REGISTRATION FORM

Today's Date: ______________________________

DEMOGRAPHIC INFORMATION				
Patient Name: Last	First	Middle	◯ Mr. ◯ Miss ◯ Mrs. ◯ Ms.	Marital Status ◯ Sing ◯ Mar ◯ Div ◯ Sep ◯ Wid

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

Street Address	P.O. Box or Apt #	Home Phone #	Cell Phone #

City	State	Zip Code	Social Security #

Number of Dependents: (Include yourself as 1)	Check One:	◯ Employed	◯ Retired	◯ FT Student	◯ Disabled	◯ Other

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

IN CASE OF EMERGENCY			
Friend/relative (not living at same address)	Relationship to patient	Home Phone #	Cell Phone #

PATIENT TREATMENT WAIVER/ASSIGNMENT OF BENEFITS

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

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

Name: ______________________________ Signature: ________________________ Date: ___________________
Patient/Parent/Guardian

Name: ______________________________ Signature: ________________________ Date: ___________________
Witness

CONSENT TO TREAT
HIPAA ACKNOWLEDGEMENT
COMMUNICATION AUTHORIZATION

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA/NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of WYH'S Health Insurance Privacy and Accountability Act (HIPAA) Notice of Privacy Practices. This notice describes how WYH may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and privacy rights I have regarding my protected health information.

CONSENT TO TREAT

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

PERSON(S) AUTHORIZED TO COMMUNICATE WITH

I give permission for WYH to communicate with the person(s) noted below in regards to all services I receive at WYH, unless I have noted any exceptions below:

EXCEPTIONS: ____

Name ___________________________ Date of Birth ___________________ Relationship ____________________

Address ____

Home phone _____________________ Cell phone _____________________ Work phone ____________________

Name ___________________________ Date of Birth ___________________ Relationship ____________________

Address ____

Home phone _____________________ Cell phone _____________________ Work phone ____________________

Please note that we will not be able to release any information about your medical condition to anyone not authorized by you. It is your responsibility to change and/or update this information as necessary.

Patient Name ______________________________ Patient Date of Birth ______________________________

Legal Guardian Name (if applicable) ______________________________ Relationship to Patient ______________________________

Signature of Patient or Legal Guardian ______________________________ Signature Date ______________________________

Witness Name ____________________ Witness Signature ____________________ Witness Date ____________________

VOLUNTARY SUPPLEMENT

This information requested below is used by Whitney M. Young, Jr. Health Services only to maintain records. YOU DO NOT HAVE TO ANSWER THESE QUESTIONS. If you DO choose to answer these questions, any information supplied by you on this voluntary supplement will not affect the quality of care at Whitney M. Young, Jr. Health Services.

Patient Name: ________________________________ Date of Birth: ________________

Race (PLEASE CHECK ALL THAT APPLY):
☐ **American Indian or Alaskan Native** (includes persons having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.) ☐ **Black or African American** ☐ **Native Hawaiian** (Persons having origins in any of the original peoples of Hawaii.) ☐ **White** ☐ **Asian** (Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.) ☐ **Pacific Islander** (Persons having origins in any of the original peoples of Guam, Samoa, Palau, Truk, or other Pacific Islands of Micronesia, Melanesia, or Polynesia. ☐ **More than one race**
Ethnicity (PLEASE CHECK ALL THAT APPLY):
☐ **Hispanic or Latino** (Persons having origins in any of the original peoples of Cuba, Mexico, Puerto Rico, South or Central America, and or Other Spanish origins.) ☐ **Non Hispanic**
UNITED STATES VETERAN:
☐ **YES** ☐ **NO**
LANGUAGE Primary Language: ______________________ Do you require interpretation services? ☐ Yes ________________________ Language ☐ No
EMail Address: ____

HIXNY ELECTRONIC DATA ACCESSCONSENTFORM
WHITNEY M. YOUNG, JR. HEALTH SERVICES

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

You may use this Consent Form to decide whether or not to allow Whitney M. Young Jr. Health Services to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

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

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

HIXNY is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about HIXNY and ehealth in New York State, read the brochure, "Your Health Information – Always at Your Doctor's Fingertips." You can ask Whitney M. Young Jr. Health Services for it, or go to the website www.hixny.org.

Please carefully read the information on the back of this form before making your decision.
Your Consent Choices. You can fill out this form now or in the future. You have two choices.

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

☐ **I DENY CONSENT for Whitney M. Young Jr. Health Services to access** my electronic health information through HIXNY for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through HIXNY.

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

Details about patient information in HIXNY and the consent process:

How Your Information Will be Used. Your electronic health information will be used by [Name of Provider Organization] **only** to:

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

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information about You Are Included**. If you give consent, [Name of Provider Organization] may access ALL of your electronic health information available through HIXNY. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases

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

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve on [Name of Provider Organization]'s medical staff who are involved in your medical care; health care providers who are covering or on call for [Name of Provider Organization]'s doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call [Name of Provider Organization] at: __________; or call HIXNY at (518) 783-0518; or call the NYS Department of Health at (877) 690-2211.

Re-disclosure of Information. Any electronic health information about you may be re-disclosed by [Name of Provider Organization] to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. HIXNY and persons who access this information through the HIXNY must comply with these requirements.

7. **Effective Period**. This Consent Form will remain in effect until the day you withdraw your consent or until such time HIXNY ceases operation.

8. **Withdrawing Your Consent**. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to (Name of Provider Organization). You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any HIXNY provider, from the HIXNY website at www.hixny.org, or by calling (518) 783-0518. **Note: Organizations that access your health information through HIXNY while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.**

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