Clifton-Fine Hospital
A SAMARITAN HEALTH PARTNER
Trusted Care. Close to Home.

Office Policies and Procedures for our Patients
New Patient Packet

Thank you for choosing *Clifton Fine Primary Care*. We realize that you have a choice in medical providers and are pleased that you have chosen to seek care with us. The staff at Clifton Fine Primary Care strive to exceed expectations in care and service in order to make your experience with us as positive as possible. Our goal is to provide quality medical care in a timely manner. In order to do so we have implemented an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care. Please feel free to contact our office if you have any questions regarding our policies.

Office Hours

Patient Appointments vary by provider between the hours of 7:00AM to 4:00PM Monday-Friday and pre-scheduled Telemedicine Appointments on Saturday. For the availability of your primary care provider, please contact the office.

Phone lines are open from 8:00AM to 4:00PM Monday-Friday, with 24/7 Prescription line access, and after hour calls directed to our hospital's nursing department. **If you need an appointment, test results, or have general questions, please call during regular business hours.**

We are NOT an Urgent Care

It is a common misconception that our office is an urgent care or accepts walk in appointments. To be seen within the Clifton Fine Primary Care Clinic, you must be an established patient with our office, meaning you doctor with us for your family medicine needs. If you are not an established patient, we will do our best to provide you with the appropriate resources to be further evaluated.

To ensure quality care, Clifton Fine Primary Care, does not treat patients we have never seen (i.e., we will not call in prescriptions, order tests, provide treatment prior to an initial visit or if not established).

If you are an active and established patient with our office, we do offer same day appointments.

Appointments

Clifton Fine Primary Care is committed to providing quality care to our patients. To ensure timely continued care, we encourage our patients to schedule appointments in advance. When calling for an appointment, please provide your name, telephone number, reason for visit, as well any updated contact or insurance information. While we strive to schedule appointments appropriately and accommodate all patient needs, emergencies can and do occur in Primary Care. We strive to give all of our patients the time they require. For this reason, we kindly request your patience and understanding should a delay or rescheduling become necessary on your appointment date.

Follow up appointments may be required to review results and develop an effective and appropriate plan for your health care needs. Failure to complete ordered tests may result in rescheduling of your appointment. We encourage you to schedule appointments for preventative health visits, physicals, chronic health conditions, in addition to your sick visits.

Same Day Appointments

We understand illness occurs. We reserve a select amount of same day appointments. If you are an active and established patient with our office, same day appointments are available by calling 315-848-5404, option 5.

Arriving Late to a Scheduled Appointment

Patients who are more than 15 minutes late to their schedule appointment may be asked to reschedule.

Cancellation of an Appointment

In order to be respectful of the medical needs of our patients please be courteous and call Clifton Fine Primary Care promptly if you are unable to attend an appointment. We ask that you try to call one (1) working day in advance. This time will be reallocated to someone who is in need of treatment. This is how we can best serve the needs of our patients. Appointments are in high demand, and your early cancellation will give another person the ability to have access to timely medical care.

No Show Policy

A "No Show" is someone who misses an appointment without canceling with advance notice. No-shows inconvenience those individuals who needs access to medical care. A failure to present at the time of a scheduled appointment will be recorded in your medical record as a "no show." You will be sent a letter alerting you to the fact that you failed to show for a scheduled appointment and did not cancel the appointment with advanced notice. A copy of the letter will be placed in your medical record. Three (3) no show's within one (1) calendar year will result in a temporary suspension of services. In order to reinstate services, you will be required to meet with your Primary Care Physician within 30 days of the third no show letter to evaluate your situation. If the event you do not respond and/or schedule an appointment within 30 days, we will consider your patient status as terminated.

Remaining Active with our Office

All patients are required to be seen at least annually to remain active with the office, with a leeway period of one year. If you have not been seen within 2 years, you will no longer be considered an active patient of the office. You would need to re-establish as a new patient. This is to ensure safety and quality in your health care.

