Valley View Family Practice Associates

213 State Route 245
Rushville, NY 14544
585-554-3119

198 Parrish St.
Canandaigua, NY 14424
585-394-4920

Geoffrey P. Ostrander, M.D.
Robert J. Ostrander, M.D.
Donna J. Schue, M.D.
Christine E. Rose, PA

John J. D'Amore, M.D.

INSTRUCTIONS

Dear Patient:

Attached are Valley View Family Practice's (VVFP)New Patient Forms, please carefully read and fill them in.

*** New Patient History Form**: fill in accordingly, as best you can.

*** Uniform Assignment/Release of Information Statements:** This authorizes us to share information with and bill your insurance company for our services. It asks you to assign sufficient monies and correct information to us regarding your bill. It also includes, acknowledgment that you were able to review the Notice of Privacy Practices.

*** Health Information Portability and Accountability (HIPAA) Consent**: This tells us to whom and how we may disclose your protected health information. This needs to be updated annually and with any major change in your life (ie. wedding, funeral,new phone number etc.)

*** Rochester RHIO:** This consent gives us permission to access/share your PHI with a state-wide Health Information Exchange. See rochesterrhio.org

*** 2018 VVFP Financial Policy:** This contains payment options and policies.

*** Release of Information**: Fill in and give to your previous doctors office, so that we may obtain your old health records.

*** Minors ONLY**
School Release - this allows us to communicate with the school district your child attends.
Authorization Form - this is for you to have on hand for a babysitter or caregiver that would bring your child to the doctor. We do like to have a copy in each childs record.

Jolene Boland
Health Information Specialist

Sabrina McClow
Office Manager

Name: **DOB:** **Sex: M F** **Todays Date**

Marital Status: Single Divorced Widowed Separated Married

Children? Yes No How Many?_____ Occupation:_____ Military Service:_____

Personal Habits: Alcohol Y N Tobacco Y N Quit____yr Caffeine Y N Recreational Drugs Y N
Quantity:_____/Wk Quanitity:_____pk/day Coffee Tea Soda
How long:_____Yrs Qty_____/wk

Medication Allergies:_____
(with Reaction)

Current Medications: **Dose**

_____ _____
_____ _____
_____ _____
_____ _____

Current Medical Problems :_____

_____
_____
_____
_____

Surgeries/Hospitalizations:

Year

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Most Recent Date For The Following:

Pneumovax Immunization:_____
MMR Immunization:_____
Tetanus Booster:_____
Eye Exam:_____Hearing:_____
Colonoscopy:_____
Mammogram:_____ Pap_____
Rectal/Prostate Exam:_____

Family History: (Parents, Grandparents, Siblings)

Age Health Problems/Cause of Death

Mother _____ _____

Father _____ _____

Siblings _____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Circle Any Diseases A Family Member Has Had

Heart Attack High Blood Pressure
Arthritis Bleeding Tendency
Cancer Type: _____
Liver Disease Tuberculosis
Kidney Disease Goiter
Epilepsy Asthma
Hepatitis Aids
Ulcers Stroke
Rheumatic Fever Thyroid Disease
Anemia Depression
Blood Clots

System Review: Circle if you now have or have had in the past:

