WHITNEY YOUNG HEALTHCARE DESIGNED AROUND HEALTH

REGISTRATION FORM

Today's Date: _____

DEMOGRAPHIC INFORMATION

Patient Name: Last	First	Middle

Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name?	Birth Date	Gender ○ M ○ F ○ Trans

Street Address	POBox/ or Apt#	Primary Phone #	Secondary Phone #

City	State	Zip Code	Social Security #

Employer Name:	Check One: ○ FT ○ PT ○ Not Emp ○ Self Emp ○ Retired ○ Military ○ Unknown

Email address:

INSURANCE INFORMATION – Please give your insurance cards to the Information Associate

IN CASE OF EMERGENCY

Name	Primary Phone #	Secondary Phone #

PATIENT TREATMENT WAIVER/ASSIGNMENT OF BENEFITS

I am requesting services from providers at Whitney M. Young Jr. Health Services. I agree that I shall be responsible for out of pocket expenses (such as co-pays, deductibles) and for charges not covered by insurance including but not limited to: non-covered service by Insurance; my failure to notify Insurance of PCP change; inactive Insurance on the date of service.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Whitney M. Young, Jr. Health Services or my insurance company to release any information required to process my claims.

Name: _____ Signature: _____ Date: _____
Patient/Parent/Guardian

Name: _____ Signature: _____ Date: _____
Witness

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CONSENT TO TREAT
COLLECTION AND SHARING OF INFORMATION
PERSON AUTHORIZED TO COMMUNICATE WITH

CONSENT TO TREAT

By signing this form, you give consent to Whitney M. Young, Jr. Health Services (WHY), staff physicians, addiction counselors, allied health professionals, nurses, dentists and technicians involved in the care of *(insert patient's name):* _____ to administer medical, behavioral health, or dental services, and to perform such treatment, operations, or procedures that are necessary in the normal course of providing these services. Certain procedures or surgeries may require additional informed consent to be signed.

COLLECTION AND SHARING OF INFORMATION

A copy of WYH's Health Insurance Privacy and Accountability Act (HIPAA) Notice of Privacy Practices was given to you. This notice describes how WYH may use and disclose your protected health information, certain restrictions on the use and disclosure of your healthcare information and privacy rights you have regarding your protected health information.

WYH participates in the Alliance for Better Health Care, LLC, a Performing Provider System (PPS) and the IHANY Accountable Care Organization (ACO). These are NYS regulated programs created to help coordinate your care and to reduce unnecessary or duplicate medical procedures and/or tests. WYH may share your health information with other healthcare providers who are also involved in your care. This information may include HIV/AIDS information, drug and alcohol treatment, mental health conditions and/or information about sexually transmitted diseases.

WYH will seek to obtain your medication history from external sources. This gives healthcare providers information about your current and past prescriptions, allowing them to be better informed about potential medication issues, and to use that information to improve safety and quality. This history would include medications prescribed by any healthcare providers involved in your care. By signing this form, you allow WYH to obtain your medication history and to share your health information with providers who are participating in your care.

By signing this form, you acknowledge you have received WYH's HIPAA Notice of Privacy Practices and you allow WYH to obtain your medication history and share your health information with providers who are participating in your care.

PERSON AUTHORIZED TO COMMUNICATE WITH

By signing this form, you give permission for WYH to communicate with the person noted below in regards to all services you receive at WYH, unless you have noted any exceptions below:

EXCEPTIONS: _____

Name _____ Date of Birth _____ Relationship _____

Address _____

Home phone _____ Cell phone _____ Work phone _____

By signing this form, you understand the consents above remain in effect until you request in writing that it be withdrawn or terminated. It is your responsibility to change and/or update this information as necessary.

_____ _____

Patient Name | Patient Date of Birth

_____ _____

Legal Guardian Name (if applicable) | Relationship to Patient

_____ _____

Signature of Patient or Legal Guardian | Signature Date

_____ _____ _____

Witness Name | Witness Signature | Witness Date

WHITNEY YOUNG HEALTHCARE DESIGNED AROUND HEALTH

ANNUAL SUPPLEMENTAL INFORMATION

Federal regulations require that we obtain this information annually in order to document we are serving low and moderate income households. The Patient/Guardian should complete this form including all persons residing in their household, regardless of whether or not they are related. The information in this report will be retained for the purposes of the aggregate reporting. Completion of this form is voluntary.