Insurances

Clifton Fine Primary Care accepts most insurance plans. If you have specific questions regarding your insurance, please contact our billing department at 315-848-5404, option 7. It is the patient responsibility to inform our office of any changes in insurance coverage. Failure to do so could case delay or denial of insurance payment.

Patients are responsible for co-pays at time of service. If applicable, you will be billed for services not covered by your insurance (as stated in your insurance contract) by our billing department

Forms and Letters

We understand that at times, various forms or letters may be required to assist you with your healthcare needs. The staff at Clifton Fine Primary Care will be happy to complete forms and write

medical letters as necessary upon your request. However, because this can be time consuming, please allow 5-7 business days for completion of requested forms/letters.

Medical Records

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form for release of medical information must be completed prior to receipt of these materials. The law allows Medical Offices 30 days to complete requests for records. However, our medical records department puts forth every effort to respond to these requests in a timely manner. For questions about your medical records please contact 315-848-5404, option 8.

Prescription Refills

Please allow up to 3 business days for refill requests. We encourage our patients to review their medications prior to their office appointments and to request refills at that time, if needed. Our Practice does not routinely order Narcotic Pain Medicine, therefore you may be required to obtain these medications through a specialty provider, such as pain management.

Our Team Approach

It is important to understand our office's unique team approach. While you will have a medical provider assigned to your care, all of our medical providers are qualified to see you. We will make all attempts to schedule you with your assigned medical provider, with the understanding there may be times you are scheduled with one of our other medical providers (sick visits, provider out of the office, surgery clearance, etc).

New Patient Packet

Please complete the attached forms and return to the office. Forms can be mailed to Clifton Fine Primary Care 1014 Oswegatchie Trail Road Star Lake NY 13690, Faxed to 315-848-2835, or physically dropped off. **Please note: Once we receive your new patient packet we will contact you to schedule an appointment. Appointments will not be scheduled until the packet is received.**

New Patients who are seeking to establish care with Clifton Fine Primary Care who fail to cancel or reschedule their initial appointment are considered no shows. The second instance of failing to keep their initial appointment as scheduled will result in denial of entry as a new patient to the office.

Office Policies and Procedures for our Patients

Receipt Acknowledgment Form

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in the Clifton Fine Primary Care Office policies and procedures for patients form.

_____

Printed Name

_____ _____

Signed Name Date

THANK YOU!

Clifton Fine Primary Care

To make your visit with our primary care office seamless, we also offer the following services on site:

Behavioral Health Services

Health not only involves your physical body functioning well, but also your mindset, emotions and overall life satisfaction. This if often referred to as Holistic Health. At Clifton-Fine Hospital, we are concerned about our patients' complete health, so we offer behavioral health services as well. If you think you could benefit from meeting with one of our counselor/therapists or are not sure and have some questions, please do not hesitate to speak to the nursing staff or your provider for more information.

Laboratory Services

The Laboratory at Clifton Fine Hospital provides a broad range of clinical services to clients of all ages. Lab professionals perform tests on blood and body fluids to help your physician/provider with diagnosing illnesses. Lab tests may also rule out a condition, avoiding unnecessary treatment or help to determine which medication will provide the most effective treatment for you. Lab tests contribute vital information about your health. Lab tests must be ordered by a physician, dentist, chiropractor, physician assistant or nurse practitioner.

Radiology Services

The radiology department at Clifton Fine Hospital offers diagnostic imaging through radiography and general x-rays, ultrasound, CT scan, bone density screening, 24 hour cardiac holter monitor, and EKG's. Diagnostic imaging contribute to vital information about your heath. All imaging and tests must be ordered by a physician, dentist, chiropractor, physician assistant or nurse practitioner.

Rehabilitation

The rehab department at Clifton Fine Hospital offers outpatient physical therapy and occupational therapy services. All patients with a valid medical prescription get a thorough individualized assessment of their specific problem. Plans of care are geared toward restoring prior levels of function and maximizing patients' potential.