Severe Dizziness	Y N	Stomach Ulcers	Y N	Gout	Y N	Loss of Libido or	
Ear Problems	Y N	Frequent Stomach or		Back Problems	Y N	Other sexual issues	Y N
Chronic Cough	Y N	Abdominal Pain	Y N	Hernia	Y N	Irregular Menses	Y N
Asthma	Y N	Vomiting Blood	Y N	Seizures	Y N	Prolonged Diarrhea	Y N
Coughing up Blood	Y N	Bloody/Black/Tarry Stool	Y N	Numbness or		Painful Menstrual	
Hay Fever	Y N	Hemorrhoids	Y N	Weakness	Y N	Cramping	Y N
Chest Pain	Y N	Gallbladder Trouble	Y N	Recent/Unexpected weight change	Y N	Loss of Consciousness	Y N
Shortness of Breath	Y N	Recent Change in Bowel Habits	Y N	Loss of Consciousness	Y N	Loss of Vision	Y N
High Blood Pressure	Y N	Hepatitis/ Jaundice	Y N	Depression	Y N	Hearing Loss	Y N
Swollen Ankles	Y N	Kidney Stones		Y N Trouble Sleeping		Y N Difficulty w/Memory	Y N
Leg Cramps w/walking	Y N	Kidney Infection		Y N Anemia		Y N Skin Rash	Y N
Phlebitis	Y N	Bladder Infection	Y N	Goiter	Y N	Chronic Swollen Glands	Y N
Heart Murmur	Y N	Difficulty Urinating		Y N Thyroid Problems		Y N Unexplained Lumps	Y N
Heart Problems	Y N	Joint Pain/Stiffness		Y N Blood Clots		Y N Heart Palpitations	Y N
Diabetes	Y N	Joint Swelling	Y N	Headache	Y N	Fever/Chills/Nightsweats	Y N
Severe Heartburn	Y N	Sinus Infection	Y N	Difficulty Swallowing	Y N		
Severe Bleeding	Y N	Constant Fatigue		Y N Anxiety		Y N	

Reviewed & Updated
May 23, 2019

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Financial Policy

EFFECTIVE JANUARY 1, 2017

Reviewed & Updated May 23, 2019

In the last few years, health care has experienced significant changes, specifically due to the Affordable Care Act signed into law in March, 2010. Physicians are now seeing more individuals with High Deductible Health Plans (HDHP), which places more financial responsibility on the patient. Due to the changes in health care, it is necessary to update our financial policy.

1. There will be a **$25.00 charge for all missed** (no-show) **or cancelled appointments with less than 24 hours notice**. **$75.00 charge for 2nd missed appointment**. Fees must be paid before you will be seen for any routine visits.
2. **Co-payments are due at the time of service**. Any co-payments not paid on the date of the visit will be charged a $10.00 fee.
3. **Self-pay patients must pay at the time of service**. Payments not received on the same day will be charged a $10.00 fee.
4. **Please note VVFP cannot give any estimates for medical services prior to being seen.** This includes the cost of the level of the visit. We can only provide an **estimated range of an anticipated charges** from the lowest to the highest level**. Again, this cost is an estimate. We cannot determine charges prior to being seen.**
5. **NOTICE OF NON-COVERAGE FOR MEDICAL SERVICES** – Valley View Family Practice will always bill your health insurance company for medical services. You are responsible for deductibles, co-payments, co-insurance amounts or any **NON-COVERED MEDICAL SERVICES**. ***It is the patient's responsibility to know and understand their health care benefits and coverage limits.*** In the event such medical services are not covered under your health insurance plan, this notice serves to inform you that your account will be billed.
6. **Medications and medical supplies must be paid for when received**.
7. For patients with **Health Plans with Deductibles, the fee collected at the time of service is based upon the level of service you receive, and this payment amount will be applied towards your account**. You will be billed for any balance due after your insurance has processed the claim (see reverse side of this notice for more explanation on High Deductible Health Plans). **If you do not pay at the time of service, a standard payment plan will be set up**.

Standard Payment Plans – Per Family*	
Balances 0 to $100.00	$20.00 per month until paid
Balances $100.00 to $300.00	$50.00 per month until paid
Balances $300.00 and up	$75.00 per month until paid

*If your account is placed on a Standard Payment Plan, **your payment must be received monthly to remain current**. We use an automated telephone service to make reminder calls on past due bills.

Patient balances carried beyond 30 days will be charged 1.5% per monthly fee. This includes accounts on payment plans.

8. **Past Due Accounts -** For all **patient** and **family balances** (multiple patients from one family) **over $100.00**, no routine visits can be scheduled until the balance is paid in full.
9. **Severely past due accounts will be turned over to collections**. In the event your account is placed into collections, a 30% fee will be added to your balance to cover the collection agency fee. Severely past due accounts can result in being released from the practice.

