HASC Diagnostic and Treatment Center
Blanche Kahn Family Health Center
1221 East 14th Street
Brooklyn, NY 11230
718-434-4600
718-434-6261

Welcome to the Blanche Kahn Family Health Center! The following is a list of what the Blanche Kahn Family Health Center requires **before** any appointments are made for a Doctor or Therapist:

A) Immunization records (if the patient is under 18 years old)
B) Any previous evaluation(s) that are pertinent
C) Copies of all your insurance cards
D) Filled out and signed registration packet
E) Proof of current PPD and Physical (if not being performed upon first visit)

For **Psychiatry:**

A) A-E from above
B) Psychosocial Evaluation
C) Psychological Evaluation
D) IF available: Neurological Evaluation, Results of head CT or MRI
E) - MAR Medication sheets for the current month (Not a list of meds) - **If Patient resides in an IRA/ICF**
F) If a patient is using medications for which blood level can be drawn, please do so prior to the initial evaluation, unless a recent (within the past 3 months) one is available. These blood levels include:
    a. Lithium
    b. Valproic Acid (Depakote, Depakene)
    c. Carbamazepine (Tegretol, Equetro)
    d. Dilantin
G) Current lab results. If current labs (within the past 3 months) are not available, **prior** to scheduling an appointment, have the client's MD obtain the following, so that the results will be available at the time of the appointment:
    a. CMP with lipid panel
    b. CBC with diff
    c. T3,T4,TSH
    d. U/A
    e. EKG (if client is over 45 or has a known cardiac problem)

Please check which service(s) you are requesting:

❑ Primary Care
❑ Women's Health (GYN)
❑ Psychiatry
❑ Neurology
❑ Endocrinology
❑ Dermatology
❑ Podiatry

Please mail these documents to the above address, Attn Tzipi or you can fax it to 718-535-2078. If you have any questions please call us at 718-535-1958. Once we have received all of the above, we will be happy to schedule an appointment for you. Your cooperation is appreciated and we look forward to serving you.

Welcome to the BLANCHE KAHN FAMILY HEALTH CENTER

(Please save this information for future reference)

BKFHC Hours and Availability of Emergency Services

The BKFHC is located at 1221 East 14th Street, Brooklyn, NY. The phone number is (718) 535-1956.

BKFHC is open: From 8:30 a.m. to 9:30 p.m. on Mondays & Thursdays
From 9:00 a.m. to 5:00 p.m. on Tuesdays
From 9:00 a.m. to 6:00 p.m. on Wednesdays
From 9:00a.m. to1:00 p.m. on Fridays
Sundays and Holidays by appointment only

Please note that we are a non-emergency center. After-hours and on holidays, messages may be left on the answering machines.

If an EMERGENCY arises please call your Primary Care Physician or utilize the appropriate emergency services available in your area. For ambulance, fire, and/or police dial 911. If 911 is busy or does not answer, dial "0" (operator) and ask for help.

When Calling for an Emergency utilize the following guidelines:

1. Give the number of the phone from which you are calling.
2. Give the address as well as instructions for where and how to reach the victim.
3. Describe the victim's condition.
4. Give your name.
5. DO NOT HANG UP until instructed to do so. Wait for emergency service.

If you choose to utilize the Blanche Kahn Family Health Center as your Primary Care Provider, in the event of hospitalization to Maimonides Medical Center, upon admission you have the option of requesting Dr. Benjamin Lifshitz, our Medical Director, to follow you and apprise involved parties of the patient's condition throughout his/her hospital stay.

During severe weather conditions, such as winter storms, BKFHC may, on rare occasions, have to close to insure your safety as well as staff safety. During severe weather conditions, please call (718) 535-1920 before leaving home in order to make sure that BKFHC is open.

Patients Rights and Responsibilities

The policy governing the rights and responsibilities of all persons receiving services by BKFHC has been developed in accordance with federal, state, and local regulations. All patients have the right to understand and use these rights. If for any reason you do not understand or you need help the medical center MUST provide assistance including an interpreter.

While at BKFHC, you have certain **RIGHTS AND RESPONSIBILITIES**. They include:

I. All persons have the civil and legal rights to receive treatment without discrimination as to race, color, religion, sex, national origin, creed, age, ethnic background, sexual orientation, diagnosis, disability, developmental delay, or source of payment.

