Elmwood Health Center

An affiliate of PeopleInc

(PLEASE FILL OUT PACKET IN BLUE OR BLACK INK ONLY)

Welcome to the Elmwood Health Center!

These are forms that you will need to fill out **before** you come in for your first appointment**. Please bring the filled out forms with you to your first visit.**

We wish to make signing up as a new patient as pleasant and quick as possible. We know that your time is valuable. Please bring this information below to your first visit:

1. New Patient Packet filled out
2. Health Insurance card or cards
3. Photo ID
4. Make sure we are listed on your insurance card as your doctor. Call your insurance company before your first appointment.

Please **come 30 minutes before your first visit time** so that we may check all paperwork and insurance information with you before your first visit. *The Elmwood Health Center is **not** a walk-in clinic and **all visits are by appointment only**.*

We thank you in advance for your help and we look forward to providing for your health care needs. If you have any questions, please call us at 716-874-4500.

Sincerely,

The Elmwood Health Center

The Elmwood Health Center is not a pain management facility. We cannot promise that a prescription for a controlled substance will be written at your first visit or any later visit. Your provider will carefully consider your needs and issues before prescribing any medications to you.

Elmwood Health Center

An affiliate of PeopleInc

Pre-Registration Form

Date of Appointment: _____ Provider: _____

Patient Name: _____

Patient Address: _____

E-mail Address: _____ Home Phone: _____

Sex (circle one): Male/Female Marital Status: _____ Race: _____

Date of Birth: _____ Social Security #: _____

Employer: _____ Work Phone: _____

Occupation: _____ Referred to Elmwood Health Center by: _____

Referring Physician or Primary Care Physician: _____

Parent/ Guardian Name: _____

Emergency Contact Name: _____

Address: _____ Phone: _____

_____ Relationship to patient: _____

Is this appointment needed due to an injury? Y / N

(a) If Yes, is this a no Fault Case due to an auto accident?

(b) If Yes, is this a Worker's Compensation Case due to a work related injury?

INSURANCE INFORMATION

Primary Insurance: _____

Insurance ID #: _____ Group #: _____

Subscriber/Guarantor: _____ Subscriber ID #: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

(PLEASE CONTINUE ON THE BACK OF THIS PAGE)

Elmwood Health Center

An affiliate of PeopleInc

Pre-Registration Form, Continued

INSURANCE INFORMATION, Continued

Secondary Insurance: _____

Insurance ID #: _____ Group #: _____

Subscriber/Guarantor: _____ Subscriber ID #: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Tertiary Insurance: _____

Insurance ID #: _____ Group #: _____

Subscriber/Guarantor: _____ Subscriber ID #: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Additional Comments: _____

_____

Signature: _____ Date: _____

Elmwood Health Center

An affiliate of PeopleInc

Name: _____ Birth Date: _____ Date:_____

All responses are **CONFIDENTIAL**

HIV/AIDS	**GYNECOLOGY**
Do you have any concerns about HIV/AIDS or drug abuse that you would like to discuss? □ **Yes** □ **No** Would you like to be tested for HIV? □ **Yes** □ **No**	Last gynecologic (GYN) exam: _____ Have you ever had an abnormal PAP smear? □ **Yes** □ **No** Last menstrual period: _____ Lost pregnancy/miscarriages? _____ Number of children: _____ Have you ever had a mammogram? If you had a mammogram when was the last mammogram? _____

General Health Survey: Please Circle next to any signs or conditions you may have.

General	**Mental Health**	**Head/Eyes/Ear/Nose/Throat**
Enlarged Glands Unexplained Lumps Recent Weight Change Chronic Fatigue Fever/Chills Other _____	Anxiety Recurrent Nightmares Upsetting Images Depression Inability to Focus Eating Disorder Panic Attacks Trouble Sleeping Too Much or Too Little Thoughts About Hurting Yourself Thoughts About Hurting Others Other _____	Difficulty with Night Visions Change in Vision Blurred Vision Double Vision Loss of vision Glaucoma Blind Spots Ear Discharge Earache Hearing Loss/Deafness Ringing in Ears Frequent Nose Bleeds Bleeding Gums Frequent Sinus Trouble Hoarseness Other _____
Lungs/Respiratory	**Heart and/or Veins**	**Gastrointestinal**
Coughing up Blood Chronic Cough Frequent Cough Shortness of Breath Wheezing Chest Tightness Asthma COPD Cancer Other _____	Leg Pain While Walking Chest Pain Irregular Heart Beat Palpations Painful Varicose Veins Heart Trouble High Cholesterol Other _____	Abdominal Pain Black Tarry Stool Bloody Stool Difficulty Swallowing Hernia Hemorrhoids Heartburn Constant Diarrhea Stomach Ache Nausea Poor Appetite Vomiting Blood Ulcer Other _____

