healthlinkny
Your link to Statewide Health Information

Healthlink NY
Health Information Exchange

CONSENT FORM INFORMATION SHEET

Details about patient information in HealthlinkNY and the consent process

1. How will your information be used? Your electronic health information will be used by the provider named on the form only to 1) provide you with medical treatment and related services, 2) check whether you have health insurance, and 3) evaluate and improve the quality of care provided to all patients.

2. What types of information will be shared? If you give consent, the provider named on the form may access your electronic health information available through HealthlinkNY. 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
- HIV/AIDS
- Mental health conditions
- Genetic (inherited) diseases or tests
- Sexually transmitted diseases
- Birth control and abortion (family planning)

3. Where does your health information come from? Information about you comes from places that have provided you with medical care. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other health organizations that exchange health information electronically. A list of current information sources is available from HealthlinkNY through their website at www.healthlinkny.com or by calling 607-651-9150.

4. Who may access your information if you give consent? Only these people may access information about you: doctors and other health care providers who serve on the provider named on this form's medical staff who are involved in your medical care; health care providers who are covering or on call for this provider's doctors; and staff members who carry out activities permitted by this Consent Form as described above in #1.

5. Public Health and Organ Procurement Organization Access. Because federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes, these entities may access your information through HealthlinkNY for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. Are there 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 you suspect that your records have been accessed by someone not authorized to do so (see #4 above), contact HealthlinkNY at www.healthlinkny.com or 607-651-9150; or the NYS Department of Health at 518-474-4987; or follow the complaint process at the following HHS Office for Civil Rights link: http://www.hhs.gov/ocr/privacy/psa/complaint/.

7. Is re-disclosure of my information permitted? Any electronic health information about you may be re-disclosed by a Participating Provider 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 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, and special requirements must be followed whenever this kind of sensitive health information is disclosed. HealthlinkNY and persons who access this information through HealthlinkNY must comply with these same requirements.

8. How long will your consent be in effect? This Consent Form will remain in effect until the day you withdraw your consent or until such time HealthlinkNY ceases operation. If HealthlinkNY merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. How do you update or withdraw your consent? You can change your consent choice any time by signing a new Consent Form. You can get these forms on HealthlinkNY's website (www.healthlinkny.com) or by calling 607-651-9150. **Forms must be presented in person with valid proof of identity.**

Note: Organizations that access your health information through HealthlinkNY 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.

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

THIS FORM MEETS ALL REQUIREMENTS OF THE FEDERAL CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS (42 C.F.R. PART 2)THE NEW YORK STATE DEPARTMENT OF HEALTH PUBLIC HEALTH LAW 18 AND THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) (45 C.F.R PARTS 160 AND 164).

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HealthlinkNY Health Information Exchange

RHIO CONSENT FORM - LEVEL ONE HEALTH INFORMATION EXCHANGE CONSENT FORM

PROVIDER: Hudson Valley Health Group

I understand that I can choose whether to allow HealthlinkNY to obtain access to my medical records through a computer network operated by HealthlinkNY, which is part of a statewide computer network. This can help collect my medical records from different places where I get health care. HealthlinkNY is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit the HealthlinkNY website at www.healthlinkny.com or to learn more about the statewide computer network, read the brochure, "Better Information Means Better Care" at www.ehealth4ny.org.

I understand that unless I select one of the consent choices listed below, my information may be accessed in the event of an emergency.

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. 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.

Please carefully read the Consent Form Information Sheet about how your information is used before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You can also change your decision at any time by completing a new form.

Please choose only one of the following three options:

☐ **I GIVE CONSENT for the Provider named above to access ALL** of my electronic health information through HealthlinkNY in connection with providing me health care services, including emergency care.

☐ **I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for the Provider named above to access my electronic health information through HealthlinkNY, if the provider has the authority to do so.

☐ **I DENY CONSENT** for the Provider named above to access my electronic health information through HealthlinkNY for any purpose, ***even in a medical emergency.***

If you want to deny consent for all Organizations participating in HealthlinkNY, you may do so by visiting www.healthlinkny.com or calling 844-840-0050

Printed ... rst Name) ... Patient Date of Birth (MM / DD / YYYY)

Please see front desk to sign document

Signat... Repres... lationship of Legal Representative to Patient(if applicable)

Date o... (MM / D... presentative (if applicable) Last name, first name

E-mail

Hudson Valley Health Group
Patient Registration Form

Today's Date:	**Doctor you are seeing today:**	
First Name:	Middle Initial:	Last Name:
Street Address:	City: State:	Zip Code:
Home Phone:( )	Work Phone: ( )	Cell Phone: ( )
Date of Birth:	Co-Pay Amount: $	
Sex: Race:	Social Security #:	
Pharmacy:	Pharmacy Phone #:	
Referring Doctor:	Primary or Family Doctor:	
E-mail Address:		

Are you here for an auto or work related accident? ____
If Yes, please ask the receptionist for additional forms to fill out.