Valley View Family Practice accepts all major credit cards (Visa, Master Card, Discover and American Express). **You may also pay your bill on-line at valleyviewfamilypractice.com.** If you are experiencing financial difficulty, payment options are available. Please contact our **Billing Specialist, Kim Maslyn, at (585) 554-5361** to set up a payment plan. If you have any questions, please ask the medical secretary, or you may contact one of the individuals listed below.

Kim Maslyn, Billing Specialist (585) 554-5361 Sabrina McClow, Practice Manager (585) 554-6069

☐ **I have read or received a copy of this policy.**

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Financial Policy
EFFECTIVE JANUARY 1, 2017
UPDATED JANUARY 1, 2018

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This Financial Policy Addendum applies to Patients with Medicaid or Medicaid Advantage Policies ONLY: (ADDENDUM – 07/28/2017)

10. Since Medicaid patients cannot be charged fees for **NO SHOW** appointments, or for **appointments canceled with less than 24-Hours' Notice,** the following policy applies:

    1. **FIRST** appointment NO SHOWED or CANCELED with less than 24-Hour Notice, within a 12 month period (NOT calendar year), the patient will be sent first Missed Appointment Notification Letter.
    2. **SECOND** appointment NO SHOWED or CANCELED with less than 24-Hour Notice, within a 12 month period (NOT calendar year), the patient will be sent second Missed Appointment Notification Letter which specifically states: ***Any further missed appointments could result in discharge from the practice.***
    3. **THIRD** appointment NO SHOWED or CANCELED with less than 24-Hour Notice, within a 12 month period (NOT calendar year), **the patient could be dismissed from the practice with authorization from the Primary Care Physician**.

If you have any questions, please ask the medical secretary, or you may contact one of the individuals listed below.

Kim Maslyn, Billing Specialist (585) 554-5361 Sabrina McClow, Practice Manager (585) 554-6069

☐ **I have read or received a copy of this policy.**

High-Deductible Health Plan (HDHP)

Many different health insurance companies (MVP, Excellus, AETNA, etc.) offer high deductible health plans. A **high-deductible health plan** (**HDHP**) is a health insurance plan with lower premiums and higher deductibles than a traditional health plan.

A deductible is the **annual dollar amount you must pay out of pocket (for expenses) before your insurance company begins to pay for any services.** Most high deductible health plans require amounts into the thousands, which means you may have to pay out of pocket for most of your primary care services.

The **deductible resets annually** depending on your plan year. Typically this is either January 1st or July 1st.

All amounts paid by you will be applied to your deductible through the same insurance and filing process used on typical policies. You will receive an Explanation of Benefits (EOB) from your insurance company letting you know your paid amount has been applied to your deductible.

For balances carried beyond 30 days, a 1.5% monthly fee will be charged to your account. Payment options are available.

Please contact our **Billing Specialist, Kim Maslyn at (585) 554-5361, ext.** 4 to set up a payment plan.

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Patient Name: _____ DOB: _____

In accordance with our Electronic Medical Record System (EMR) we need to have *explicit* directions from you on how you prefer to be contacted by Valley View Family Practice. Valley View Family Practice uses an automated system to confirm appointments. If you do not wish to participate in the automated calls or have any other concerns regarding how we get in touch with you please submit a written explanation on a separate piece of paper.

By marking yes, you are agreeing to have us contact you by these means regarding appointment information, medical information or results, billing information, etc.

May we call your home phone?	Y	N
May we call your mobile phone?	Y	N
May we text your mobile phone?	Y	N
May we call you at your place of work?	Y	N
May we send mail to your home address?	Y	N
May we email/patient portal you?	Y	N

As stated in our Notice of Privacy Practices, we may disclose to a person you identify (relative, friend, etc.) protected health information (PHI) that directly relates that person's involvement in your healthcare. We request that you designate here, individuals with whom we may discuss your health and other information about your care here at Valley View Family Practice. In case of emergency we will contact them in order.