II. All persons receiving services through our Center shall be given consideration, respect and dignity regardless of race, color, religion, sex, national origin, creed, age, ethnic background, sexual orientation, developmental disability or other handicap, or health condition, such as being tested for or diagnosed as having an HIV infection.

a) Employees are expected to acknowledge and respect these rights and will receive information and training in those areas which affect and/or contribute to situations that may be in violation of the rights of a person and/or their parent(s), guardian(s) and /or collaterals.
b) No employee may violate a person's rights for disciplinary purposes, for retribution or for reasons of convenience.

III. As a patient you have the right to complain without fear of reprisal about the care and services you are receiving, and to have the staff respond to you with a written response. If you are not satisfied with the response you may complain to the New York State Health Department at 1-800-804-5447.

a) All persons and their parents, guardian(s) and/or collateral have the right to express without fear or reprisal, grievances, concerns and suggestions to BKFHC's executive officers.

IV. As an individual served by The BKFHC , you are assured we will uphold your rights to the following:

a. The person receiving services and/or his/her legal guardian or collateral will be notified (whenever possible in their primary language) about the person's rights prior to or at the time of admission, and be advised about the due process procedures through which a person may question or appeal a given treatment prior to or at the time of admission.

b. The receipt of information on or prior to admission, regarding the services that BKFHC will provide or for which additional charges will be made, and timely notification of any changes thereafter.

c. A safe, sanitary and smoke free environment.

d. Receive emergency care if you need it.

e. Freedom from physical, verbal, psychological, sexual abuse.

f. Freedom from discrimination, abuse or any adverse reaction based on one's status as one who is the subject of an HIV related test or who has been diagnosed as having HIV infection, AIDS or HIV related illness.

g. Freedom from unnecessary use of restraining devises and unnecessary or excessive medication, except if authorized in writing by a physician for a specific period of time and a specified reason.

h. Be treated with consideration, dignity, respect and full recognition of individuality, including privacy in treatment and in meeting personal care needs.

i. The confidentiality with regard to all information contained in the person's record. Access to records is available only to authorized staff and legally responsible parents and/or guardians. Release of information to persons not authorized under the law to receive it will be done only with the written consent of the person and/or legal guardian.

j. To review your medical records without charge, and to receive an itemized bill and explanation of charges if you request it.

k. Protection from commercial or other exploitation.

l. Right to treatment or therapies (which by law or regulation require the written order of a professional) by staff practicing in accordance with, or within the scope of their professional license.

m. Right to treatment or therapies by staff who are trained to administer services adequately, skillfully and humanely with full respect for your dignity.

n. Right to be informed of the name and position of the doctor or therapist who will be providing service to you, as well as the names positions and functions of any staff involved in your care.

o. Receive all the information that you need to give informed consent for any proposed procedure or treatment that requires informed consent. This information shall include the possible risks and benefits of the procedure or treatment.
    1. When requested, you will receive all the information you need to give informed consent for an order not to resuscitate/ health care proxy. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Do Not Resuscitate Orders – A Guide for Patients and Families."

p. Receive complete information about your diagnosis, treatment and prognosis.

q. To refuse treatment, examination or observation by any staff involved in your care and be told what effect this may have on your health.

r. The opportunity to participate in all decisions about your treatment. Such rights include:
    - The opportunity to participate in the development and modification of a written individualized Treatment Plan, unless constrained by the person's ability to do so;
    - The opportunity to object to any provision within an individualized Treatment Plan, and the opportunity to appeal any decision made in relation to his or her objection to the plan with which the person disagrees and;
    - The provision for meaningful and productive activities within the person's capacity, although some risk may be involved, and which take into account his or her interest.

V. No person and/or his/her family will be used as subjects for research without the prior approval of the Research Review Committee and the written informed consent of the person and/or his/her guardian.

VI. All persons will be transferred and/or discharged from BKFHC when such action is the most appropriate clinical/medical decision.

VII. Information concerning individuals receiving services may be exchanged as necessary among OPWDD-operated facilities, voluntary-operated facilities and others providing services to the individual pursuant to a local or unified services plan (insofar as such disclosures are made for the purposes of that program's need to exercise its statutory functions).

