalf to the Physician/Clinic for any services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient Signature: _____ Date: _____

Responsible Party: _____ Date: _____



AUTHORIZATION FOR ACCESS TO PATIENT INFORMATION

New York State Department of Health

Through a Health Information Exchange Organization

Patient Identification Number: _____

Patient First & Last Name: _____ Date of Birth: _____

Patient Address: _____ City: _____ State: _____

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 NY Cancer and Blood Specialists | NY Health to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix 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 Healthix's website at www.healthix.org.

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 NY Cancer and Blood Specialists | NY Health to access ALL of my electronic health information through Healthix to provide health care.

2. I DENY CONSENT for NY Cancer and Blood Specialists | NY Health to access my electronic health information through Healthix for any purpose.

** If I want to deny the consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.*

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)



AUTHORIZATION FOR ACCESS TO PATIENT INFORMATION - *continued*

Details about the information accessed through Healthix and the consent process:

1. **How Your Information May be Used.** Your electronic health information will be used **only** for the following healthcare services:
 - **Treatment Services.** Provide you with medical treatment and related services.
 - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
 - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
 - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included?** If you give consent, the Provider Organization(s) listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date, this form is signed. Your health records may include 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 include sensitive health conditions, including but not limited to:
 - Alcohol or drug use problems
 - Birth control and abortion (family planning)
 - Genetic (inherited) diseases or tests
 - HIV/AIDS
 - Mental health conditions
 - Sexually transmitted diseases
 - Medication and Dosages
 - Diagnostic Information
 - Allergies
 - Substance use history summaries
 - Clinical notes
 - Discharge summary
 - Employment Information
 - Living Situation
 - Social Supports
 - Claims Encounter Data
 - Lab Test

3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.



AUTHORIZATION FOR ACCESS TO PATIENT INFORMATION - *continued*

6. 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 NY Cancer and Blood Specialists | NY Health at: (631) 751-3000; or visit Healthix's website:

www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: <http://www.hhs.gov/ocr/privacy/hipaa/complaints/>.

7. Re-disclosure of Information. Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding the prohibition of re-disclosure.

8. Effective Period. This Consent Form will remain in effect until the day you change your consent choice, death or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. Changing Your Consent Choice. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. Copy of Form. You are entitled to get a copy of this Consent Form.



HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

INTRODUCTION

We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of “protected health information.” “Protected health information” or “PHI” includes any individually identifiable information that we obtain from you or others that relates to your past, present, or future physical or mental health, the health care you have received, or payment for your health care. We will share protected health information with one another, as necessary, to carry out treatment, payment, or health care operations relating to the services to be rendered at New York Health.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain. You can always request a written copy of our most current privacy notice from our reception team or log onto NYHealth.com.

PERMITTED USES AND DISCLOSURE

We can use or disclose your PHI for purposes of *treatment, payment, and health care operations*. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

Treatment means the provision, coordination, or management of your health care, including consultations between health care providers relating to your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to contact a physical therapist to create the exercise regimen appropriate for your treatment.

Payment means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determination of eligibility and coverage, and other utilization review activities. For example, we may need to provide PHI to your Third-Party Payor to determine whether the proposed course of treatment will be covered. When we subsequently bill the Third Party Payor for the services rendered to you, we can provide the Third Party Payor with information regarding your care if necessary to obtain payment. Federal or State law may require us to obtain a written release from you prior to disclosing certain specially protected PHI for payment purposes, and we will ask you to sign a release when necessary under applicable law.

Health care operations mean the support functions of New York Health-related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your PHI to evaluate the performance of our staff when caring for you. We may also combine PHI about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose PHI for review and learning purposes. In addition, we may remove information that identifies you so that others can use the de-identified information to study health care and health care deliverer without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may also use your PHI in the following ways:

- To provide appointment reminders for treatment or medical care.
- To tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.
- To your family or friends or any other individual identified by you to the extent directly related to such person’s involvement in your care or payment for your care. We may use or disclose your PHI to notify or assist in the notification of, a family member, a personal representative, or another person responsible for your care, of your location, general condition, or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.
- When permitted by law, we may coordinate our uses and disclosures of PHI with public or private entities authorized by law or by charter to assist in disaster relief efforts.
- We will allow your family and friends to act on your behalf to pick up filled prescriptions, medical supplies, x-rays, and similar forms of PHI when we determine, in our professional judgment that it is in your best interest to make such disclosures.
- We may contact you as part of our fundraising and marketing efforts as permitted by applicable law. You have the right to opt-out of receiving such fundraising communications.
- We may use or disclose your PHI for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all patients who received a particular medication. All research projects are subject to a special approval process that balances research needs with a patient’s need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.
- We will use or disclose PHI about you when required to do so by applicable law.
- In accordance with applicable law, we may disclose your PHI to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer or New York Health as required by applicable law.