Genital or Urinary	Musculoskeletal	Neurological
Bladder Trouble Blood in Urine Prostate Problems Problems with Sexual Function Frequency Infertility Painful Urination Difficulty Starting or Stopping Urination Urinating 3x/Night Other _____	Back Pain Neck Pain Joint Pain Joint Swelling Joint Injury Carpal Tunnel Syndrome Other _____	Numbness and Tingling of Hands, Feet, Arms, Legs Dizziness Fainting Headaches Memory Loss Tremor Loss of Coordination Stroke/Mini-Stroke Mental Confusion Injury to the Brain or Spine Other _____
Skin/Hair	**Endocrine**	**Hematology**
Rash or Itching Thinning Hair Sores Color Changes Other _____	Low Blood Sugar High Blood Sugar Diabetes Thyroid Heat or Cold Intolerance Other _____	Bleeding Problems Bruising Easily Other _____

Elmwood Health Center

An affiliate of PeopleInc

Name: _____ Birth Date: _____ Date:_____

All responses are **CONFIDENTIAL**

Previous doctor(s): _____

Current doctors or counselors you see: _____
_____
_____
_____

Medical History: (serious illness, chronic medical conditions, mental illness, hospitalizations, surgeries, etc.) _____ _____ _____ _____ _____ _____ _____ _____ _____	**Allergies:** _____ _____ _____ **Medications:** (include over-the-counter and dietary supplements) _____ _____ _____ ***Please ask your pharmacy for a printout of all your current medications and bring this list with you to the first visit**
Last Tetanus Shot: _____ Last Flu Shot: _____ Pneumonia Shot: _____ Shingles Shot: _____ Have you had chick pox (varicella)? □ **Yes** □ **No**	Do you exercise at least three times per week? □ **Yes** □ **No**
Family History: medical conditions (such as diabetes, cancer, heart disease, depression, substance abuse), deaths (approximate age). Please list family member who had cancer and what type of cancer family member had. Brothers Sisters Mother Father Grandparents Other family members	Social History: Last grade completed: _____ Are you single/married/divorced? Do you have any children? □ **Yes** □ **No** Who lives at home: _____ _____ Do you or did you smoke? □ **Yes** □ **No** How many years? _____ How many packs/day? _____ Do you or did you use any drugs? □ **Yes** □ **No** If so what drug/drugs are you using? _____ Do you drink alcohol? □ **Yes** □ **No** If you how much per day/week? _____ Have you had any problems with alcohol or substance Abuse? □ **Yes** □ **No** Do you have communication needs and preferences of (such as interpreter, pitch or tone of voice, language interpreter)? □ **Yes** □ **No** Do you have a health care proxy? □ **Yes** □ **No**

Reviewed by: _____ Date of Review: _____

Elmwood Health Center

An affiliate of PeopleInc

Consent for Service

NAME: _____

DATE OF BIRTH: _____

PATIENT ID#: _____

I hereby request that a person authorized by the ELMWOOD HEALTH CENTER perform examinations or test(s) and provide appropriate treatment when indicated.

Referral will be made for further diagnosis and/or treatment where indicated. I understand that if follow-up is needed, I will assume the responsibility for such follow-up.

I am aware that information on DO NOT RESUSCITATE ORDERS and HEALTH CARE PROXY is available upon request.

I authorize payment of medical benefits to the undersigned physician or supplier for services rendered.

I have read the patient Bill of Rights and all of the above.

Assignment of Benefits
We will bill the appropriate insurance companies for the services covered by your individual plan(s). You will; be responsible for and deductible or insurance balance. We will bill you for any remaining balance after your insurance has paid its portion of the bill. Self-pay patients are responsible for their balances in their entirety.

YOUR INSURANCE CARD IS REQUIRED AT THE TIME OF EACH VISIT. INSURANCE CO-PAYMENTS ARE DUE AT THE TIME OF EACH VISIT.

If you do not have insurance coverage, we will gladly discuss our fee schedule.

PAYMENT IS EXPECTED AT THE TIME OF YOUR VISIT

Please notify our office immediately if your insurance coverage changes.

I hereby assign all medical benefits to include all Medicare, Medicaid, Community Blue, Blue Cross/ Blue Shield, Independent Health, Univera, and/or other health plans to the Elmwood Health Center.