Contact 1.) Name: Relationship: Phone #:

_____

Contact 2.) Name: Relationship: Phone #:

_____

Signature: Date:

_____

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Authorization to Release Medical Information

Patient Name:	Date Of Birth:	Phone 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*** _____. In the event the health information described below includes any of these types of information, and I initial the line, I specifically authorize release of such information to the person(s) indicated.
2. With some exceptions, health information once disclosed may be redisclosed 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 redisclosing 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/AIDSrelated information, I may contact the New York State Division of Human Rights at 18883923644. 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. 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. This authorization is valid for: [ ]This request only. [ ]One year from this request. [ ]This request and any future treatment of the type described.

Name, Address, and Phone Number of Health Provider to Release Information:
Name, Address, and Phone Number of Health Provider to Receive Information:

Purpose for this request: [ ] Transfer of Care [ ]Legal [ ]Specialist [ ]Other

This request and authorization applies to:

- ☐ Entire Medical Record
- ☐ General Medical Record ***(includes last 5 years of office notes, and 2 years of consults, tests, x-rays and labs)***
- ☐ Medication List, Problem List, Immunization Record
- ☐ Specific Information/Dates:_____

Patient/Representative Legal Signature ***Today's Date***

There may be a fee that applies

ROCHESTER RHIO

Regional Health Information Organization

New York State Department of Health

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

PROVIDER: VALLEY VIEW FAMILY PRACTICE

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

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 above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans attached to this form to obtain access to my medical records through the health information exchange organization called Rochester RHIO. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Rochester RHIO 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 Rochester RHIO's website at **www.RochesterRHIO.org**.

My information may be accessed in the event of an emergency, unless I complete this form and check box #2, which states that I deny consent even in a medical emergency.

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 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.

☐ **I GIVE CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access ALL of my electronic health information through Rochester RHIO to provide health care services (including emergency care).

☐ **I DENY CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access my electronic health information through Rochester RHIO for any purpose, ***even*** *in a medical emergency (except for minor patients)*.

If I want to deny consent for all Provider Organizations and Health Plans participating in Rochester RHIO to access my electronic health information through Rochester RHIO, I may do so by visiting Rochester RHIO's website at **www.RochesterRHIO.org** or calling Rochester RHIO at 1-877-865-RHIO(7446).

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 Rochester RHIO 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(s) and/or Health Plan(s) listed may access ALL of your electronic health information available through Rochester RHIO. 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

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 the named Provider Organization(s) or Rochester RHIO. You can obtain an updated list at any time by checking Rochester RHIO's website at www.RochesterRHIO.org or by calling 1-877-865-RHIO(7446).

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. If there is an emergency, doctors and other staff members will be able to use the Rochester RHIO 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 Rochester RHIO 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 at: (585)554-3119; or visit Rochester RHIO's website: www.RochesterRHIO.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 Rochester RHIO ceases operation (or until 50 years after your death whichever occurs first). If Rochester RHIO 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(s). Organizations that access your health information through Rochester RHIO 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.

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UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

Name:_____ DOB:_____

I hereby authorize any Valley View Family Practice Physician to review any medical records prepared by any other physician where services are rendered relating to my care and treatment. I hereby further authorize release of information in relation to medical treatment by any physician at Valley View Family Practice and the appropriate facility, to governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care or to the facility where services are rendered, laboratories or others, for the purpose of billing and collecting fees for medical services provided on my behalf and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

_____ _____
Date Signature of Patient or Authorized Representative

I hereby assign to the treating physicians of Valley View Family Practice sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or to others who are financially liable for my hospitalization and medical care to cover the costs of the care and treatment rendered to myself or my dependent in said facility or hospital.

_____ _____
Date Signature of Patient or Authorized Representative

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided a copy of, or been offered the opportunity to receive the Valley View Family Practice Notice of Privacy Practices.

_____ _____
Date Signature of Patient or Authorized Representative

FOR PATIENTS ENTITLE TO MEDICARE BENEFITS LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVIII for the Social Security Act is correct. I authorize any Valley View Family Practice holder of medical information or other information about me to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this on my behalf to the physician or organization furnishing the services provided to me. I authorize any holder of medical information about me to release to the MEDIGAP insurer any information needed to determine these benefits or the benefits payable for related services. I request that payment under the medical insurance program be made either to me or to any physician for services provided to me.