Each individual has the responsibility to:

- Attend scheduled appointments regularly and avoid unnecessary absences. Three (3) or more consecutive non-substantiated absences will result in an administrative intervention;
- Notify the center when unable to attend due to illness or any other situation.
- Notify the center if you are running late for an appointment.
- Provide the center with information on health coverage (changes with Medicaid, Medicare or Private Insurance).
- Respect the rights and property of others and treat property with care and regard.
- Come to appointments free of illegal drugs and alcohol.
- Refrain from bringing dangerous objects or substances to the clinic.
- Refrain from smoking on the premises.
- Evacuate the building in an orderly fashion during an emergency.
- Enter and leave clinic appointments in a well-behaved, age appropriate manner.
- All persons have the responsibility to attend scheduled appointments regularly and avoid unnecessary absences

- Provide the center with updated Tuberculosis testing results.
- Provide the center with a diagnostic exams, assessments, reports and/or special studies including findings and conclusions relevant to your treatment.
- Know your rights and speak up when your rights are violated.

Attendance Agreement

If you will not be able to make your scheduled appointment, please notify us at least 24 hours before your scheduled appointment time. Individuals who cancel appointments repeatedly or who do not show up for more than three consecutive appointments may lose their scheduled appointment times, be terminated from services and/or referred to another center.

Grievance Procedure

While at BKFHC, if you have a **Grievance**, below is the procedure that should be followed:

Any Objection(s), Problem(s) or concern(s) should be brought to the attention of your Treating Clinician. If your Clinician cannot resolve your concern and/or issue, the problem should be addressed to the Clinic Administrator. Documentation of this discussion will be included in the individual's record. The Clinic Administrator will respond to all grievances, in writing, within 10 working days. If the issue remains unresolved and the Clinic Administrator was not able to resolve your concern or if the resolution is not to your satisfaction, you may appeal to the Clinic Director. A review and a response to your concern will take place within 5 days.

BKFHC Grievance Procedure is an upward-directed process. We are committed to resolve disputes at the most appropriate level. Generally, objections or concerns should be addressed to the appropriate treating professional for resolution. However, if the nature of the concern does not lend itself to discussion at this level, you and/or your parent, guardian or correspondent may express your concern to any of the following BKFHC staff members:

PRACTICE MANAGER: Shaina Rosenfeld
1221 East 14th Street
Brooklyn, NY 11230
(718) 535-1972

MEDICAL DIRECTOR: Dr Benjamin Lifshitz
1221 East 14th Street
Brooklyn, NY 11230
(718) 535-1970

CLINIC DIRECTOR: Dr. Wakslak, Ph.D
1221 East 14th Street
Brooklyn, NY 11230
(718) 535-1942 cell: (646) 285-5301

EXECUTIVE DIRECTOR: Samuel Kahn
5601 1st Avenue
Brooklyn, NY 11220
(718) 745-7575 cell: (646) 285-5300

If all of the above mentioned efforts fail, we will assist you in directing you to the following individuals and offices:

New York STATE DEPARTMENT OF HEALTH'S REGIONAL OFFICE
New York City Office
90 Church Street - 15th Floor

New York, NY 10007-2919
(212) 417-5550

Statement of Financial Agreement

BKFHC will bill Medicare and/or Medicaid for services rendered to individuals eligible for coverage. A sliding fee, based on family income and family size, will be applied to individuals who are uninsured; have exhausted their insurance benefits; have their coverage terminated; denied coverage by their own insurance company or receive services not covered by their insurance company.

I. I understand that my health insurance plan and/or I will be billed for services provided by BKFHC .

II. I agree to assist BKFHC in securing any third party insurance payment for services which I have received.

III. I agree to provide BKFHC with current insurance information to assist in collecting payment for services provided.

IV. I agree to endorse to BKFHC any checks received directly from my insurance carrier and forward them along with a copy of all related paperwork to the clinic.

V. I agree to update BKFHC should any insurance information change.

VI. I understand that if I do not have insurance I will be charged for services based upon BKFHC 's published sliding scale fee.

