APS0015

PATIENT REGISTRATION FORM

Patient Legal Name (Last, First, Middle)		Date of Birth (mm/dd/yyyy): ____/____/_____
Previous Name: (if applicable)		SSN#: (optional):
Birth Sex: ☐ M ☐ F	Current Gender:	Relationship Status:
Gender Identity: ☐ Male ☐ Female ☐ Other ☐ Choose not to disclose		
Mailing Address		Street Address (if different)
City, State, Zip		City, State, Zip
Home Phone	Cell Phone	Day Phone
Email Address		

May we send you a MyCare portal invite to this address so you can access your health information online? ☐ Yes ☐ No

Emergency Contact (Optional)

Name: Phone Number:

Communication: WMC Health Advanced Physician Services uses a variety of methods to communicate information to our patients regarding appointment reminders, practice cancellations/closures, patient registration, and overall health information and education. By choosing to accept, you are agreeing to receive communication via phone (including pre- recorded appointment reminder messages), text messages, or emails to any of the telephone/cell phone numbers and email addresses you have provided.

☐ Accept
☐ Decline (By choosing to decline, you will only receive appointment reminders to the home phone number listed above)

Race (Government *mandated question)*
☐ American Indian/Alaska native ☐ Asian ☐ Black/African American ☐ White/Caucasian
☐ Other Pacific Islander ☐ Other Race ☐ Decline to answer

Language (Government *mandated question)* ☐ English ☐ Spanish ☐ Other, please specify:

Ethnicity (Government *mandated question)* ☐ Hispanic ☐ Non-Hispanic ☐ Decline to answer	**Religion** *(Optional)*
Primary Care Physician Name: Address: Phone:	**Preferred Pharmacy** Name: Address: Phone:

Employer Name: Address: Phone:

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PATIENT REGISTRATION FORM

Primary Insurance	Secondary Insurance (if applicable)
Payer Name	Payer Name
Policy Number	Policy Number
Policy Holder Retired? ☐ Yes ☐ No	Policy Holder Retired? ☐ Yes ☐ No
Date of Retirement _____/_____/_____	Date of Retirement _____/_____/_____
Is the patient the Policy Holder? ☐ Yes ☐ No ***If No***, please complete below:	**Is the patient the Policy Holder?** ☐ Yes ☐ No ***If No***, please complete below:
Policy Holder Legal Name	Policy Holder Legal Name
Policy Holder DOB (mm/dd/yyyy): ____/____/_____	Policy Holder DOB (mm/dd/yyyy): ____/____/_____
Policy Holder Address	Policy Holder Address
Patient Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other	Patient Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other

Guarantor/Responsible Party (ONLY If patient is under 18 or Legal Dependent)			
Legal Name (Last, First, Middle)	SSN (Optional) _____-_____-_____	DOB (mm/dd/yyyy) ____/____/_____	Birth Sex: ☐ M ☐ F
Mailing Address	City, State, Zip		
Home Phone	Day/Work Phone		
Mother's Maiden Name	Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other		

Acknowledgment/Authorization

- I hereby acknowledge that I have received the WMC Health Notice of Privacy Practices.
- I hereby acknowledge that I have received the Patient Code of Conduct and understand I may request a copy.
- I consent to examination and treatment by the physicians and staff of WMC Health.
- I consent to making my health care information available to other health care providers for treatment purposes.
- I authorize and direct WMC Health to release to governmental agencies, insurance carriers and others who are financially liable for my medical care, any information necessary to process, or substantiate payment, for my insurance claims.
- I hereby assign or transfer to WMC Health Advanced Physician Services the payment of benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical care to cover the cost of care and treatment rendered to myself and my dependents. I request that payment of authorized benefits be made on my behalf and I understand, and agree that, regardless of my insurance status, I am ultimately responsible for charges not covered by policy or plan.
- I agree that this authorization shall be valid until canceled in writing or replaced with one of a later date. A photocopy of this assignment shall be considered as valid as the original.
- Legal Name is defined as being the complete name on government issued identification or as attesting to on this registration form.
- I have read all the information above and fully understand the terms thereof.
- I certify that this information is true and correct to the best of my knowledge. I will notify WMC Health of any changes to the above information.

_____ _____

Signature of Patient/Guardian **Date**

WMC Health | WMCHealth Physicians
Advanced Physician Services
Westchester Medical Center Health Network

Patient Representative Authorization Form

Patient Name:_____

Date of Birth:_____ Social Security Number:_____

This form does not serve as an advanced directive such as a New York State Health Care Proxy Form or a Durable Power of Attorney

Patient Representative Information

I hereby give permission to WMC Health Advanced Physician Services, its practitioners, employees and representatives, to discuss all aspects of my medical care and treatment, including, but not limited to my protected health information, and to discuss all payment issues with the individual designated below.

Name of Individual: _____

Relationship to Patient:_____

Date of Birth:_____ Telephone number:_____

Address:_____

Patient Signature:_____ Date:_____

Please note:

- A separate authorization must be completed to share highly sensitive information such as HIV, alcohol and substance abuse treatment, and/or mental health information.
- This does not grant the patient representative the right to access printed medical charts or information and does not give them right to request them on the patient's behalf.
- In order to revoke the rights of the Patient Representative listed above, a new form must be completed with updated information.

APS MEDICATION AUTHORIZATION CONSENT FOR MEDICATION HISTORY ACCESS

MEDICATION AUTHORIZATION:

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies, contribute to the collection of this history. Medication history is important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

The medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

I hereby authorize Westchester Medical Center Advanced Physicians Services PC to electronically obtain my medication history from my pharmacy, my health plans, and my other healthcare providers, so that it may be included as part of my electronic health record.