This assignment remains in effect until revoked by me in writing. I understand than I am financially responsible for all charges if not paid by said insurance.

_____ _____

Signed Date Witness Date

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.

Provider uses your Protected Health Information for your treatment, to obtain payment for our services and for our operational purposes, such as improving the quality of care we provide to you. We are committed to maintaining your confidentiality and protecting your health information. We are required by law to provide you with this Notice, which describes our health information privacy and those of affiliated health care providers.

This Notice applies to all information and records related to your care that our Provider workforce members and Business Associates have received or created. It also applies to health care professionals, such as physicians, and organizations that provide care to you from the various Provider Departments. It informs you about the possible uses and disclosures of your Protected Health Information and describes your rights and our obligations regarding your Protected Health Information.

We are required by law to:

- Maintain the privacy of your Protected Health Information;
- Provide to you this detailed Notice of our legal duties and privacy practices relating to your Protected Heath Information; and
- Abide by the terms of the Notice that are currently in effect. We reserve the right to change the terms of this Notice, and will notify you or your personal representative if we make any material changes to the Notice.

I. WITH YOUR CONSENT, WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

We are required by New York State Law to obtain a signed Consent *(Attachment A-3)* allowing us to use and disclose your Protected Health Information or Private Information (collectively referred to as "Protected Health Information") to others to provide you with treatment, obtain payment for our services, and run our health care operations. Here are examples of how we may use and disclose your health care information.

FOR TREATMENT: Our staff and affiliated health care professionals may review and record information in your record about your treatment and care. We will use and disclose this health information to health care professionals in order to treat and care for you. For example, a physician may consult with another physician located at another location to determine how to best diagnose and treat you.

FOR PAYMENT: The Provider may use and disclose your Protected Health Information to others in order for the Provider to bill for your health care services and receive payment. For example, we may include your health information in our claim to your insurance company, Medicaid, or Medicare in order to receive payment for services provided to you. We may also disclose your health information to other health care providers so that they can receive payment for their services.

FOR HEALTH CARE OPERATIONS: We may use and disclose your Protected Health Information to others for the Provider's business operations. For example, we may use Protected Health Information to evaluate the Provider's services, including the performance of our staff, and to educate our staff.

APPOINTMENT REMINDERS: We may use and disclose your information to contact you as a reminder that you have an appointment for treatment or medical care.

II. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR OTHER SPECIFIC PURPOSES

BUSINESS ASSOCIATES: We may share your Protected Health Information with our vendors and agents who create, receive, maintain or transmit PHI for certain functions or activities on behalf of the Provider. These are called our "Business Associates". To protect and safeguard your health information, we require our Business Associates and subcontractors to appropriately safeguard your information.

FAMILY AND FRIENDS INVOLVED IN YOUR CARE: Unless you object, we may disclose your Protected Health Information to a family member or close personal friend, including clergy, who is involved in your care or payment for that care.

PERSONAL REPRESENTATIVE: If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclsoures of your health information. If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative or to your next of kin, as permitted under state and federal law.

DISASTER RELIEF: We may disclose your Protected Health Information to an organization assisting in a disaster relief effort.

PUBLIC HEALTH ACTIVITIES: We may disclose your Protected Health Information for public health activities including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation and/or intervention. We may also disclose your information to notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition if a law permits us to do so.

HEALTH OVERSIGHT ACTIVITIES: We may disclose your Protected Health Information to health oversight agencies authorized by law to conduct audits, investigations, inspections and licensure actions or other legal proceedings. These agencies provide oversight for the Medicare and Medicaid programs, among others.

REPORTING VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE: If we have reason to believe that you have been a victim of abuse, neglect or domestic violence, we may use and disclose your Protected Health Information to notify a government authority if required or authorized by law, or if you agree to the report.

LAW ENFORCEMENT: We may disclose your Protected Health Information for certain law enforcement purposes or other specialized governmental functions.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We may disclose your Protected Health Information in the course of certain judicial or administrative proceedings.

RESEARCH: We will request that you sign a written authorization before using your Protected Health Information or disclosing it to others for research purposes.

CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTOS, ORGAN PROCUREMENT ORGANIZATIONS: We may release your Protected Health Information to a coroner, medical examiner, funeral director or, if you are an organ donor, to an organization involved in the donation of organs and tissue.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY: We may use and disclose your Protected Health Information when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person. However, any disclosure would be made only to someone able to help prevent the threat.