VII. I understand that I will be responsible for any co-payment or balance if my insurance does not cover the full amount billed.

VIII. I authorize BKFHC to release to my health insurer any information needed to process claims for service provided.

While at BKFHC, you may be assigned a Treatment Coordinator. The Treatment Coordinator's role is internal to the clinic itself and is separate and distinct from any external case management services you may be receiving.
Your Treatment Coordinator will coordinate the provision of all treatments and therapies as prescribed. Your Treatment Coordinator may check on maintenance of appointment, obtain information to address recipient questions, transmit information to the referral source, outside case manager or other appropriate parties. Your Treatment Coordinator will also review your clinical record to ensure compliance with regulations and evaluate your satisfaction with services. Your Treatment Coordinator functions as the liaison between you, your clinician and outside providers. Please do not hesitate to contact your Treatment Coordinator or other liaison with any questions, concerns or comments.

Your Treatment Coordinator is: _____. He/she can be reached at:
1221 East 14th Street, Brooklyn, NY 11230. Phone #: (718)535-1958, Fax #: (718)434-6261.

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.

If you have any questions about this Notice, please contact our Privacy Officer who is Shaindy Itzkowitz, c/o Blanche Kahn Family Health Center. Phone: 718-535-1978
E-mail: sitzkowitz@HASCCenter.org

We understand that health information about you is personal. We are committed to protecting health information about you. We need to maintain certain information about you to provide you with quality services and comply with law and regulation. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition, related health care services and payment for those services.

We are required to abide by the terms of this Notice of Privacy Practices. We are also required to notify you following a breach of unsecured health information. We may change the contents of our notice, at any time. The new notice will be effective for all protected health information that we maintain. You may obtain any revised Notice of Privacy Practices by accessing our website http://www.bkhealthcenter.org , calling us and requesting that a revised copy be sent to you or asking for one when meeting with staff. We will promptly revise and make available this Notice whenever there is a material change to the uses or disclosures, your rights related thereto, our legal duties, or other privacy practices stated in this Notice.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by The Blanche Kahn Family Health Center staff to sign a consent form. This document includes consent to the use and disclosure of your protected health information for treatment, payment and health care operations purposes, as described in this Section 1. Your protected health information may be used and disclosed by our staff and those outside of our agency that are involved in your care and treatment for the purpose of providing services to you. Your protected health information may also be used and disclosed to bill your insurance and to support the operation of The Blanche Kahn Family Health Center.

Following are examples of the types of uses and disclosures of your protected health care information that The Blanche Kahn Family Health Center is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our Agency.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your services. This includes the coordination or management of your services with a third party that has already obtained your permission to have access to your protected health information, such as another service provider. For example, we might disclose your protected health information, as necessary, to a physician that provides care to you or to your Medicaid Service Coordinator.

Payment: Your protected health information will be used, as needed, to obtain payment for services that we provide to you, such as: making a determination of eligibility or coverage for insurance benefits, and undertaking utilization review activities. For example, obtaining services may require that your relevant protected health information be disclosed to the health plan to obtain approval for The Blanche Kahn Family Health Center services. In addition, bills may be sent to you or third party payers, such as insurance companies or health plans. The information on the bill may contain information that identifies you, your diagnosis and services provided.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of The Blanche Kahn Family Health Center These activities include, but are not limited to, quality assessment activities, employee review activities, training of health professionals and students, licensing, and conducting or arranging for other business activities. For example, we may use your information to evaluate the performance of staff involved in your care, to assess the quality of care you receive, and to learn how to improve our services.

We will share your protected health information with third party "business associates" that perform various activities for The Blanche Kahn Family Health Center. Whenever an arrangement between our Agency and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose certain information about you in order to contact you for fundraising activities supported by The Blanche Kahn Family Health Center You have the right to opt out of receiving these materials. If you or your family does not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Certain uses and disclosures require your authorization. An authorization is required, with certain exceptions, for any use or disclosure of your protected health information for marketing purposes or for purposes involving the sale of your protected health information. Also, a specific authorization is required for the release of HIV/AIDS, mental health, and psychotherapy notes and information.