Note: Incidental uses and disclosures of PHI sometimes occur and are not considered to be a violation of your rights. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures that are limited in nature and cannot be reasonably prevented.



HIPAA NOTICE OF PRIVACY PRACTICES - *continued*

SPECIAL SITUATIONS

Subject to the requirements of applicable law, we will make the following uses and disclosures of your PHI:

Organ and Tissue Donation. If you are an organ donor, we may release PHI to organizations that handle organ procurement or transplantation as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the Armed Forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

Worker's Compensation. We may release PHI about you for programs that provide benefits for work-related injuries or illnesses.

Public Health Activities. We may disclose PHI about you for public health activities, including disclosures:

- to prevent or control disease, injury, or disability;
- to report births and deaths, child abuse or neglect;
- to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if the patient agrees or when required or authorized by law.

Health Oversight Activities. We may disclose PHI to federal or state agencies that oversee our activities (e.g., providing health care, seeking payment, and civil rights).

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI subject to certain limitations.

Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- In response to a court order, warrant, summons, or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime under certain limited circumstances;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct on our premises; or
- In emergency circumstances, to report a crime, the location of a crime or the victims, or the identity, description or location of the person who committed the crime

Coroners, Medical Examiners, and Funeral Directors. We may release PHI to a coroner or medical examiner. We may also release PHI about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release PHI about you to authorize federal officials for intelligence, counterintelligence, and other national security activities authorized by law, or to authorized federal officials so they may provide protection to the President or foreign heads of state.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official. This release would be necessary (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose PHI if we, in good faith, believe that the use of disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual.

Note: HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records, and other specially protected health information may enjoy certain special confidentiality protections under applicable state and federal law. Any disclosures of these types of records will be subject to these special protections.

OTHER USES OF YOUR HEALTH INFORMATION

Certain uses and disclosures of PHI will be made only with your written authorization, including uses and/or disclosures: (a) of psychotherapy notes (where appropriate); (b) for marketing purposes; and (c) that constitute a sale of PHI under the Privacy Rule. Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

1. You have the right to request restrictions on our uses and disclosures of PHI for treatment, payment, and health care operations. However, we are not required to agree to your request. We are, however, required to comply with your request if it relates to a disclosure to your health plan regarding health care items or services for which you have paid the bill in full. To request a restriction, you may make your request in writing to the Privacy Officer at New York Health.
2. You have the right to reasonably request to receive confidential communications of your PHI by alternative means or at alternative locations. To make such a request, you may submit your request in writing to the Privacy Officer at New York Health.
3. You have the right to inspect and copy the PHI contained in your medical/billing records, except:
 - (i) for psychotherapy notes, (i.e., notes that have been recorded by a mental health professional documenting counseling sessions and have been separated from the rest of your medical record);
 - (ii) for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
 - (iii) for PHI involving laboratory tests when your access is restricted by law;
 - (iv) if you are a prison inmate, and access would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, any officer, employee, or another person at the correctional institution or person responsible for transporting you;
 - (v) if we obtained or created PHI as part of a research study, your access to the PHI may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;
 - (vi) for PHI contained in records kept by a federal agency or contractor when your access is restricted by law; and
 - (vii) for PHI obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information.In order to inspect or obtain a copy of your PHI, you may submit your request in writing to the Medical Records Section at New York Health. If you request a copy, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.
- (ix) We may also deny a request for access to PHI under certain circumstances if there is a potential for harm to yourself or others. If we deny a request
- (x) for access for this purpose, you have the right to have our denial reviewed in accordance with the requirements of applicable law.