MILITARY AND VETERANS: If you are, or were, a member of the armed forces, we may use and disclose your Protected Health Information as required by military command authorities. We may also use and disclose Protected Health Information about foreign military personnel as required by the appropriate foreign military authority.

WORKERS' COMPENSATION: We may use or disclose your Protected Health Information to comply with laws relating to worker's compensation or similar programs.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES; PROTECTIVE SERVICES: We may disclose Protected Health Information to authorized federal officials who are conducting national security and intelligence activities or as needed to provide protection to the President of the United States, or other important officials.

AS REQUIRED BY LAW: We will disclose your Protected Health Information when required by law to do so.

III. YOUR AUTHORIZATION IS REQUIRED FOR OTHER USES OF YOUR PROTECTED HEALTH INFORMATION

We will use and disclose your Protected Health Information other than as described in this Notice or required by law only with your written Authorization. You may revoke your authorization to use or disclose Protected Health Information in writing, at any time. To revoke your Authorization, contact the appropriate Provider Staff. If you revoke your Authorization, then we will no longer use or disclose your Protected Health Information for the purposes covered by the Authorization, except where we have already relied on the Authorization.

Fundraising.

Provider may contact you or your personal representative to raise money for the Provider. We may also share your demographic information with a charitable foundation that may contact you or your personal representative to raise money on our behalf. In certain circumstances, you must provide us with your written authorization for our use of your information for fundraising and you also have the opportunity to opt out or restrict your receiving future fundraising communications. Your request to opt out of receiving future fundraising communication will revoke any prior authorizations and you will not receive any future communications.

Marketing.

In most circumstances, Provider is required by law to receive your written authorization before we use or disclose your health information for marketing purposes. Under no circumstances will we sell our individual lists or your health information to a third party without your written authorization.

Psychotherapy Notes.

In most circumstances, Provider is required by law to obtain your written authorization before we use or disclose psychotherapy notes.

IV. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights with respect to your health information. If you wish to exercise any of these rights, you should make your request to the appropriate Provider Staff.

RIGHT OF ACCESS TO PROTECTED HEALTH INFORMATION: You have the right to request, either orally or in writing to inspect and obtain a copy of your Protected Health Information, subject to some limited exceptions. If available, you have the right to access your information in electronic format. We must allow you to inspect your records within 10 days of your request. If you request copies of the records, we must furnish you a copy within 30 days of that request if the records are maintained on site and within 60 days if maintained off site. We may charge a reasonable fee for our costs in copying and mailing your requested information or provision of information in electronic format.

In certain limited circumstances, we may deny your request to inspect or receive copies. If we deny access to your Protected Health Information, we will provide you with a summary of the information, and you have a right to request review of the denial. We will provide you with information on how to request a review of our denial and how to file a complaint with us or the Secretary of the Department of Health and Human Services.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request restrictions on the way we use and disclose your Protected Health Information for our treatment, payment or health care operations. You also have the right to request restrictions on our disclosures of your Protected Health Information to a family member, friend or other person who is involved in your care or the payment for your care.

We are not required to agree to your requested restriction, and in some cases, the law may not permit us to accept your restriction. However, if we do agree to accept your restriction then we will comply with your restriction EXCEPT IF: (1) you are being transferred to another health care institution; (2) the release of records is required by law, or (3) the release of information is needed to provide you emergency treatment. If your restriction applies to disclosure of information to a health plan for payment or health care operations purposes and is not otherwise required by law, and where you paid out of pocket, in full, for items or services, we are required to honor that request.

RIGHT TO RECEIVE NOTICE OF A BREACH: We will notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. A "Breach" means the unauthorized access, acquisition, use, or disclosure of Protected Health Information which compromises the security or privacy of Protected Health Information, except: (1) an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information; (2) any unintentional acquisition, access, or use of PHI by an employee or individual acting under the authority of a covered entity or business associate (a) was made in good faith and within the course and scope of the employment or other professional relationship of such employee, or individual, respectively, with the covered entity or business associate; and (b) such information is not further acquired, accessed, or used or disclosed by any person; or (3) any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by a covered entity or business assosciate to another similarly situated individual at the same facility provided that any such information received as a result of such disclosure is not further acquired, accessed, used, or disclosed without authorization. The Provider must notify you of any breach unless we can demonstrate, based on a risk assessment, that there is a low probability that the PHI has been compromised.

"Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable and undecipherable to unauthorized users. The notice is required to include the following information:

- a brief description of the breach, including the date of the breach and the date of its discovery, if known;
- a description of the type of Unsecured Protected Health Information involved in the breach;
- steps you should take to protect yourself from potential harm resulting from the breach;
- a brief description of action we are taking to investigate the breach, mitigate losses, and protect against further breaches; and
- contact information, including a toll-free number, e-mail address, Website or postal address to permit you to ask questions or obtain additional information.

In the event the breach involves 10 or more individuals whose contact information is out of date, we will post a notice of the breach on the home page of our web site or in a major print or broadcast media. If the breach involves more than 500 individuals in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 individuals, we are required to immediately notify the Secretary of Health and Human Services. We are also required to submit an annual report to the Secretary of a breach that involved less than 500 individuals during the year and will maintain a written log of breaches involving less than 500 indivduals. Notification to the Secretary will occur within 60 days of the end of the calendar year in which the breach was discovered.

RIGHT TO AN ACCOUNTING OF DISCLOSURES: You have the right to request an "accounting" of our disclosures of your Protected Health Information. This is a listing of certain disclosures of your Protected Health Information made by the Provider or by others on our behalf, but does not include disclosures made for treatment, payment and health care operations or certain other purposes unless the records are maintained in an Electronic Health Record. Records maintained in an Electronic Health Record will include disclosures made for treatment, payment, health care operations and other purposes.

You must submit a request in writing, stating a time period beginning after April 13, 2003 that is within six years from the date of your request. Where an Electronic Health Record is used, we will provide you with an accounting of disclosures for a 3 year period. You are entitled to one free accounting within one 12-month period. For additional requests, we may charge you our costs.

We will usually respond to your request within 60 days. Occasionally, we may need additional time to prepare the accounting. If so, we will notify you of our delay, the reason for the delay, and the date when you can expect the accounting.

RIGHT TO REQUEST AMENDMENT: If you think that your Protected Health Information is not accurate or complete, then you have the right to request that the Provider amend such information for as long as the information is kept in our records. Your request must be in writing and state the reason for the requested amendment. We will usually respond within 60 days, but will notify you within 60 days if we need additional time to respond, the reason for the delay and when you can expect our response. We may deny your request for amendment, and if we do so, we will give you a written denial including the reasons for the denial and an explanation of your right to submit a written statement disagreeing with the denial.

RIGHT TO A PAPER COPY OF THIS NOTICE: It is the Provider policy to provide you with a paper copy of this notice.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS: You have the right to request that we communicate with you concerning personal health matters in a certain manner or at a certain location. For example, you can request that we speak to you only at certain private locations. We will accommodate your reasonable requests.

V. COMPLAINTS

If you believe that your privacy rights have been violated, then you may file a complaint in writing with Provider or with the Office of Civil Rights in the U.S. Department of Health and Human Services. To file a complaint with the Provider, contact:

People, Inc.
Corporate Compliance Officer
1219 North Forest Road
Williamsville, NY 14221

No one will retaliate or take action against you for filing a complaint.

VI. CHANGES TO THIS NOTICE

We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice. We reserve the right to change this Notice and to make the revised or new Notice provisions effective for

all Protected Health Information already received and maintained by the Provider as well as for all Protected Health Information we receive in the future. We will post a copy of the current Notice in the appropriate Provider Department. In addition, we will provide a copy of the revised Notice to all individuals receiving our services.

If you have any questions about this Notice or would like further information concerning your privacy rights, then please contact:

People, Inc.
Corporate Compliance Officer
1219 North Forest road
Williamsville, NY 14221

INDIVIDUAL'S WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Name: _____

I acknowledge that I have received a copy of the Provider's Notice of Privacy Practices and have been advised of how the Provider [and the other named individuals and organizations listed in the Notice] will handle my Protected Health Information. I have also been advised of my rights to obtain access to and control my Protected Health Information. I understand that I may receive other notices which describe how the Provider will handle specialized forms of Protected Health Information such as HIV/AIDS-related, alcohol and drug abuse, and genetic information and psychotherapy notes.

SIGNATURE

I have received a copy of the Provider's Notice of Privacy Practices. I have had an opportunity to ask questions about the Notice and the use or disclosure of my Protected Health Information.