Except as described in this Notice, uses and disclosures will be made with your written authorization. You may revoke such authorization, at any time, in writing, except to the extent that The Blanche Kahn Family Health Center has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. In this regard, we will ask you to provide us with the names of persons to whom we may speak. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or passing. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, tract products; to enable product recalls; to make repairs or replacements, or to conduct post-marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request or other lawful process. Special rules apply for HIV/AIDS information and mental health information.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and as otherwise required by law, (2) limited information requests for identification and location purposes, (3) disclosures pertaining to victims of a crime, (4) where there is suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of The Blanche Kahn Family Health Center and (6) medical emergency (not on The Blanche Kahn Family Health Center 's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donations purposes.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorize federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or other legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 *et. seq.*

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for as long as we maintain the protected health information.

We may charge a reasonable, cost-based fee for the costs of copying, mailing or other supplies associated with your request, up to $0.75 per page for copied records. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access, you may request that the denial be reviewed by The Blanche Kahn Family Health Center and/or the New York State Office of Mental Health. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The Blanche Kahn Family Health Center is not required to agree to a restriction that you may request, except we must agree to your request to restrict the information we provide to your health plan if the disclosure is not required by law and the information relates to health care being paid in full by someone other than the health plan. If The Blanche Kahn Family Health Center believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If The Blanche Kahn Family Health Center does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by contacting our Privacy Officer in writing.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have The Blanche Kahn Family Health Center amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, pursuant to your request, or for notification purposes.

You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice electronically.

Other Uses of Health Information: Certain releases of health information may be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by contacting the Office for Civil Rights, U.S. Department of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza - Suite 3312, New York, NY 10278; Phone (800) 368-1019. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Shaindy Itzkowitz, at 718-535-1978 for further information about the complaint process.

This Notice was published and becomes effective on **8/1/2017**..

REFERRAL INFORMATION FORM

For scheduling please contact: _____ **Phone:** _____

Date of Referral: _____

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____ E-mail: _____

Would you like to receive Appointment Reminder Phone Calls or Texts? ❑ Yes ❑ No Which do you prefer? ❑Call ❑Text

Preferred Time to Call/Text? _____AM / PM

Preferred Phone Number to receive Reminder Phone Call? _____

Marital Status: _____

Race: ❑ White ❑ Black or African American ❑ Asian ❑ Native Hawaiian ❑ American Indian

Ethnicity: ❑ Hispanic ❑ Non-Hispanic Language Spoken: ❑ English ❑ Other: _____

Sexual Orientation: ❑ Straight ❑ Gay/Lesbian ❑ Bisexual ❑ Don't know ❑ Something Else ❑ Choose not to disclose

Gender Identity ❑ M ❑ F ❑ Transgender (M→F) ❑ Transgender (F→M) ❑ Other

Social Background ❑ Veteran ❑ Migrant ❑ Seasonal ❑ Homeless ❑ Public Housing ❑N/A

Medical Providers:

Primary Care Physician: _____ Phone #: _____

Medical Hx/ Diagnosis: _____

Allergies: _____ Special Alerts: _____

Insurance Information:

SS#: _____-_____-_____ Medicare #: _____ Medicaid #: _____

❑ No Insurance Other Insurance/Type: _____ Policy Holder: _____

Policy Number: _____ Group Number: _____

Employer: _____

Address: _____City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Pharmacy: _____

Address: _____City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Family and Guardian Information:

Spouse's Name (Last, First): _____ Cell #: _____

Father's Name (Last, First): _____ Cell #: _____

Mother's Name (Last, First): _____ Cell #: _____

Parents' Address: _____

Home Phone #: _____ Business #: _____ Cell #: _____

Guardian Name (if different from parents): _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: _____

Address: _____

Phone #: _____ Cell #: _____

Services Requested (Check all that apply):

❑ Primary Care ❑ Women's Health (GYN) ❑ Psychiatry ❑ Neurology ❑ Endocrinology
❑ Dermatology ❑ Podiatry

If applicable, please complete the following:

Primary Diagnosis: _____ Level of disability, if applicable _____

Type of Residence: ❑ Family ❑ ICF ❑ IRA ❑ Other: _____ Agency:_____

Residence Manager_____ Phone #: _____ Email: _____

Residence Nurse: _____ Phone #: _____ Email: _____

Residence Fax: _____

Case Manager: _____ Current ISP? ❑ Yes ❑ No

Agency: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____ E-mail: _____

Day program/Employer: _____ Is this a Day Treatment Program? ❑ Yes ❑ No

Address: _____City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____

Program Director: _____ Phone: _____ Email: _____

FOR OFFICE USE ONLY

This referral was received on _____ by _____

Patient Medical History Questionnaire

Patient Name: _____ Date: _____ / _____ / _____

Does the patient smoke? □ Yes □No □Unknown Each Day _____ How Long _____

Does the patient consume alcohol? □Yes □No □Unknown Each Day_____ How Long _____

Does the patient wear a hearing aid? □Yes □No □Unknown □ Right ear □ Left ear □ Both

Does the patient wear dentures? □Yes □No □Unknown □ Upper □ Lower □ Both

Does the patient wear a prosthetic device? □Yes □No □Unknown *Specify type: _____

Can the patient walk independently? □Yes □No
*If no, which device is needed? □Wheelchair □Walker □Crutches □Cane □Other _____

Does the patient wear glasses or contact lenses? □Yes □No □Unknown *Specify _____

Blurred Vision: □ Yes □ No □ Unknown Glaucoma □ Yes □ No □ Unknown
Cataracts: □ Yes □ No □ Unknown

Please check all that apply:

Heart:

High Blood Pressure:	□Yes	□No	□Unknown	Heart Problems:	□Yes	□No	□Unknown
Low Blood Pressure:	□Yes	□No	□Unknown	Rheumatic Fever:	□Yes	□No	□Unknown
Heart Attack:	□Yes	□No	□Unknown	Heart Murmur:	□Yes	□No	□Unknown
Chest Pains:	□Yes	□No	□Unknown	Chest Tightness:	□Yes	□No	□Unknown
Irregular Heartbeat:	□Yes	□No	□Unknown	Dizziness:	□Yes	□No	□Unknown

Lungs:

Lungs Problems	□Yes	□No	□Unknown				
Shortness of Breath:	□Yes	□No	□Unknown	Bronchitis:	□Yes	□No	□Unknown
Pneumonia:	□Yes	□No	□Unknown	Cough or Sputum:	□Yes	□No	□Unknown
Tuberculosis:	□Yes	□No	□Unknown	Asthma:	□Yes	□No	□Unknown

Gastrointestinal and Urinary Systems:

Difficulty chewing:	□Yes	□No	□Unknown	Difficulty swallowing:	□Yes	□No	□Unknown
Digestive Problems:	□Yes	□No	□Unknown	Chronic Diarrhea:	□Yes	□No	□Unknown
Ulcers:	□Yes	□No	□Unknown	Inflammation of Colon:	□Yes	□No	□Unknown
Stomach Inflammation:	□Yes	□No	□Unknown				

Unintentional weight change (10 lbs. or more) in last 3 months? □Yes □No □Unknown
*If "yes", pounds gained: _____ pounds lost: _____

Jaundice:	□Yes	□No	□Unknown	Hiatal Hernia:	□Yes	□No	□Unknown
Hepatitis:	□Yes	□No	□Unknown	Urinary Disorder:	□Yes	□No	□Unknown
Pancreatitis:	□Yes	□No	□Unknown	Kidney Stones:	□Yes	□No	□Unknown
Urinary Infections:	□Yes	□No	□Unknown				

Musculoskeletal System:

Musculoskeletal Problems: □Yes □No □Unknown Arthritis: □Yes □No □Unknown
Limited Joint Motion: □Yes □No □Unknown Fractures: □Yes □No □Unknown
Muscle Weakness: □Yes □No □Unknown

Neurological System:
Developmental Disability: □Yes □No □Unknown If yes, please specify: _____
Neurological Disorder: □Yes □No □Unknown Seizures: □Yes □No □Unknown
Head Injury with Fainting: □Yes □No □Unknown *Specify type: _____
Head Injury without Fainting: □Yes □No □Unknown Headaches: □Yes □No □Unknown
Numbness /Tingling of Extremities: □Yes □No □Unknown
Sleeping Trouble: □Yes □No □Unknown Drowsy: □Yes □No □Unknown
Hrs of sleep patient gets per night: _____ HRS