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For more information or explanation you may contact our *Privacy Officer: 315-848-3351*

This notice is also available on our website: cliftonfinehospital.org

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	· You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. · We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	· You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. · We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	· You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. · We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	· You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. · If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	· You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. · We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	· You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	· If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. · We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	· You can complain if you feel we have violated your rights by contacting us using the information on page 1. · You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** · We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	· Share information with your family, close friends, or others involved in your care · Share information in a disaster relief situation · Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	· Marketing purposes · Sale of your information · Most sharing of psychotherapy notes
In the case of fundraising:	· We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	· We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	· We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	· We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	· We can share health information about you for certain situations such as: · Preventing disease · Helping with product recalls · Reporting adverse reactions to medications · Reporting suspected abuse, neglect, or domestic violence · Preventing or reducing a serious threat to anyone's health or safety
Do research	· We can use or share your information for health research.
Comply with the law	· We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	· We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	· We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	· We can use or share health information about you: · For workers' compensation claims · For law enforcement purposes or with a law enforcement official · With health oversight agencies for activities authorized by law · For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	· We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- We do not create or manage a hospital directory

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective: 4/4/2003, 10/1/2017, 1/28/2021, 1/4/2023

DATE _____

PATIENT REGISTRATION

PATIENT INFORMATION

SOCIAL SECURITY # _____

FIRST NAME _____ MIDDLE INITIAL _____

LAST NAME _____ MAIDEN NAME _____

SEX _____ DATE OF BIRTH _____/_____/_____

MARITAL STATUS _____ ETHNICITY _____

BILLING ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____)_____ ❒ *Please check*

CELL PHONE (_____)_____ ❒ *preferred method*

WORK PHONE (_____)_____ ❒ of *contact.*

E-Mail _____ ❒

CHECK ONE ❒ Unemployed ❒ Retired ❒ Student ❒ Employed

EMPLOYER & ADDRESS _____

INSURANCE INFORMATION – Please present card(s)

PRIMARY INS. ❒ Commercial ❒ Medicare ❒ Medicaid ❒ Comp

INSURANCE COMPANY _____

POLICY # _____

CARDHOLDER'S NAME _____ DOB _____

RELATIONSHIP TO PATIENT _____

CARDHOLDER'S EMPLOYER & ADDRESS _____

_____

SECONDARY INS. ❒ Commercial ❒ Medicare ❒ Medicaid ❒ Comp

INSURANCE COMPANY _____

POLICY # _____

CARDHOLDER'S NAME _____ DOB _____

RELATIONSHIP TO PATIENT _____

CARDHOLDER'S EMPLOYER & ADDRESS _____

Primary Pharmacy:_____ **Secondary Pharmacy:** _____

FOR PEDIATRIC PATIENTS ONLY: ***Please check each name that has custody/permission to contact. Legal docs may be requested.***

❒ Mother _____ Phone _____ Maiden Name _____

❒ Father _____ Phone _____

GUARANTOR / RESPONSIBLE PARTY (If not SELF, then the Insurance Subscriber or Parent/Guardian if minor)

SOCIAL SECURITY # _____ SEX _____ RELATIONSHIP TO PATIENT _____

FIRST NAME _____ MIDDLE _____ LAST NAME _____ DOB _____

HOME ADDRESS _____ HOME PHONE (_____) _____

_____ WORK PHONE (_____) _____

CITY _____ STATE _____ ZIP _____ CELL PHONE (_____) _____

EMERGENCY CONTACT (Parent/Guardian if Minor, in addition to Guarantor)

FIRST NAME _____ MIDDLE _____ LAST NAME _____DOB_____

SEX _____ RELATIONSHIP TO PATIENT _____

HOME PHONE (___) _____ WORK PHONE (___) _____ CELL PHONE (___) _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

Please check one and initial: ❒ I authorize _____ ❒ I do not authorize _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize the release of any information to my current insurance company or third party contractor upon their request.