Signature of Individual or Personal Representative: _____

Print Name of Individual or Personal Representative: _____

Description of Individual Representative's Authority: _____

Date: _____

CONTACT INFORMATION

Contact information of the personal representative who signed this form:

Address: _____

_____

_____

Telephone: _____ (Daytime) _____ (Evening)

For Provider Use Only

Date Notice Provided _____

Name of Staff Member_____Title_____

Elmwood Health Center

Authorization to Use or Disclose Health Information

Patient Name:_____
Date of Birth:_____

I allow the release of my medical information from Elmwood Health Center

1. The type of information to be given is as follows: (Please mark an X next to the information to be given)

____Medication list
____List of allergies
____Immunization records
____Medical history
____All Lab results (all unless written here):_____
____All Radiology reports (or just the following):
_____
____Other (please describe):
_____

2. The information named above may be used by or may be given by mail, e-mail, telephone or given right to myself or other people or organization(s):

Name:

Address:

Phone Number:

Email Address:

Name:

Address:

Phone Number:

Email Address

3. This information for which I'm giving my release will be used for the following use:
□ my personal records
□ share with family members, friends and/or others
□ sharing with other health care providers as needed

□ other (please describe):_____

4. I understand that I have a right to cancel this release at any time. I understand that if I cancel this release, I must do so in writing and present my written cancellation to the health information management department. I understand that the cancellation will not apply to information that has already been released in reply to this consent. I understand that the cancellation will not apply to my insurance company when the law gives my insurer with the right to fight a claim under my policy.

7. This permission will end in (put in date or event): _____
If I do not give an end date or event, this release will continue forever.

8. I know that once the above information is released, it may be re-released by the person or organization that I gave my permission to. The information may not be protected by federal privacy laws or regulations.

9. I understand by giving my permission to release my health information to people or organizations I allow giving my information to is not needed. I do not need to sign this form to make sure I or my child receives healthcare treatment.

_____ _____
Signature of patient or legal representative Print Name

_____
Date

If signed by legal representative, relationship to patient

_____

Signature of witness
_____ Date: _____

Distribution of copies: Original to EMR; copy to patient

Processing Information: Date sent: _____
Sent via:
Mail: Address: _____
E-Mail Address: _____
Provided to Patient Directly _____
Other: _____

Consent to Use and Disclose Protected Health Information for Treatment, Payment and Health Care Operations

Section A:

Individual Name: _____ Individual ID Number: _____

I authorize the use and disclosure of my Protected Health Information by the Provider listed below and by the Provider's staff and Business Associates for purposes of treatment, payment and health care operations.

Name of Provider Using and Disclosing the Information:

Elmwood Health Center

Provider's Address:

2128 Elmwood Avenue
Buffalo, NY 14207

Section B: Important Information Regarding Consent:

1. I understand New York laws require my consent before the Provider may use or disclose my Protected Health Information for treatment, payment or health care operations.

2. I understand that this information may be used or disclosed by the Provider to:
   - Plan my care and treatment;
   - Communicate among various health care professionals who are involved in my care or treatment;
   - Obtain payment for care provided by the Provider or for the payment of activities of another health care provider or entity;
   - Provide information to my health insurance company or plan;
   - Obtain payment from my health insurance company or plan; and review the quality of my care.

3. I understand that my signature on the consent is required in order for me to receive care from the Provider and that the Provider may condition my treatment on obtaining my consent for use and disclosure of my Protected Health Information for treatment, payment and health care operations.

4. I understand that further information on the Provider's uses and disclosures of my Protected Health Information for treatment, payment and health care operations is included in the Provider's Notice of Privacy Practices which I have received.

SIGNATURE

I have read and understand the terms of this consent. I have had an opportunity to ask questions about the disclosure of my Protected Health Information.

Signature of Individual or Personal Representative: _____

Print Name of Individual or Personal Representative: _____

Description of Personal Representative's Authority: _____

Date: _____

CONTACT INFORMATION

Address: _____
_____
_____

Telephone: _____(Daytime) _____(Evening)

For Provider Use Only

Date Provider Obtained Consent: _____

Name and Title of Person Obtaining Consent: _____

Action Taken by Provider on Consent: _____
_____
_____

Section C: Authorization Use of E-mail

I authorize the use or discloser of my protected health information ("PHI") by the provider via E - mail. The provider is authorized to use or disclose my PHI via E-mail to the following people at the following E-mail address:

Name (please print)	**E-mail (please print)**
1._____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

I have been informed that if the person(s) listed above is not a health care provider, a health plan, or a health plan clearinghouse that they may disclose the PHI without obtaining my permission. Furthermore, I recognize that once the PHI is disclosed to the person(s) listed above, the provider can not control further disclosures by the person(s).

I understand that once an email is sent over the internet, third-parties may gain access to the contents of the email regardless of the level of security used by the provider and that the provider does not have any control or authority over who has access to the above-named recipient's computer and the level of security used by the above-name recipients.