INFORMATION PROVIDED ON THIS FORM IS KEPT CONFIDENTIAL AND IS NOT SHARED WITHOUT YOUR PERMISSION EXCEPT AS REQUIRED BY LAW TO CONFIRM INCOME ELIGIBILITY OF PARTICIPANTS IN FUNDED PROGRAMS.

Patient Name: _____ Date of Birth: _____

Home address: _____

RACE:

☐ **American Indian or Alaskan Native** (includes persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.)

☐ **Native Hawaiian** (Persons having origins in any of the original peoples of Hawaii.)

☐ **Asian** (Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

☐ **Other Pacific Islander** (Persons having origins in any of the original peoples of Guam, Samoa, Palau, Truk, or other Pacific Islands of Micronesia, Melanesia, or Polynesia.

☐ **Black or African American** ☐ **White**

ETHNICITY:

☐ **Hispanic or Latino** (Persons having origins in any of the original peoples of Cuba, Mexico, Puerto Rico, South or Central America, and or Other Spanish origins.)

☐ **Non Hispanic or Latino**

LANGUAGE:

Primary Language: _____

Do you require interpretation services? ☐ Yes _____ Language required ☐ No

UNITED STATES VETERAN: ☐ **YES** ☐ **NO**

GENDER:

☐ Male ☐ Transgender Male / Female-to-Male ☐ Other

☐ Female ☐ Transgender Female / Male-to-Female ☐ Choose not to disclose

SEXUAL ORIENTATION:

☐ Lesbian or Gay ☐ Bisexual ☐ Don't know

☐ Straight (not lesbian or gay) ☐ Something else ☐ Choose not to disclose

ANNUAL HOUSEHOLD INCOME:

☐ $_____ ☐ Choose not to disclose

Number of family and non-family members living in your household:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ _____

I certify the above information is true and correct to the best of my knowledge.

Patient/Guardian signature: _____ Date: _____

Hixny

Hixny Electronic Data Access Consent Form
Whitney M. Young Jr. Health Services

In this Consent Form, you can choose whether to allow Whitney M. Young Jr. Health Services to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Whitney M. Young Jr. Health Services to see and obtain access to your electronic health records in this way. 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 may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, Whitney M. Young Jr. Health Services's staff involved in my care may see and get access to all of my medical records through Hixny."

If you check the **"I DENY CONSENT"** box below, you are saying "No, Whitney M. Young Jr. Health Services may not be given access to my medical records through Hixny for any purpose."

Hixny is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services.

Please carefully read the information on both pages of this form before making your decision.
You have two choices:

- ☐ **I GIVE CONSENT for Whitney M. Young Jr. Health Services to access ALL of** my medical records through Hixny in connection with providing me any health care services, including emergency care.

- ☐ **I DENY CONSENT for Whitney M. Young Jr. Health Services to access** my medical records through Hixny for any purpose, *even in a medical emergency*. Unless you check this box, New York State law allows medical providers treating you in an emergency to get access to your medical records, including records that are available through Hixny.

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

Details about patient information in Hixny and the consent process:

How Your Information Will Be Used

Your electronic health information will be used by Whitney M. Young Jr. Health Services only to:

- Provide you with medical treatment and related services
- Check whether you have health insurance and what it covers
- Evaluate and improve the quality of medical care

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.

What Types of Information About You Are Included

If you give consent, Whitney M. Young Jr. Health Services may access ALL of your electronic health information available through Hixny. This includes information created before and after the date of this Consent Form. 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 relate to 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

***If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, such as medications and dosages, lab test results, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social support, and health insurance claims history.**

Where Health Information About You Comes From

Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Hixny. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

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 Whitney M. Young Jr. Health Services's medical staff who are involved in your medical care; health care providers who are covering or on call for Whitney M. Young Jr. Health Services's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

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 Whitney M. Young Jr. Health Services at: (518) 465-4771; or call Hixny at (518) 640-0021; or call the NYS Department of Health at 518-474-4987.

Re-disclosure of Information

Any electronic health information about you may be re-disclosed by Whitney M. Young Jr. Health Services 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. Hixny and persons who access this information through the Hixny must comply with these requirements.

Effective Period

This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

Withdrawing Your Consent

You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Whitney M. Young Jr. Health Services. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 640-0021.

NOTE: Organizations that access your health information through Hixny 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.

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