Please check one and initial: ❒ I authorize _____ ❒ I do not authorize _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, acknowledge that I have received a copy of Clifton Fine Hospital's notice of Privacy Practices. This Notice describes how Clifton Fine HOspital may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Please check one and initial: ❒ I received _____ ❒ I do not receive _____

If this patient is a minor, the following individuals may accompany my child to appointments in my absence.

	Name of Individuals	Relationship	Phone
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Or, check here if applicable: ❒ I do not authorize any individuals _____

_____ _____ _____ _____

SIGNATURE (Patient or Parent/Guardian if Minor) Initials RELATIONSHIP TO PATIENT (if Minor) DATE

Name	Date of Birth	Clifton Fine Clinic New Patient Packet

☑ Check Yes or No: If Yes, please describe Type and Amount			
Social History	**Yes**	**No**	**Type and How Much (Circle)**
Do you use tobacco?			Cigarettes / Cigar / Vape/ E-cigarettes / Smokeless Tobacco **Start Date:** **Packs per Day:**
Former Tobacco User?			**Start and End Date:**
Are you interested in quitting?			
Do you use alcohol?			Never / Rare / Occasional / Every Day / In Recovery / Quit **How many Drinks?** **Per day / week / month**
Do you drink Caffeine?			Coffee _____ Cups per day (6oz) Tea _____ Cups per day (6oz) Soda _____ Cups per day (12oz) Other:
Do you exercise?			Frequency _____ times per day / week Type of exercise? Aerobic / Strength / Cardio / Other:
Home Equipment	**Yes**	**No**	**Type and Begin Dates (Circle)**
Do you utilize any assistive devices?			Oxygen ____ Liters Cane / CPAP / Walker / Nebulizer / Shower Chair / Wheel Chair **Begin Dates:**
Sexual History			**(Circle)**
Sexual Orientation			Straight or Heterosexual / Gay or Homosexual / Bisexual ☐Choose not to disclose
Gender Identity			**Identifies as :** Male / Female / Female to Male (Transgender Male) / Male to Female (Transgender Female) / Gender Queer (Neither exclusively male or female / Non-binary ☐Choose not to disclose ☐Additional Gender, please specify:

Please list any hospitalizations or surgeries

Date	Surgery	Location	Date	Hospitalizations/Injury	Location

Complete the date if you have had any Preventative Screenings

Date	Screening	Date	FEMALE ONLY	Date	MALE ONLY
	Colonoscopy		Bone Density		PSA
	Fecal Occult Blood		Cervical (PAP Smear)		
	Cologuard		Mammogram		
	Low Dose Lung Cancer Screen		Pregnancies: #		

Vaccinations – Have you ever had the following?

Vaccination	Yes	No	Date and Where
COVID Vaccine			
Shingles Vaccine			

Name	Date of Birth	Clifton Fine Clinic New Patient Packet

Vaccinations – Have you ever had the following?

Vaccination	Yes	No	Date and Where
Pneumococcal Vaccine			
Tetanus Vaccine			

Allergies

Type	Yes	No	Reaction
Food			
Drug			
Environmental			

Medications

Please list all medications you take, including Over the Counter Medications. Please bring up to date list or pill bottles to your appointment.

Medication	Dose	Frequency

Preferred Pharmacy:

Specialty Providers

Please indicate below if you see any specialty providers

Do you see a specialty provider? ☐Yes ☐No If Yes, proceed to below columns.