I hereby release, discharge, and agree to indemnify and hold harmless People Inc. and its directors, officers, agents, employees, volunteers, and administrators from any and all liabilities, claims, demands, losses, damages, or costs (including, but not limited to, attorneys' fees and litigation expenses) arising out of or relating to this Authorization that I or anyone acting on behalf of me or Individual shall make.

I understand that I may revoke and/or modify this authorization at any time by sending a written notice to People Inc. to the following: **Corporate Compliance Officer, People Inc., 1219 North Forest Road, Williamsville, NY 14221**. I understand that such revocation or modification will become effective on the date that People Inc. receives the revocation or modification and will have no effect on the uses and/or disclosures made prior to that date. I understand that I am under no obligation to sign this form, but if I do sign it, I must be provided a copy of the signed form.

This authorization will be effective until revoked or modified in writing in accordance with the above paragraph or until such date that Individual no longer receives any services from provider.

I have been informed that I am under no obligation to sign this Authorization and that the provider will not condition services or treatment on my decision to sign this form. I have signed this form voluntarily.

I have had an opportunity to read and understand the contents of this Authorization, and my signature confirms that the Authorization accurately reflects my understandings and wishes.

Signature of Individual or Personal Representative _____

Date _____

Authority/Relationship of Personal Representative (if applicable)

_____

Elmwood Health Center

An affiliate of PeopleInc

Patient Policy for Cancellations and "No-Show" Appointments

Cancellation of an Appointment

In order to be respectful of the medical needs of other, please be polite and call the Elmwood Health Center right away if you are not able to keep your appointment. Your appointment time will be used for another patient who is in need of care.

If you must cancel a scheduled appointment, we require that you call The Elmwood Health Center at least of twenty-four (24) hours ahead of the scheduled appointment time. Late cancellations of less than twenty-four (24) hours will be considered a "no-show".

No-Show Policy

A "no-show" is someone who misses an appointment without cancelling it twenty-four (24) hours ahead of time.

IN THE CASE OF A NO-SHOW FOR THE FIRST APPOINTMENT, ANOTHER APPOINTMENT WILL NOT BE SCHEDULED FOR THE PATIENT AT ELMWOOD HEALTH CENTER.

For established patients, three (3) "no-shows" will cause the patient to be discharged from The Elmwood Health Center. In those cases, a letter will be sent to the patient giving them 30 days notice of the discharge.

Your signature below shows that you understand and will follow this policy.

Patient Name (Print):_____DOB:_____

Patient Signature:_____Date:_____

Witness:_____ Date:_____

(For office use only)

People Inc. and Affiliates

Authorization for Release of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, the Provider may not use or disclose your Protected Health Information except as provided in our Notice of Privacy Practices without your authorization. The Provider maintains your Protected Health Information in your record that includes information that we generate as well as information received from other providers involved in your care. Your signature of this form indicates that you are giving permission for the uses and disclosures of your Protected Health Information described below. This authorization may include disclosure of information relating to Alcohol and Drug Abuse and Mental Health information, except psychotherapy notes, and only if the boxes below are initialed by you. If authorizing release of this information, the recipient is prohibited from re-disclosing such information unless permitted to do so under federal or state law. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to Corporate Compliance Officer, 1219 North Forest Rd, Williamsville, NY 14221.

Individual Name:	Date of Birth
Individual Address:	
Release this information TO: Elmwood Health Center	Release this information FROM
Address to send information TO: 2128 Elmwood Avenue Buffalo, New York 14207	Address information sent FROM:

Information to be released (check all that apply):

□ Respond to all requests for confidential information about me made by the person listed above contained with my medical record

□ Records dated (enter start date): ___/___/_____ to (enter end date) ___/___/_____

□ Specific Medical Records or other protected health information:_____

_____

Include (Indicate by initialing): _____ Alcohol/Drug Treatment _____ Mental Health Information

NOTE: HIV-Related information is only released through a DOH approved HIV release of information form. Psychotherapy notes are only released through a specific psychotherapy note release of information form.

Reason for release of information:	Date or event on which the authorization will expire:
□ Requested by the individual named above to have the information □ Other:_____	Beginning date:_____ End date or event:_____ Enter "until revoked" if an end date cannot be determined

*I understand that the provider cannot guarantee that the recipient of the information will not re-disclose to additional parties if the recipient described on this form is not required by law to protect the privacy of the information.

