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 Effective Date: April 15, 2003

This notice describes how medical information about our consumers may be used & disclosed, & how our consumers, their guardians & / or their personal representatives, can get access to this information. Guardians & personal representatives should be aware that the word "you" in this notice refers to the consumer, not to the guardian. Please review it carefully. We are committed to protecting the privacy of you & your family, & sharing information about you only with those who need to know & who are permitted by law to receive this information. We are required by both federal & state law protect the privacy &

confidentiality of mental hygiene information that may reveal your identity, & to provide you with a copy of this notice which describes the clinical information privacy practices of our agency, its staff, & affiliated service providers that jointly provide services for you. A copy of our current notice will always be posted in our reception area. You will also be able to obtain a copy by calling our office at 718 434 4600, or asking for one at the time of your next visit. *If you have any questions about this notice or would like further information, please contact* Avi Sacks, Director of Quality Assurance *at 718 535 1947, or write to 1221 E. 14th Street, Brooklyn, NY 11230.*

Confidentiality Of Mental Hygiene Information

Clinical information about you may be used by our agency (or its business associates) in connection with our duties to provide you with treatment, to obtain payment for that treatment[1], or to conduct our agency's business operations. We will not disclose clinical information about you **without your consent** or written authorization**,** except for the following purposes:

- When we are communicating with other agencies which are currently providing services to you, or working with us to plan for services for you, if this communication is about treatment, payment[2], or agency operations[3].
- To a personal representative who is authorized to make health care decisions on your behalf;
- To government agencies or private insurance companies in order to obtain payment for services we provided to you;
- To comply with a court order;
- To appropriate persons who are able to avert a serious & imminent threat to the health or safety of you or another person;
- To appropriate government authorities to locate a missing person or conduct a criminal investigation as permitted under Federal & State confidentiality laws;
- To other licensed agency emergency services as permitted under Federal & State confidentiality laws;
- To an attorney representing you in an involuntary hospitalization or medication proceeding. (We will not disclose clinical information about you to an attorney for any other reason without your authorization, unless we are ordered to do so by a court.)
- To authorized government officials for the purpose of monitoring or evaluating the quality of care provided by the agency or its staff;
- To qualified researchers when such research poses minimal risk to your privacy;
- To coroners & medical examiners to determine cause of death; &
- If you are an inmate, to your correctional facility if they certify that the information is necessary in order to provide you with health care, or to protect the health or safety of you or any other persons at the correctional facility.

Funeral Directors; In the event of your death, we may release this information to funeral directors as necessary to carry out their duties. *Organ & Tissue Donation*; In the event of your death, we may disclose your health information to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is appropriate & possible under applicable laws. Your organs & / or tissue would not be used for transplant without written consent by a legally authorized person. *Emergencies or Public Need*; we may use or disclose clinical information about you in an emergency or for important public needs. For example, we may share your information with public health officials at the New York State or City Health Departments who are authorized to investigate & control the spread of diseases. We may use or disclose clinical information about you if we have removed any information that might reveal who you are.

As Required By Law; We may use or disclose your clinical information if we are required by law to do so, or if a court orders us to do so in a lawsuit or judicial proceeding. We also will notify you of these uses & disclosures if notice is required by law.

- *Victims of Abuse, Neglect or Domestic Violence;* We may release clinical information about you to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence. For example, we may report your information to government officials if we reasonably believe that you have been a victim of abuse, neglect or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.
- *National Security & Intelligence Activities or Protective Services;* We may disclose clinical information about you to authorized federal officials who are conducting national security & intelligence activities or providing protective services to the President or other important officials.

If you do not object, we may disclose information about you in the following situations:

- *Disclosure to Friends & Family Involved in Your Care.* We will ask you whether you have any objection to sharing clinical information about you with your friends & family involved in your care.
- *Agency Director;* If & when BKFHC creates an agency directory, we will ask you whether you have any objection to including information about you in our Agency Directory.
- *Facility Directory;* If & when BKFHC creates a facility directory, unless you object, we will include your name, your location in our facility & your general condition in the directory while you are a consumer at our facility. This directory information, except for your religious affiliation, may be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if he or she doesn't ask for you by name.

Special Situations

- *Fundraising;* We may use demographic information about you (such as your age, gender, where you live or work, & the dates that you received services) in order to contact you to raise money to help us operate. We may also share this information with a charitable foundation that will contact you to raise money on our behalf. If you do not want to be contacted for these fundraising efforts, please write to QA, 1221 E.14th Street, Brooklyn, NY 11230.
- *Research;* In most cases, we will ask for your written authorization before using clinical information about you or sharing it with others in order to conduct research. However, under some circumstances, we may use & disclose your clinical information without your authorization if we obtain

[1] Treatment means that we may share clinical information about you inside our agency, or with another agency, to plan for & provide services for you. If you agree, we may also share information about you with others outside service system when necessary to provide other services; for example, we may disclose certain information about you to a prospective employer in connection with a job placement or training program.