HIPAA NOTICE OF PRIVACY PRACTICES - *continued*

YOUR RIGHTS - *Continued*

4. You have the right to request an amendment to your PHI but we may deny your request for an amendment if we determine that the PHI or record that is the subject of the request:
 - (i) Was not created by us, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;
 - (ii) Is not part of your medical or billing records or other records used to make decisions about you;
 - (iii) Is not available for inspection as set forth above; or
 - (iv) Is accurate and complete. In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records. In order to request an amendment to your PHI, you must submit your request in writing to the Medical Records Section at our office along with a description of the reason for your request.
5. You have the right to receive an accounting of disclosures of PHI made by us to individuals or entities other than to you for the six years prior to your request, except for disclosures:
 - (i) to carry out treatment, payment, and health care operations as provided above;
 - (ii) incidental to a use or disclosure otherwise permitted or required by applicable law;
 - (iii) pursuant to your written authorization;
 - (iv) to persons involved in your care or for other notification purposes as provided by law;
 - (v) for national security or intelligence purposes as provided by law;
 - (vi) to correctional institutions or law enforcement officials as provided by law;
 - (vii) as part of a limited data set as provided by law.
 - (viii) To request an accounting of disclosures of your PHI, you must submit your request in writing to the Privacy Officer at our office. Your request must state a specific time period for the accounting (e.g., the past three months). The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.
6. You have the right to receive a notification, in the event that there is a breach of your unsecured PHI, which requires notification under the Privacy Rule.

Complaints

If you believe that your HIPAA privacy rights have been violated, you should immediately contact the Privacy Officer at **(212) 324-3334**. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Region II Office for Civil Rights, 26 Federal Plaza, New York, NY 10278.

Contact Person

If you have any questions or would like further information about this HIPAA notice, please contact the Privacy Officer at (631) 574-8316. This notice is effective as of September 17, 2013.

Patient Rights

We respect the dignity and pride of each individual we serve. We comply with applicable Federal civil rights laws and do not discriminate on the basis of age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law. Each individual shall be informed of the patient's rights and responsibilities in advance of administering or discontinuing patient care. We adopt and affirm as policy the following rights of patients who receive services from our facility:

Considerate and Respectful Care

- To receive **ethical, high-quality, safe and professional care** without discrimination
- To be free from all forms of **abuse and harassment**
- To be treated with **consideration, respect, and recognition** of their individuality, including the need for privacy in treatment. This includes the right to request the facility provide a person of one's own gender to be present during certain parts of physical examinations, treatments or procedures performed by a health professional of the opposite sex, except in emergencies, and the right not to remain undressed any longer than is required for accomplishing the medical purpose for which the patient was asked to undress

Information regarding Health Status and Care

- To be **informed of his/her health status** in terms that patient can reasonably be expected to understand, and to participate in the development and the implementation of his/her plan of care and treatment
- The right to be informed of the **names and functions** of all physicians and other health care professionals who are providing direct care to the patient
- The right to be informed about any **continuing health care requirements** after his/her discharge from the surgery center and each patient will be provided with written discharge instructions and when necessary, overnight supplies. The patient shall also have the right to receive assistance from the physician and appropriate staff in arranging for required follow-up care after discharge
- To be informed of **risks, benefits and side effects** of all medications and treatment procedures, particularly those considered innovative or experimental
- To be informed of all appropriate **alternative treatment procedures**
- To be informed of the **outcomes** of care, treatment, and services
- To appropriate assessment and **management of pain**
- To be informed if the surgery center has authorized **other health care and/or education institutions** to participate in the patient's treatment. The patient shall also have a right to know the identity and function of these institutions and may refuse to allow their participation in his/her treatment



HIPAA NOTICE OF PRIVACY PRACTICES - *continued*

Decision Making and Notification

- To choose a person to be his/her **healthcare representative and/or decision-maker**. The patient may also exercise his/her right to exclude any family members from participating in his/her healthcare decisions
- To have a family member, chosen representative and/or his or her own physician notified promptly of **admission** to the hospital
- **To request or refuse treatment**. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate
- To be included in **experimental research** only when he or she gives informed, written consent to such participation. The patient may refuse to participate in experimental research, including the investigations of new drugs and medical devices
- To formulate **advance directives** and be informed prior to receiving treatment how the surgery center will or will not comply with these directives
- To **leave the surgery center** against your physician's advice to the extent permitted by law

Access to Services

- To receive, as soon as possible, the free services of a **translator and/or interpreter, telecommunications devices**, and any other necessary services or devices to facilitate communication between the patient and the surgery center's health care personnel (e.g., qualified interpreters, written information in other languages, large print, accessible electronic formats)
- To bring a service animal into the facility, except where service animals are specifically prohibited pursuant to facility policy (e.g., operating rooms, areas where invasive procedures are performed, etc.)
- To **pastoral counseling** and to take part in **religious and/or social activities** while in the surgery center, unless your doctor thinks these activities are not medically advised
- To **safe, secure and sanitary accommodation** and limited refreshments prior to discharge
- To access people outside the facility by means of verbal and written **communication**
- To have **accessibility** to facility buildings and grounds. We recognize the Americans with Disabilities Act, a wide-ranging piece of legislation intended to make American society more accessible to people with disabilities. The policy is available upon request
- To a prompt and reasonable **response to questions and requests** for service

