REGISTRATION FORM

Email completed form to: registration@wmyheatlh.org

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		POB/Apt #	Primary Phone #	Cell Phone #
City		State	Zip Code	Social Security #
Employer Name:	Check One: ○ FT ○ PT ○ Not Emp ○ Self Emp ○ Retired ○ Military ○ Unknown			
Email address:				

INSURANCE INFORMATION

Insurance Company Name	Subscriber #	Group #
Card Holder Name	Patient Relationship to Card Holder	Policy #

IN CASE OF EMERGENCY

Name	Primary (Home) Phone #	Cell 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

- **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 acknowledge you have received WYH's HIPAA Notice of Privacy Practices and you allow WYH to obtain your medication history, to share your health information with non-WYH providers who are participating in your care, and to obtain records from non-WYH 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 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.

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? ☐ No ☐ Yes _____ Language required

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

GENDER IDENTITY:

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

☐ Female ☐ Transgender Woman / Male-to-Female ☐ Other: specify _____

SEXUAL ORIENTATION:

☐ Lesbian, Gay or Homosexual ☐ Bisexual ☐ Do not know

☐ Straight or Heterosexual ☐ Choose not to disclose ☐ Something else: describe _____

ANNUAL HOUSEHOLD INCOME: **PLEASE CHOOSE** your family size and income on the same line.

FAMILY SIZE	100% & below	101% - 150%	151% - 200%	Over 200%
1	◉ $0 - $12,490	○ $12,491 - $18,735	○ $18,736 - $24,980	○ $24,981 or more
2	○ $0 - $16,910	○ $16,911 - $25,365	○ $25,366 - $33,820	○ $33,821 or more
3	○ $0 - $21,330	○ $21,331 - $31,995	○ $31,996 - $42,660	○ $42,661 or more
4	○ $0 - $25,750	○ $25,751 - $38,625	○ $38,626 - $51,500	○ $51,501 or more
5	○ $0 - $30,170	○ $30,171 - $45,255	○ $45,256 - $60,340	○ $60,341 or more

OTHER:

HOUSEHOLD SIZE: _____

INCOME: _____

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

Patient/Guardian signature: _____ Date: _____

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**.**

Whitney M. Young, Jr. Health Center, Inc.

NOTICE OF PATIENT PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Health Information Technology for Economic and Clinical Health of 2009 (HITECH) and the Omnibus Rule of 2013

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU MAY ACCESS YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Whitney M. Young, Jr. Health Center (WMY) is dedicated to maintaining the privacy of your "Protected Health Information" (PHI). PHI is any individual identifiable health information we create or receive that relates to your past, present or future health care or medical condition. PHI includes paper, electronic and oral data.

We are required by law to maintain the confidentiality of PHI. We also are required to provide you with this notice of our legal duties and the privacy practices that we maintain concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Our practice will post the current Notice of Privacy Practices on our Website at www.wmyhealth.org, and you may request a copy of our Notice at any time.

B. WMY MAY USE AND DISCLOSE YOUR PHI IN THE FOLLOWING WAYS

1. Treatment. Our practice may use your PHI to provide, coordinate and manage your health care. We may disclose medical information about you to other doctors, nurses, technicians, clinical laboratories, imaging companies, or other personnel in an unrelated organization for purposes related to your treatment including care coordination. For example, we may refer you to a specialist and share your PHI with that provider. Or we might disclose your PHI to a pharmacy when we order a prescription for you.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. We may use your PHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. For example, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Business Associate. We may disclose information to a person or entity we contract with to perform some of our business functions-for example, a billing service or attorney. Business associates and sub-contractors are held to the applicable provision of HIPAA standards.

5. Appointment Reminders and Treatment Options. Our practice may use and disclose your PHI to contact you and remind you of an appointment in a generic manner and to inform you of potential treatment options or alternatives.

6. Family/Friends. Our practice may release directly relevant PHI to a family member or friend that is involved in your care, helps pay for your care or who assists in taking care of you, unless you provide written instructions not to. Similarly, after your death, relevant disclosures may be made to these same people. HIPAA protection is eliminated 50 years after a patient's death.

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority for you before we take any action.

7. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

8. Alcohol and Substance Abuse, Mental Health and HIV PHI. Disclosure of information related to Alcohol and Substance Abuse, Mental Health and HIV treatment is further protected in by Federal Regulation 42 CFR. Specific authorization for release of these treatment records is required. WMY uses NYS DOH for 5032 for appropriate authorization to release these treatment records.

C. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

1. **Childhood Immunizations**. WMY may disclose immunizations to schools required to obtain proof of immunizations prior to admitting the student as long as we have and document in the EMR the parent's or legal guardian informal agreement to the disclosure.

2. Public Health Risks. WMY may disclose your PHI for public health activities and purposes. For example, we may disclose information to a public health authority that is authorized to receive such information for the purpose of controlling disease, injury or disability. WMY may also disclose your PHI to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law or rule permits us to do so.

3. Abuse or Neglect. We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, if we believe that you have been a victim of abuse, neglect or domestic violence, we may disclose your PHI to the governmental entity or agency authorized to receive such information.

4. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

5. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

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

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement;
- Concerning a death we believe has resulted from criminal conduct;
- Regarding criminal conduct at our offices;
- In response to a warrant, summons, court order, subpoena or similar legal process;
- To identify/locate a suspect, material witness, fugitive or missing person; or
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

7. Research. We may disclose your PHI to researchers if an institutional review board reviews and approves the research proposal and protocols to ensure your privacy.

8. Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Specialized Governmental Functions. Our practice may use or disclose PHI for specialized governmental functions, such as disclosing information about a member of the armed services to the military to assure the proper execution of a military mission, or disclosing information about inmates to a correctional facility for security, continued health care or safety or other important purposes.

10. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

11. Marketing Communications. WMY must obtain your written authorization to market a third party's product or service to you except when:

- WMY receives no compensation for marketing the third party's product or service;
- The communication is face to face;
- The communication involves a drug or biologic that you are currently being prescribed and the payment is limited to reasonable reimbursement of the cost of the communication (no profit);
- The communication involves general health promotion, rather than the promotion of a specific product or service; or
- The communication involves government or government sponsored programs.

12. Sale of PHI. WMY will not sell your data to an outside entity, nor will we permit an outside entity to access your information for purposes of informing you of health-related benefits or services without your explicit written authorization.

13. Fundraising. Our practice may use demographic data, dates of service, department of service, treating provider, outcome information and health insurance information to send you material in connection with our efforts to raise funds. If we do, we will have a clear and conspicuous method to let you know how to opt out of receiving any future fundraising materials.

D. YOUR RIGHTS REGARDING YOUR PHI

Although your health records are the physical property of WMY and the health care providers who created it, you have the following rights with regard to the information contained therein and the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to WMY specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict disclosure of your PHI to individuals involved in your care or the payment for your care, such as family members and friends. You must provide us with a written request which states the specific restriction requested and to whom you want the restriction to apply. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

Also, if you pay for a service or health care item in full, you may ask us not to share the information for the purpose of payment or our operations with your health insurance. We will honor your request unless required by law. This restriction request must in writing.

3. Inspection and Copies. You have the right to inspect and obtain an electronic or paper copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to WMY. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.

4. Amendment. You may ask us to correct your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. You must provide us with written request and a reason that supports your request for amendment. Our practice may deny your request to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. You have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. All requests for an "accounting of disclosures" must be in writing, state a time period, which may not be longer than six (6) years from the date of disclosure. We'll provide one accounting a year for free but will charge a reasonable, cost based fee if you ask for another one within 12 months.

6. Notice of Breach. You have the right to receive a written notice of a breach of your unsecured PHI by first class mail or by secured email if that is your recorded preference. WMY will send the notice without unreasonable delay and within 60 days of the discovery of the breach.

7. Right to a Copy of This Privacy Notice. You are entitled to receive a paper copy of our notice of privacy practices at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

8. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice by calling **the Corporate Compliance Officer** at 1-518-591-4905 or sending a letter to the address below. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, DC 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/orc/privacy/hipaa/complaints/**... **You will not be penalized or retaliated against for filing a complaint**.

9. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Corporate Compliance Officer
920 Lark Drive
Albany, NY 12207
518-591-4905

It is the policy of WMY that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.