*I understand that I may revoke this authorization at any time by signing the revocation section of my copy and returning it to Corporate Compliance Officer, 1219 North Forest Rd, Williamsville, NY 14221. I understand that the revocation does not apply to information already released as per this authorization.

*I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or receive services at the Provider unless: a. I am participating in clinical research and I am receiving research related treatment or b. If I am requesting an examination only for purposes of sending information about my health status to a third party such as an employer.

*I understand that I will get a copy of this form after I have signed it.

Individual or Personal Representative Signature:	Date Signed:
Print Name of Individual or Personal Representative:	Description of Personal Representative's Authority:
Address of the Personal Representative who signed this form (Required):	Telephone of the Personal Representative who signed this form (Required)::

For Provider Use Only

Date Provider Obtained Authorization:	Name and Title of Person Obtaining Authorization:
Action Taken by Provider on Authorization:	

Revocation Section

(To be completed and returned to Corporate Compliance Officer, 1219 North Forest Rd, Williamsville, NY 14221)

I hereby revoke this authorization Signature:	Date Signed:
Date Provider Received Request to Revoke Authorization:	Name and Title of Person Handling Request to Revoke Authorization:
Action Taken by Provider on Revocation:	

Elmwood Health Center

An affiliate of PeopleInc

Patient Responsibilities

The patient (or his/her parents, guardian, or surrogate) is responsible:

1) To provide a complete and correct medical history including past illnesses, hospitalizations, medications, family history of illness and any other concerns relating to your present health.

2) To report any sudden problem or change in your condition to the nurses or medical staff in the health center.

3) To provide a copy of your Healthcare Proxy or Living Will (advanced directive), if you have one, to the Elmwood Health Center.

4) To commit to your own wellness by discussing and joining in your treatment plan with your provider. Ask questions if you do not understand what your nurse or doctor is saying. This is for all tests, procedures, medications and treatment plans. Once agreed upon, follow the treatment plan carefully.

5) To respect of the property of other persons and the property of this facility. **Verbal or physical threats of any nature will not be tolerated** and may result in all services being terminated.

6) To keep all scheduled appointments or give 24 hour notice to change or cancel an appointment. If 24 hour notice is not given, the appointment will be considered a "NO-SHOW". A pattern of "NO SHOW" appointments will result in discharge from the Elmwood Health Center.

NOTE: The Elmwood Health Center is not a walk-in clinic and all visits are by appointment only.

7) To pay close attention to your medication(s) and give the health center at least 3 – 5 business days to process refills. Refill requests **must** begin with the patient's pharmacy or patient's portal. If a refill request requires a prior authorization that can take up to thirty (30) days to complete depending on insurance carrier.

8) To notify the Elmwood Health Center of any change in your address, telephone number, emergency contact, or health insurance information.

9) To notify staff of any complaint or concern about your care or treatment.

10) To pay your financial debt to the Health Center promptly.

Elmwood Health Center

An affiliate of PeopleInc

Patients' Bill of Rights

As a patient of the Elmwood Health Center located in New York State, you have the right, consistent with law, to:

(a) receive service(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or sponsor;
(b) be treated with consideration, respect, and dignity including privacy in treatment;
(c) be informed of the services available at the center;
(d) be informed of the provisions for off-hour emergency coverage;
(e) be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care;
(f) receive an itemized copy of his/her account statement, upon request;
(g) obtain from his/her healthcare practitioner, or the practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand;
(h) receive from his/her practitioner information necessary to give informed consent prior to the start of any nonemergency procedure or treatment or both. An informed consent shall include, at minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision;
(i) refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action;
(j) refuse to participate in experimental research;
(k) voice grievances and recommend changes in policies and services to the center's staff, the operator, and the New York State Department of Health without fear of reprisal;
(l) express complaints about the care and services provided and to have the center investigate such complaints. The center is responsible for providing the patient or his/her designee with a written response within 30 days, if requested by the patient, indicating the findings of the investigation. The center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the response, the patient may complain to the New York State Department of Health's Office of Health Systems Management;
(m) privacy and confidentiality of all information pertaining to the patient's treatment
(n) approve or refuse the release or disclosure of the contents of his/her medical record to any healthcare practitioner and/or healthcare facility except as required by law or third party payment contract;
(o) access his/her medical record pursuant to the provisions of section 18 of the Public Health Law, and Subpart 50-3 of this title;
(p) authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors; and
(q) make known your wishes in regard to anatomical gifts. You may document your wishes in your healthcare proxy on a donor card, available from the center.