[2] Payment means that we may use clinical information about you, or share it with others, so that we obtain payment for your services

[3] Operations means that we may use clinical information about you, or share it with others, in order to conduct our normal business operations. For example, we may use clinical information about you to evaluate the performance of our staff in providing services to you, or to educate our staff on how to improve the care they provide for you.

approval through a special process to ensure that research without your authorization poses minimal risk to your privacy, or if we do not allow researchers to use your name or identity publicly, or to people who are preparing a future research project, so long as any information identifying you does not leave our facility. In the unfortunate event of your death, we may share your clinical information with people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you.

What Information Is Protected

We are committed to protecting the privacy of clinical information we gather about you while providing services. Some examples of protected clinical information are:

- If you are a participant at, or receiving services from, our agency, information about your condition, information about health care products or services you have received or may receive in the future (such as a medication or equipment), or information about your health care benefits under an insurance plan (such as whether a prescription is covered).
- Geographic & demographic information (such as where you live or work & your race, gender, or ethnicity)
- Unique numbers that may identify you (such as your social security number, your phone number, or your Medicaid number); & other types of information that may identify who you are.

Incidental Disclosures. While we will take reasonable steps to safeguard the privacy of your information, certain disclosures of your information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your information. For example, during the course of a treatment session, other consumers in the treatment area may see, or overhear discussion of, your information.

What Rights Do You Have

How to Access Your Clinical Information. You generally have the right to inspect & copy your clinical information. For more information, please see later in this notice. See (1) under the section below titled *"Your Rights"*.

How to Correct Your Clinical Information. You have the right to request that we amend your clinical information if you believe it is inaccurate or incomplete. For more information, please see later in this notice. See (2) under the section below titled *"Your Rights"*.

How to Keep Track of the Ways Your Health Information Has Been Shared with Others. You have the right to receive a list from us, called an "accounting list," which provides information about when & how we have disclosed clinical information about you to outside persons or organizations. Many routine disclosures we make will not be included on this accounting list, but the accounting list will identify non-routine disclosures of your information. For more information, please see later in this notice. See (3) under the section below titled *"Your Rights"*.

How to Request Additional Privacy Protections. You have the right to request further restrictions on the way we use clinical information about you or share it with others. We are not required to agree to the restriction you request, but if we do, we will be bound by our agreement. For more information, please see (4) under the section below titled *"Your Rights"*.

How to Request More Confidential Communications. You have the right to request that we contact you in a way that is more confidential for you, such as at home instead of at work. We will try to accommodate all reasonable requests. For more information, please see later in this notice. See (5) under the section below titled *"Your Rights"*.

How Someone May Act On Your Behalf. You have the right to name a personal representative who may act on your behalf to control the privacy of your clinical information. Parents & guardians will generally have the right to control the privacy of clinical information about minors unless the minors are permitted by law to act on their own behalf.

How to Learn About Special Protections For HIV, Alcohol & Substance Abuse, & Genetic Information. Special privacy protections apply to HIV-related information, alcohol & substance abuse treatment information, & genetic information. Some parts of this general Notice of Privacy Practices may not apply to these types of information. If your clinical records include this type of information, you will be provided with separate notices explaining how the information will be protected. To request copies of these other notices now, please contact QA at 718 535 1973.

How to Obtain a Copy of This Notice. You have the right to a paper copy of this notice. You may request a paper copy at any time, even if you have previously agreed to receive this notice electronically. To do so, please call contact us. You may also obtain a copy by requesting a copy at your next visit.

How to Obtain a Copy of Revised Notice. We may change our privacy practices from time to time. If we do, we will revise this notice so you will have an accurate summary of our practices. The revised notice will apply to all of your clinical information, & we will be required by law to abide by its terms. We will post any revised notice in our agency reception area. You will also be able to obtain your own copy of the revised notice by calling our office, or asking for one at the time of your next visit. The effective date of the notice will always be noted in the top right corner of the first page.

How to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health & Human Services. To file a complaint with us, please contact QA. Please use the address listed above. No one will retaliate or take action against you for filing a complaint.

Language to be added for specific types of providers. A health care provider that is a component of the Department of Defense or Transportation; "Upon your separation or discharge from military service, we may disclose your health information to the Department of Veterans Affairs to determine if you are eligible for certain benefits." A health care provider that is a component of the Department of Veterans Affairs; "We may use your health information to determine whether you are eligible for certain benefits or disclose that information to the appropriate officials within the Department of Veterans Affairs to determine your eligibility for these benefits."