Provider Name	Specialty	Location	Next Appointment

☑ Check all boxes of family conditions that apply

Family History *Specify Family Member*	Age	Heart Disease	Diabetes	High BP	Thyroid Disea	Dementia	Seizures	Stroke	Kidney Disea	Depression	High Cholster	Heart Attack	**No longer living**
Mother													
Father													
Sister													
Brother													

☑ Check all boxes of family conditions that apply

Family History	Age	Heart Disease	Diabetes	High BP	Thyroid Disea	Dementia	Seizures	Stroke	Kidney Disea	Depression	High Cholster	Heart Attack	Other
		CANCER (Specify Type:											

Additional Family History not listed:

☑ Check all boxes if you have now or have ever had any of the following conditions/illnesses

	ADHD		A-Fib		Anemia		Arthritis
	Asthma		Bleeding Disorder		Blood Clots/DVT		Cancer
	Celiac Disease		Chicken Pox		COPD		Crohns Disease
	Depression		Diabetes Type 1		Diabetes Type 2		Diverticulosis
	Epilepsy		Edema		Gout		Heart Attack
	Heart Disease/CHF		Heart Murmur		Hemorrhoids		Hepatitis
	Hernia		HIV		High BP		High Cholesterol
	Kidney Stones		Kidney Disease		Lung Disease		Lyme Disease
	Measles / Mumps		Migraines		Multiple Sclerosis		Neuropathy
	Osteoporosis		Polio		GERD/Reflux		Seizures
	Thyroid Disease		Stroke		Ulcers		Pacemaker
	Anxiety		Glaucoma		Back Issues		Pneumonia

Any other Conditions/Illness (Please List):

☑ Check all boxes that relate to your current health status REVIEW OF SYSTEMS

Review of Systems	Yes	No	Comment or Explain
General Health (Do you feel well?)			
Heartburn, belching, nausea, vomiting, bloating, or difficulty swallowing?			
Change in bowel habits?			
More than 5 lb weight change in last year?			
Abdominal pain, pressure, or discomfort?			

Name	Date of Birth	Clifton Fine Clinic New Patient Packet

☑ Check all boxes that relate to your current health status			REVIEW OF SYSTEMS
Review of Systems	**Yes**	**No**	**Comment or Explain**
Urinary Problems? (Pain, burning, incontinent, etc.)			
Headaches, Dizziness, loss of consciousness?			
Poor Memory?			
Chest Pain or shortness of breath?			
Irregular Heart Beat			
Difficulty breathing, coughing, or lung congestion?			
Changes in eyesight? Eye pain?			
Loss of hearing? Ear or sinus pain? Ringing or buzzing in ears?			
Changes of self-breast exam?			
Rash, skin discoloration, or other skin concerns?			
Bruising or bleeding?			
Bone or joint pain, muscle aches?			
Increased thirst, fatigue, loss of hair?			
Swelling in neck, groin, or armpit?			
Depression or anxiety?			
Miscellaneous			
Are you interested in HIV Testing?	☐Yes	☐ No	
Are you interesting in Hepatitis C Testing?	☐Yes	☐ No	

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification 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. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. 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 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

Clifton Fine Hospital and Primary Care, 1014 Oswegatchie Trail Road Star Lake NY 13690

7. Purpose for Release of Information:
Establishment/Transfer/Continuity of Care

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ (INSERT START DATE) until _____ (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except:

For the following to be included, indicate the specific information to be disclosed and initial below.

	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

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

_____ (SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW) _____ (DATE)

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ (STAFF PERSON'S NAME AND TITLE) _____ (SIGNATURE) _____ (DATE)

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

Clifton-Fine Hospital

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
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 the Organization named above to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network.

HealtheConnections 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 HealtheConnections website at http://healtheconnections.org/.

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent *even* in a medical emergency.

The choice I make on this form will NOT affect my ability to get medical care. The choice I make on 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 medical bills.

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.

☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for the Organization named above to access my electronic health information through HealtheConnections.

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

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

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
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through HealtheConnections 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**. If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through HealtheConnections. This includes information created before and after the date this form is signed. 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 include sensitive health conditions, including but not limited to:

Alcohol or drug use problems	HIV/AIDS
Birth control and abortion (family planning)	Mental Health conditions
Genetic (inherited) diseases or tests	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 HealtheConnections. You can obtain an updated list at any time by checking HealtheConnections website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access, who carry out activities permitted by this form, as described above in paragraph one.