Insurance Company Name:	ID/Member #:	
Mailing Address:	City:	State:
Zip Code:	Ins Co. Phone #:	
Policyholder's Name:	Policyholder DOB:	
Policyholder's SS#:	Policyholder's Employer:	
Employers Address:		
Ins. Group #:	Effective Date:	
Relationship to Insured:		

Insurance Company Name:	ID/Member #:	
Mailing Address:	City:	State:
Zip Code:	Ins Co. Phone #:	
Policyholder's Name:	Policyholder DOB:	
Policyholder's SS#:	Policyholder's Employer:	
Employers Address:		
Ins. Group #:	Effective Date:	
Relationship to Insured:		

I agree that this information in true and accurate to the best of my knowledge. In the event my insurance denies this claim, I understand that I am financially responsible for today's visit.

Signed _____ Printed Name _____

Privacy Information (HIPAA)
Hudson Valley Health Group

In order to comply with the federal regulations regarding your privacy in our office, we ask that you complete the following questions:

Leave appointment messages on/with:		Leave medical information messages on/with:	
Answering Machine?	__Yes __No	Answering Machine?	__Yes __No
Office Voice Mail?	__Yes __No	Office Voice Mail?	__Yes __No
With another Person?	__Yes __No	With another Person?	__Yes __No
Send through the mail?	__Yes __No	Send through the mail?	__Yes __No
Send via e-mail?	__Yes __No	Send via e-mail?	__Yes __No
Cell Phone?	__Yes __No	Cell Phone?	__Yes __No

If you answered **YES** to allowing us to discuss your appointment and/or medical information with another person, please list their name(s), relationship(s) and phone number below:

Name:	**Relationship:**	**Phone:**	**Cell Phone:**

Additional HIPAA Contact Instructions:

_____

_____

Authorization of Treatment and Assignment of Benefits

I authorize Hudson Valley Health Group to provide me with treatment. I further authorize the release of medical information necessary for the completion of insurance forms.

I authorized payment directly to Hudson Valley Health Group for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments, deductibles, co-insurance, and any charges not paid/covered by my insurance carrier. A photocopy of this authorization shall be considered effective as the original. I understand that if my physician, or any person employed by or under the direction and control of my physician(s), is directly exposed to my bodily fluids in any manner which may, according to the current guidelines for the Center for Disease Control, transmit the Human Immunodeficiency Virus (HIV) or hepatitis B or C viruses that I am deemed by law to have consented to be tested for HIV or Hepatitis B or C viruses. I further understand that by law I will have deemed consent to the release of these test results to the person(s) who has been exposed to my bodily fluids.

Patient Signature: _____ Date _____

HIPAA Authorization form

Hudson Valley Health Group

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Hudson Valley Health Group** to use and/or disclose certain protected health information (PHI) about me to _____.

This authorization permits Hudson Valley Health Group to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

The Practice will ___ will not ___ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Hudson Valley Hudson Group. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Hudson Valley Heath Group
3141 Route 9W
New Windsor, New York 12553

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Print Patient's Name — Date

_____

Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

Hudson Valley Health Group, LLP
Javier Ruiz, M.D.
Oncology/Hematology

In an effort to serve our patients and to contain our fees, Dr. Ruiz has implemented a No-Show Policy for all of our patients, effective May 31, 2013.

You will be billed $25 if you miss an appointment and you have not contacted us to cancel at least 24 hours before the appointment. If the appointment is Monday, you must contact us by noon on the Friday before.

If you miss (3) appointments in a row you may be discharged as a patient of this practice.

To cancel appointments please call your physician's office. If you do not reach the secretary, you may leave a detailed message with our answering service.

Thank you for your cooperation.

Sincerely,

Javier Ruiz, M.D.

Name of Patient: _____

Signature of Patient: _____

Date: _____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
3141 ROUTE 9W, SUITE 100, NEW WINDSOR, NEW YORK 12553

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**N/A**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Your healthcare is of optimum importance to our practice. Please help us continue to provide the best care possible by understanding and agreeing to our attached Financial Policy, effective immediately.

HUDSON VALLEY HEALTH GROUP FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered. This includes applicable coinsurance and copayments for participating insurance companies. **Hudson Valley Health Group** accepts cash, personal checks (in-state only), VISA, and MasterCard. There is a service charge for returned checks.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments. We realize that financial difficulty is a reality. In such cases we have options available to assist you with high balances.

INSURANCE:
Please understand

1) It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
2) If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.
3) It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories. For example
    a. Not all plans cover annual healthy (well) physicals, sports physicals, or hearing and vision screenings. If these are not covered, you will be responsible for payment.
4) It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.
5) Self-pay patients are expected to pay for services in FULL at the time of the visit.
6) For scheduled appointments, prior balances must be paid prior to the visit.

Initial: _____

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full.

Your time of service receipt includes all information necessary for submitting claims to your insurance company if necessary.

If you need assistance or have questions, please contact **The Billing Coordinator between 9:00 a.m. and 4:00 p.m., Monday through Friday at 845-565-9800 x 202.**

REFUNDS:

Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts $20.00 and greater will automatically be refunded to the patient/guarantor.

MANAGED CARE:

If you are enrolled in a managed care insurance plan (i.e., HMO), you must receive a referral from our office before seeing a specialist. Retroactive referrals are not guaranteed.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you and to to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand the **Hudson Valley Health Group** Financial Policy. I agree to assign insurance benefits to the **Hudson Valley Health Group** whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections. I understand that once my account has been referred to a collection agency, I may be discharged from the practice.

Signature of insured or Authorized representative: _____

Date: _____