A health care provider that is a component of the Department of State**;** "We may use your health information to make certain medical suitability determinations authorized by law, or disclose that information to other appropriate officials within the Department of State to make these determinations."

How You Can Exercise Your Rights to Access, & Control Your Clinical Information

We want you to know that you have the following rights to access & control your clinical information. These rights are important because they will help you make sure that the clinical information we have about you is accurate. They may also help you control the way we use your information & share it with others, or the way we communicate with you about your medical matters.

1. **Right to Inspect & Copy Records:** You have the right to inspect & obtain a copy of any of any clinical information that may be used to make decisions about you & your treatment for as long as we maintain this information in our records. This includes medical & billing records. To inspect or obtain a copy of your clinical information, please submit your request in writing to QA. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. The standard fee is $0.75 per page & must generally be paid before or at the time we give the copies to you. We will respond to your request for inspection of records within 10 days. We ordinarily will respond to requests for copies within 30 days

if the information is located in our facility & within 60 days if it is located off-site at another facility. If we need additional time to respond to a request for copies, we will notify you in writing within the time frame above to explain the reason for the delay & when you can expect to have a final answer to your request. Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide you with a summary of the information instead. We will also provide a written notice that explains our reasons for providing only a summary, & a complete description of your rights to have that decision reviewed & how you can exercise those rights. The notice will also include information on how to file a complaint about these issues with us or with the Secretary of the Department of Health & Human Services. If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we cannot let you inspect or copy.

2. **Right to Request Amendment of Records:** If you believe that the clinical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept in our records. To request an amendment, please write to QA. Your request should include the reasons why you think we should make the amendment. Ordinarily we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay & when you can expect to have a final answer to your request. If we deny part or your entire request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records. For example, if you disagree with our decision, you will have an opportunity to submit a statement explaining your disagreement which we will include in your records. We will also include information on how to file a complaint with us or with the Secretary of the Department of Health & Human Services. These procedures will be explained in more detail in any written denial notice we send you.

3. **Right to An Accounting Of Disclosures:** After 04/14/03, you have a right to request an "accounting of disclosures" which is a list that contains certain information about how we have shared your information with others. An accounting list, however, will not include any information about:

- Disclosures we made to you, disclosures we made pursuant to your authorization, disclosures we made for treatment, payment or health care operations, disclosures made in the facility directory, disclosures made to your friends & family involved in your care or payment for your care, disclosures made to federal officials for national security & intelligence activities, disclosures that were incidental to permissible uses & disclosures of your clinical information, disclosures for purposes of research, public health or our normal business operations of limited portions of your clinical information that do not directly identify you.
- Disclosures about inmates to correctional institutions or law enforcement officers;

To request this accounting list, please write to QA. Your request must state a time period within the past 6 years (but after 04/14/03) for the disclosures you want us to include. For example, you may request a list of the disclosures that we made between 01/01/04 & 01/01/05. You have a right to receive one accounting list within every 12 month period for free. However, we may charge you for the cost of providing any additional accounting list in that same 12 month period. We will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred. Ordinarily we will respond to your request for an accounting list within 60 days. If we need additional time to prepare the accounting list you have requested, we will notify you in writing about the reason for the delay & the date when you can expect to receive the accounting list. In rare cases, we may have to delay providing you with the accounting list without notifying you because a law enforcement official or government agency has asked us to do so.

4. **Right to Request Additional Privacy Protections:** You have the right to request that we further restrict the way we use & disclose your clinical information to treat your condition, collect payment for that treatment, or run our agency's normal business operations. You may also request that we limit how we disclose information about you to family or friends involved in your care. For example, you could request that we not disclose information about a surgery you had. To request restrictions, please write to QA. Your request should include (1) what information you want to limit; (2) whether you want to limit how we use the information, how we share it with others, or both; & (3) to whom you want the limits to apply. We are not required to agree to your request for a restriction, & in some cases the restriction you request may not be permitted under law. However, if we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law. Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so; in other cases, we will need your permission before we can revoke the restriction.

5. **Right to Request Confidential Communications**

You have the right to request that we communicate with you about your medical matters in a more confidential way by requesting that we communicated with you by alternative means or at alternative locations. For example, you may ask that we contact you by fax instead of by mail, or at work instead of at home. To request more confidential communications, please write to QA. We will not ask you the reason for your request, & we will try to accommodate all reasonable requests. Please specify in your request how or where you wish to be contacted, & how payment for your health care will be handled if we communicate with you through this alternative method or location.

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)