Please carefully read the information carefully before making your decision.

_____I GIVE CONSENT to access my electronic medication history in connection with providing me any health care services, including emergency care.

____ I DENY CONSENT to access my electronic medication history for any purpose, even in a medical emergency.

Please refer to Westchester Medical Center Health Network's Notice of Privacy Practice for any questions regarding your personal health information.

WMC Health | WMCHealth **Physicians**
Advanced Physician Services
Westchester Medical Center Health Network

PATIENT OR LEGAL AUTHORIZED REPRESENTATIVE

Signed: _____
Patient

Signed: _____
Legal authorized Representative

Witness: _____

Date: _____Time: _____

TELEPHONE CONSENT IF GRANTED BY (if required)

Signed: _____
Name of legal representative and relationship to patient.

Signed: _____
Signature of caller.

Witness: _____

Date: _____Time: _____

Signature: _____ Date: _____ Time: _____

WMCHealth

Authorization for Access to Patient Information Through Health Information Exchange Organizations

Name	Date of Birth	Identification Number
Other Names Used (e.g. Maiden Name)		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow employees, agents, or members of the medical staff of the Provider Organizations of WMCHealth * to obtain access to my medical records through the following participating health information exchange organizations: HealtheConnections and Hixny. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network called the SHIN-NY. HealtheConnections and Hixny are not-for-profit organizations that share information about people's health electronically and meet the privacy and security standards of HIPAA and New York State Law. To learn more, visit these websites:

www.healtheconnections.org
www.hixny.org
https://www.nyehealth.org/shin-ny/what-is-the-shin-ny/

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my bills. You can make that choice in a separate Consent Form that health insurers must use.

My Consent Choice. ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change my decision at any time by completing a new form.
☐ I GIVE CONSENT for WMCHealth to access ALL of my electronic health information through the SHIN-NY to provide health care services (including emergency care).
☐ I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY for WMCHealth to access my electronic health information through the SHIN-NY.
☐ I DENY CONSENT for WMCHealth to access my electronic health information through the SHIN-NY for any purpose, even in a medical emergency (except for minor patients). Unless you check this box, New York State law allows medical providers treating you in an emergency to get access to your medical records, including records that are available through the SHIN-NY.

If I want to deny consent for all Provider Organizations and Health Plans participating in the Statewide Health Information Network for New York (SHIN-NY) that access my electronic health information through one of the following HIEs, I may do so by contacting each of the HIEs individually:

HealtheConnections	www.healtheconnections.org	315-671-2241 x 5
Hixny	www.hixny.org	518-640-0021

My questions about this form have been answered and I have been provided a copy of this form.

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

Details about the information accessed through the SHIN-NY and the consent process:

1. **How Your Information May be Used.** Your electronic health information will be used only for the following healthcare services:
   - Treatment Services. Provide you with medical treatment and related services.
   - Insurance Eligibility Verification. Check whether you have health insurance and what it covers.
   - Care Management Activities. These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - Quality Improvement Activities. Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included. I**f you give consent, WMCHealth may access ALL of your electronic health information available through the SHIN-NY. This includes information created before and after the date this form is signed. Your health records may include clinical notes, discharge summaries, allergies, a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), treatments you have received, your diagnoses, and lists of medicines you have taken. These records may contain all of this information about 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

   ** If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from WMCHealth, HealtheConnections, and/or Hixny. You can obtain an updated list at any time by checking the websites of the participating organizations or calling them at the numbers on this form.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of WMCHealth who carry out activities permitted by this form as described above in paragraph one. If there is an emergency, doctors and other staff members will be able to use the SHIN-NY to see the health information of patients who are minors.

5. **Public Health and Organ Procurement Organization Access.** 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 the SHIN-NY for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **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 WMCHealth at 914-493-2600; or visit the websites of HealtheConnections or Hixny; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

7. **Re-disclosure of Information**. Any organization(s) you have given consent to access health information about you may re-disclose your health information, but 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. Alcohol/drug treatment-related information or confidential HIV related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period.** This Consent Form will remain in effect until the day you withdraw or change your consent choice or until such time as WMCHealth, HealtheConnections or Hixny cease operations (or until 50 years after your death whichever occurs first). If HealtheConnections or Hixny merge with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s) or submitting a Withdrawal of Consent Form to WMCHealth. Organizations that access your health information through the SHIN-NY while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form.** You are entitled to get a copy of this Consent Form.

*Definition. By signing this consent form, you are permitting the providers, employees, agents and members of the Medical Staffs of each of the provider entities below affiliated with WMCHealth to access your records through the SHIN-NY. More information on WMCHealth locations is available at: https://www.wmchealth.org/contact-us

- Westchester Medical Center including:
  Maria Fareri Children's Hospital
  Behavioral Health Center
- MidHudson Regional Hospital
- Good Samaritan Hospital of Suffern, N.Y.
- St. Anthony Community Hospital, Warwick, New York
- Bon Secours Community Hospital
- St. Francis at the Knolls (Mt. Alverno Center)
- Villa Frances at the Knolls (Schervier Pavilion)
- HealthAlliance Hospital
- Margaretville Hospital
- Mountainside Residential Care Center
- Westchester Medical Center Advanced Physician Services, P.C.
- Bon Secours Charity Health System Medical Group, P.C.
- North Road LHCSA