Endocrine System:
Endocrinology Disorder: □Yes □No □Unknown Thyroid: □Yes □No □Unknown
Diabetes: □Yes □No □Unknown Other: _____

Hematology:
Blood Disorder: □Yes □No □Unknown Sickle Cell: □Yes □No □Unknown
Anemia: □Yes □No □Unknown Blood Transfusions: □Yes □No □Unknown
Other: _____

Mental Health:
Behavioral Disorder: □Yes □No □Unknown Depression: □Yes □No □Unknown
Other: _____

Please check all Vaccinations received:
Measles: □Yes □No □Unknown Mumps: □Yes □No □Unknown
German Measles (rubella): □Yes □No □Unknown Chicken Pox: □Yes □No □Unknown

Ever been hospitalized? □Yes □No □Unknown *Specify when and why: _____

Ever had surgery? □Yes □No □Unknown *Specify when and why:_____

Patient's biological mother living? □Yes □No □Unknown *If deceased, cause of death: _____
Patient's biological father living? □Yes □No □Unknown *If deceased, cause of death: _____
History of illness in family? □Yes □No □Unknown *Specify when and why: _____

Women Only/ Men Only:
Last Gynecological Exam: _____ Last Mammogram: _____
Last Menstrual Period: _____ Last Prostate Exam: _____

Pediatric Patients Only:
Born Prematurely: □Yes □No □Unknown Breath-Holding Spells: □Yes □No □Unknown
History of Bradycardia: □Yes □No □Unknown

Completed by: _____ Date: _____/_____/_____
Relationship: _____

FOR PSYCHIATRY REFERRALS PLEASE COMPLETE THIS PAGE

Patient Name: _____ Date: _____ / _____ / _____

Does the patient have a history of ("x" all that apply)

□ Diabetes □Seizure D/O □Asthma □HTN □Allergies- Specify _____

Medical/Surgical History: _____

Internist's Name, Phone #, UPIN #, NYS License #: _____

Mobility:	□ walks independently	□ wheelchair	□ needs crutch, walker, etc.
Speech:	□ verbal	□ non-verbal	
Hearing:	□ totally deaf	□ partially deaf	□ uses hearing aid(s)
Sight:	□ blind	□ wears glasses	□ unimpaired sight
Toileting:	□ needs total assistance	□ needs some help	□ independent
	□ urinary incontinence	□ fecal incontinence	
Bathing:	□ needs total assistance	□ needs some help	□ independent
Dressing:	□ needs total assistance	□ needs some help	□ independent
Travel:	□ needs total assistance	□ needs some help	□ independent

Is the patient known to be/have: ("X" all that apply)

□ Down's Syndrome	□ Autism	□ post-op brain damage	□ s/p head trauma
□ Fragile X Syndrome	□ CP	□ Fecal-alcohol Syndrome	□ Prader-Willi
□ Meconium baby	□ Fecal Anoxia	□ Turner Syndrome	□ Kleinfelter Syndrome
□ Congenital Malformations	□ Other _____		

Does the patient have a history of: ("X" all that apply)

□ Psychiatric Hospitalization(s) If so, provide dates, places, reason for hospitalization(s):

_____

_____

_____

□ Self injurious behavior(s) Specify _____

□ Violence	□ Aggression toward others	□ Destruction of property
□ Suicide attempts or gestures	□ Running away	
□ Sexual Abuse / Rape	□Physical Abuse	Use of □ Cigs □ ETOH □ Drugs

Prescribed Medications

Are there any physical or medical limitations to the applicant's ability to participate in clinic activities? Explain:
_____ _____

Is there anything else about the applicant that we should know in order to provide the services you are requesting?
_____

Allergies and Reactions: _____

_____

MEDICATION LIST

Diagnosis	Medication	Dosage	Frequency

Name of person completing form: _____

Relationship to applicant: _____

Signature: _____

Date of Signature: _____

1. General Consent - Permission for Examination and Treatment

I hereby authorize The Blanche Kahn Medical Center/HASC Diagnostic and Treatment Center **(The Center)** and or its clinical departments or divisions, professional Medical Staff and Clinical Staff to provide medical & therapeutic care and to administer routine diagnostic evaluations, tests and procedures, including but not limited to: routine assessment and evaluations, the administration and or injection of pharmaceutical products, medications, the drawing of blood specimens as deemed necessary in the judgment of the clinic personnel and/or other services BKFHC physician(s)/therapists deem necessary or advisable in this patient's care.