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 HealtheConnections 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 the Provider Organization directly by accessing their contact information on the HealtheConnections website at http://healtheconnections.org/; 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. 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 change your consent choice or until such time as HealtheConnections ceases operation (or until 50 years after your death, whichever occurs first). If HealtheConnections merges 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. Organizations that access your health information through HealtheConnections 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**.**

Clifton-Fine Hospital
A SAMARITAN HEALTH PARTNER

PERMISSION TO VERBALLY SHARE MEDICAL INFORMATION

Patient Name: _____ **Date of Birth:**_____

I hereby give Clifton-Fine Hospital permission to verbally share specific medical information, in person or over the phone, with the individuals listed below:

Name: _____
Relationship: _____
Address(city/state): _____
Phone: _____

Name: _____
Relationship: _____
Address(city/state): _____
Phone: _____

Name: _____
Relationship: _____
Address(city/state): _____
Phone: _____

Name: _____
Relationship: _____
Address(city/state): _____
Phone: _____

The information that can be shared: (circle Y or N)

(Y / N) Appointment Date/Times (Y / N) Diagnosis (Y / N) X-ray Results (Y/ N) Lab Test / Results
(Y / N) Medications (Y / N) Care Plan
____ Other: (Specify): _____

Indicate if this additional Confidential Information can be shared:
(Y / N) Mental Health (Y / N) HIV Information (Y / N) Alcohol / Drug Information

This authorization shall remain in effect until (Please check one):

_____ (Specify expiration date or event) _____
_____ When revoked in writing
_____ NO EXPIRATION DATE

_____

Signature of Patient or Personal Representative: _____ Date: _____

Printed name (If signed by personal representative): _____

_____

If patient cannot physically sign, and has verbally granted permission, or Personal Representative has verbally granted permission, two (2) CFH employees may witness and sign below:

CFH Employee printed Name:_____Title: _____

Signature: _____Date:_____

CFH Employee printed Name:_____Title: _____

Signature: _____Date:_____

TO OBTAIN WRITTEN INFORMATION AN AUTHORIZATION TO RELEASE RECORDS MUST BE COMPLETED

NorthCountry Initiative

AAFP

Social Determinants of Health Screening Tool

A lot of things are related to your health—including your housing, finances, and more. If you tell us you have any needs below, we'll talk with you about services available to meet those needs.

Patient Name: _____

Patient DOB: _____

Today's Date: _____

Housing

1. Are you worried that in the next 12 months, you may not have stable housing?

☐a. Yes
☐b. No

2. Think about the place you live. Do you have problems with any of the following? (Check all that apply)

☐ a. Bug infestation
☐ b. Mold
☐ c. Lead paint or pipes
☐ d. Inadequate heat
☐ e. Oven or stove not working
☐ f. No or not working smoke detectors
☐ g. Water leaks
☐ h. None of the above

3. Where do you live now?

☐ a. Own my home/apartment
☐ b. Rent my home/apartment
☐ c. Live in a friend or relative's house
☐ d. Shelter
☐ e. Street homeless
☐ f. Supportive housing
☐ g. Other: _____

Food & Nutrition

4. In the last 12 months, did you eat less than you felt you should because there wasn't enough money for food?

☐ a. Often True
☐ b. Sometimes True
☐ c. Never True

5. Do you wish you could eat healthier, but have trouble getting healthy foods and/or making meals? (Check all that apply)

☐ a. I can't afford healthy foods
☐ b. I can't get transportation to buy healthy foods
☐ c. I'm not sure what/how to make healthy meals
☐ d. None of the above

Transportation

6. Do you put off going to the doctor because of distance or transportation?

☐ a. Yes
☐ b. No

7. Are there other needs you can't meet because of transportation issues?

☐ a. Yes: _____
☐ b. No

This was adapted from the AAFP ToolKit

Utilities (water, gas, electricity, oil)

8. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

☐ a. Yes
☐ b. No

Childcare

9. Do problems getting childcare make it difficult for you to work or study?

☐ a. Yes
☐ b. No

Personal Safety

10. Are you afraid you might be hurt by another person in your apartment building, house, life, or community?

☐ a. Yes
☐ b. No

11. How often does anyone, including family, insult or talk down to you?

☐ a. Never
☐ b. Rarely
☐ c. Sometimes
☐ d. Fairly Often

12. How often does anyone, including family, physically hurt you?

☐ a. Never
☐ b. Rarely
☐ c. Sometimes
☐ d. Fairly often

Finances

13. How often does this describe you? "I don't have enough money to pay my bills."

☐ a. Never
☐ b. Rarely
☐ c. Sometimes
☐ d. Fairly Often
☐ e. Frequently

14. In the last 12 months, have you needed to see a doctor, but could not because of cost?

☐ a. Yes
☐ b. No

15. Do you have a job?

☐ a. Yes
☐ b. No

Other

16. Do you ever need help reading or understanding papers or forms that you get from your doctor or other healthcare providers?

☐ a. Yes
☐ b. No

17. Are there any other situations at home that make it hard for you to take care of yourself?

☐ a. Yes: _____
☐ b.

This was adapted from the AAFP ToolKit

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Immunization

Consent For Participation in NYSIIS for Individuals 19 Years of Age or Older

The New York State Immunization Information System (NYSIIS) is a confidential, computerized system that contains immunization records and allows authorized users access to a person's shot record. Strict federal and state laws protect the privacy of your personal information in the system. The benefits of participating in NYSIIS include:

- Your health care provider can use NYSIIS to be sure that you receive the needed immunizations, and proper medical treatment is received when needed.
- There will be a permanent and easily accessible record of your immunizations.

Participation in NYSIIS for people 19 years of age and older is voluntary, so your consent is needed. If you want to participate, please carefully read the consent below and sign in the space provided. For additional information about this consent, please call (518) 473-2839.

I give my consent for Clifton Fine Primary Care **(name of doctor or organization) to release my immunization(s) and identifying information to the New York State Immunization Information System (NYSIIS). I understand the purpose of NYSIIS is to assist in my medical care and to record the immunizations that I have had or will receive in the future. My immunization information may potentially be used by the Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes. Information used for quality improvement or any research purposes will have my personal identifying information removed.**

The immunization information in NYSIIS may be released to the following: myself, my health insurance plan, the state and local health departments, the school that I am registered to attend, and authorized medical providers that deliver my medical care.

I understand that there will be no effect on my treatment, payment, or enrollment for benefits if I choose not to enroll in NYSIIS. This consent may be withdrawn at any time by using the form provided. Information about immunizations received by NYSIIS with my consent will remain in NYSIIS if I later choose to withdraw my consent. However, future immunizations will not be recorded in NYSIIS.

Print Name _____ Date of Birth _____

Signature _____ Date _____

Clifton-Fine Hospital
A SAMARITAN HEALTH PARTNER

CONSENT TO USE OF ELECTRONIC COMMUNICATIONS

Patients of Clifton Fine Hospital may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. I consent to communicate with Clifton Fine Hospital using the following means of electronic communication.

☐Text Message | Cell Phone Number (____)-_____-_____

☐Email | Email Address _____

Patient Acknowledgement and Agreement

I understand that this request to receive electronic communications will apply to all future appointment reminders/feedback/health information unless I request a change in writing.
I understand I have the right to withdraw my consent to receive/obtain electronic communications from Clifton Fine Hospital at any time.
I agree to notify Clifton Fine Hospital if my cell phone number or email changes.
I understand that I assume any costs incurred related to receipt/sending of text messages.
I understand that electronic media and delivery methods such as e-mail and text messaging pose certain risks to the privacy and security of my protected health information. I agree to assume such risks personally and to hold Clifton Fine Hospital and agents harmless in the event that my protected health information is breached or compromised because of my directing and authorizing Clifton Fine Hospital and agents to transmit or deliver such information electronically.

Patient (Please Print): _____

Signature: _____**Date**: ___/___/____