Access to Medical Records

- To have his/her **medical records**, including all computerized medical information, kept confidential and to access information within a reasonable time frame. The patient may decide who may receive copies of the records except as required by law
- Upon leaving the healthcare facility and in accordance with the surgery center's policies regarding records requests, patients have the right to obtain **copies** of their medical records

Ethical Decisions

- To participate prior to receiving treatment in **ethical decisions** that may arise in the course of care including issues of conflict resolution, withholding resuscitative services, foregoing or withdrawal of life-sustaining treatment, and participation in investigational studies or clinical trials
- If the healthcare facility or its team decides that the patient's refusal of treatment prevents him/her from receiving appropriate care according to ethical and professional standards, the **relationship with the patient** may be terminated

Protective Services

- To access **protective and advocacy services**
- To be **free from restraints** of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff
- To all **legal and civil rights** as a citizen unless otherwise prescribed by law
- To have upon request to patient's physician an impartial review of **hazardous treatments** or irreversible surgical treatments prior to implementation except in emergency procedures necessary to preserve your life
- To an impartial review of alleged **violations of patient rights**
- To expect **emergency procedures** to be carried out without unnecessary delay
- To give **consent** to a procedure or treatment and to access the information necessary to provide such consent
- To not be required to perform **work for the facility** unless the work is part of the patient's treatment and is done by choice of the patient
- To file a complaint with the Department of Health, Federal, State and/or Local Agencies, or other quality improvement, accreditation or other certifying bodies if he /she has a concern about **patient abuse**, neglect, about misappropriation of a patient's property in the facility or other unresolved complaints, patient safety or quality concern
-

Payment and Administration

- To examine and receive an explanation of the patient's **healthcare facility's bill** regardless of the source of payment, and may receive upon request, information relating to the availability of known financial resources
- A patient who is eligible for **Medicare** has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate
- To receive, upon request, prior to treatment, a reasonable **estimate of charges** for medical care
- To be informed in writing about the **facility policies and procedures** for initiation, review, and resolution of patient complaints, including the address and telephone number of where complaints may be filed



HIPAA NOTICE OF PRIVACY PRACTICES - *continued*

Additional Patient Rights

- Except in emergencies, the patient may be **transferred to another facility** only with a full explanation of the reason for transfer, provisions for continuing care and acceptance by the receiving institution
- To initiate their own contact with the **media**
- To get the **opinion of another physician**, including specialists, at the request and expense of the patient
- To wear appropriate personal clothing and **religious or other symbolic items**, as long as they do not interfere with diagnostic procedures or treatment
- To request a **transfer to another** area (if medically appropriate) if another patient or a visitor in the room is unreasonably disturbing him/her

PATIENT RESPONSIBILITIES

The care a patient receives depends partially on the patient him/herself. Therefore, in addition to the above rights, a patient has certain responsibilities. These should be presented to the patient in the spirit of mutual trust and respect.

- To provide accurate and complete information concerning his/her health status, medical history, hospitalizations, medications and other matters related to his/her health
- To report perceived risks in his/her care and unexpected changes in his/her condition to the responsible practitioner
- To report comprehension of a contemplated course of action and what is expected of the patient, and to ask questions when there is a lack of understanding
- To follow the plan of care established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders
- To keep appointments or notifying the facility or physician when he/she is unable to do so
- To be responsible for his/her actions should he/she refuse treatment or not follow his/her physician's orders
- To assure that the financial obligations of his/her healthcare care are fulfilled as promptly as possible
- To follow facility policies, procedures, rules and regulations
- To be considerate of the rights of other patients and facility personnel
- To be respectful of his/her personal property and that of other persons in the facility
- To help staff to assess pain, request relief promptly, discuss relief options and expectations with caregivers, work with caregivers to develop a pain management plan, tell staff when pain is not relieved, and communicate worries regarding pain medication
- To inform the facility of a violation of patient rights or any safety concerns, including perceived risk in his/her care and unexpected changes in their condition.