2. **Acknowledgement of Receipt of Required Forms**

By signing below I acknowledge receipt of:

- ☐ **The Center's** Hours and Availability of Emergency Services
- ☐ Patient's Rights and Responsibilities
- ☐ Grievance Procedure
- ☐ Statement of Financial Agreement
- ☐ Assigned Treatment coordinator (when applicable)
- ☐ Notice of Privacy Practices

3. **Assignment of Insurance Benefits/Signature on File**

a. I understand that The Center will bill my health insurance for services provided.
b. I agree to assist The Center in securing any third party (insurance) payments for the services which I have received.
c. I agree to provide The Center with all current insurance information (i.e. Medicaid, Medicare and Commercial insurance forms and cards, etc.) to assist in collecting payment for services provided.
d. I agree to update The Center should any insurance information change.
e. I understand that I may be responsible for any copayment or balances if my insurance does not cover the full amount billed.
f. I understand that refusing to pay for services may result in being discharged from The Center and or referred to another facility.
g. I understand that should the account be referred to an attorney for collection, I shall be responsible, and agree, to pay all reasonable attorney fees and collection expenses.
h. I request that payment of authorized benefits be made on my behalf to The Center for services furnished to me by their providers. I authorize the release of any medical/therapy information about me to Medicare, Medicaid, and or my commercial insurance carrier to determine benefits or the benefits payable for related services.

4. **Authorization for Release of Information**. By signing below, I authorize **The Center** to release my health information: (1) to any requesting health care provider for my further diagnosis, care of treatment or for that provider's payment or health care operation purposes; (2) to any person or entity which may be responsible for billing/collection of claims for medical services or products; (3) to any person or entity which is, or may be liable to **The Center** or me for all or part of **The Center's** charges, including but not limited to, insurance companies, HMO or third party payors; (4) to any governments agency or other organization responsible for oversight of **The Center** or a third party payor; (5) for the Center normal health care operations. I authorize T**he Center** to allow the individuals listed above to access such information through any medium including over the Internet, reviewing hard records and through **The Center's** electronic medical record system. *Additionally,* By signing below I authorize the BKMC to acquire health record information from outside providers, caregivers, pharmacies, and databases in order to complete my medical record and allow for the most up to date and accurate information. Specifically, I allow the BKMC to extract my external RX history into my medical record.

I have carefully read and fully understand this informed consent form and have had all my questions answered.

Print Patient Name		Date
Patient Signature		Signature of Parent / Legal Guardian / Representative (Please circle one and print name next to signature)

Health Care Proxy Directives

I, _____ (Please print name), acting as;

☐ **Patient** ☐ **Legal Guardian**
☐ **Patient's Representative** ☐ **Relative (check appropriate designation)**

do hereby acknowledge that I have been offered the opportunity to discuss and ask any questions about the following information:

- The description of state law prepared by the Department of Health entitled "Planning In Advance For Your Medical Treatment" a The document prepared by the Department of Health entitled, "Appointing Your Health Care Agent-New York State's Proxy Law"
- A document entitled, "About The Health Care Proxy"
- A sample, "Health Care Proxy"

I further attest that I have informed **The Center** of the existence, if any, of instructions pertaining to Advance Directives, Living Wills, DNR Orders, Health Care Proxy, or other forms of an expression of patient self-determination, I have, and or will provide a copy of the duly executed instrument and acknowledge that said copy will become a part of the patient medical record.

I have an Advance Directive: ☐ YES ☐ NO Type:_____

I understand and acknowledge that it is the responsibility of the patient, or his I her representative, to inform **The Center** immediately, of any change in the conditions of the above mentioned expression of patient self-determination.

Print Patient Name	Date
Patient Signature	Signature of Parent / Legal Guardian / Representative (Please circle one and print name next to signature)