_____ _____
Date Medicare Beneficiary Signature

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RELEASE OF MEDICAL INFORMATION TO SCHOOL DISTRICT

Student's Name:_____ DOB:_____

As stated in our Notice of Privacy Practices, we may only disclose information to whom you identify. Schools typically require physicals and immunizations be shared, occasionally, and only with your explicit permission we may share more. If you do not wish to share anything with your child's school, please indicate that in writing. (Can use the back of this form)

I, _____ parent/guardian of child above give Valley View Family Practice permission to forward copies of my Childs record to the school district indicated below.

Please Check One:

____ Marcus Whitman ____ Bloomfield

____ Canandaigua ____ Midlakes

____ Naples ____ Penn Yan

____ Geneva ____ Victor

____ Other (write in)_____

_____ Date:_____
Parent/Guardian Signature

VALLEY VIEW FAMILY PRACTICE

Editor's note: Revised to reflect the 2013 HIPAA/HITECH Omnibus Final Rule

OUR COMMITMENT REGARDING YOUR PERSONAL HEALTH INFORMATION

Valley View Family Practice is committed to maintaining and protecting the confidentiality of our patient's personal information. This Notice of Privacy describes how your health information may be used and disclosed and how you can access this information. This notice provides you with information to protect the privacy of your confidential health care information, hereafter referred to as protected health information (PHI). The Notice also describes the privacy rights you have and how you can exercise those rights. Please review it carefully.

HIPAA Notice of Privacy Practices

Effective Date: 7/10/2014

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.

If you have any questions about this notice, please contact Jolene Boland VVFP's Hipaa Security Officer. (585)-554-3119 Ext. 14 *or* jolenebolandvvfp@gmail.com or Sabrina McClow, Office Manager 554-6069 *or* smvvfp@outlook.com

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Security Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We

may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend (designated by you). We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we use Medent Software to record and manipulate our health records. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the

information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Jolene Boland, Valley View Family Practice, 213 State Route 245, Rushville NY 14544. We have up to 30 days to make your Protected Health Information available to

you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Jolene Boland, Valley View Family Practice, 213 State Route 245, Rushville NY 14544.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Sabrina McClow, Valley View Family Practice, 213 State Route 245, Rushville NY 14544

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Jolene Boland, Valley View Family Practice, 213 State Route 245, Rushville NY 14544. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Jolene Boland, Valley View Family Practice, 213 State Route 245, Rushville NY 14544 Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may

ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice call Jolene or mail a request to 213 State Route 245, Rushville NY 14544.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Jolene Boland 213 State Route 245 Rushville NY 14544. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

We may change the terms of this Notice at any time. If we change this Notice, we may make the new Notice terms effective for all of your PHI that we maintain, including any information we created or received before we issued the new Notice. If we change this Notice, we will make it available to you.

AUTHORIZATION
FOR MEDICAL TREATMENT OF MINORS
THIS IS A LEGAL DOCUMENT

Names of Minors	Birthdates	Indicate allergies, special conditions and medication

I/We, being the parent(s) or legal guardian(s) of the above named minor(s), do hereby appoint:

Name(s)	Address	Phone

To act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minor(s) during the period of my/our absence from:

Month / Day / Year through Month / Day / Year

This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization my be required.

Parent/Guardian	Parent/Guardian
Signature	Signature
Address Date	Address Date
WITNESS	**WITNESS**
Signature	Signature
Address Date	Address Date

Hospitalization Coverage For Above Named Minor(s):	
Insurance Company or Government Program	ID or Contract Number

Family Physicians	
Name & Phone Number	Name & Phone Number

BROUGHT TO YOU BY THOMPSONHEALTH

PHONE NUMBERS

HOW TO USE THIS FORM

This form is a LEGAL document. Leave it with your baby sitter or whoever takes care of your child. In the event of an emergency, the doctor, hosptial, or emergency will require this signed form in order to treat your child.

Thompson Emergency Center: (716) 396-6600

Ambulance: _____

Fire Department: _____

Police: _____

Poison Control: 1-800-333-0542

Doctor: _____

Dentist: _____

We may be reached at: _____