

Welcome to People Inc. Rehabilitative Health and Counseling Services!

Enclosed is an information packet and forms that you will need to complete **before** you come in for your first appointment. **It is our expectation that you will bring the completed forms with you for your first appointment.**

We wish to make your registration as pleasant and timely as possible. We know that your time is valuable, so in addition to bringing this packet with you to your first appointment, we ask that you **bring your health insurance card(s) and a photo ID with you**, as well as a list of any referrals that you may need.

Please **arrive 15 minutes before your first appointment time,** so that we may review all paperwork and insurance information with you before your initial visit. *Please note that People Inc. Rehabilitative Health and Counseling Services are* ***not*** *walk-in clinics and that* ***all visits are by appointment only***.

We thank you in advance for your cooperation and we look forward to providing for your health care needs. If you have any questions, please call us at 716-566-5050.

Sincerely,

People Inc. Rehabilitative and Counseling Services



**Pre-Registration Form:** **Rehabilitative Health and Counseling Services**

Date of Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex (circle one): Male / Female Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician or Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/ Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this appointment needed due to an injury? Y / N

1. If Yes, is this a no Fault Case due to an auto accident?
2. If Yes, is this a Worker’s Compensation Case due to a work related injury?



**INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber/Guarantor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber/Guarantor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tertiary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber/Guarantor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**People Inc. Rehabilitation Health Services Intake Form**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Problem you are seeking services for**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**a) Is today’s problem a result of a(n):** □ Auto Accident/No-fault □ Workman’s Compensation □ Neither

**b)** **How long have you had this problem**?

**2.** **Are you currently receiving any of the following services?**

□ Physical Therapy □ Occupational Therapy □ Speech Therapy □ None

**3. Are you currently receiving Home Health Care for any concern?** □ Yes □ No

a) If yes what service is home health providing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **What is your current living situation?**

□ Independently in home/apartment

□ Group living situation: ○ ICF ○ IRA ○ Supported apartment

**5. Who else have you seen for your problem? (Check all that apply)**

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER physician □ Orthopedist

□ Massage Therapist □ Physical Therapist □ No one □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6.** **Do you have a DD (developmental disability) diagnosis?** □Yes □No

a. If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7.** **Are you currently attending a day program**? □ Yes □ No

a. If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8.** **Name/phone # of Service Coordinator/Case Worker (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Do you have a diagnosis of any of the following:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| High blood pressure | □ Yes | □ No |  | Arthritis/Osteoarthritis | □ Yes | □ No |
| Heart disorders | □ Yes | □ No |  | Osteoporosis | □ Yes | □ No |
| High Cholesterol | □ Yes | □ No |  | Cancer | □ Yes | □ No |
| Lung Disorders | □ Yes | □ No |  | Pacemaker | □ Yes | □ No |
| Circulation disorders | □ Yes | □ No |  | Are you pregnant? | □ Yes | □ No |
| Dizzy Spells | □ Yes | □ No |  | Allergies to tapes or lotions? | □ Yes | □ No |
| Seizures | □ Yes | □ No |  | Tobacco use | □ Yes | □ No |
| Diabetes | □ Yes | □ No |  | Alcohol use | □ Yes | □ No |

1. **Please list any other current medical diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**11. Are you experiencing any of the following symptoms?**

□ Unintentional weight gain or loss □ Fevers □ Night sweats □ Swelling/edema □ Swollen glands

1. **Please list all current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**13.** **Please list all** **past and pending surgical procedures:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**14. Have you had any recent falls?** □ Yes □ No

**15. Do you use any of the following assistive devices?**

□ Wheelchair □ Communication device □ Walker □ Communication book

□ Cane □ Adaptive feeding equipment □ Shower chair □ Leg braces (AFOs)

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**16.** **Are you having any trouble with any aspects of daily living including (buttoning shirts, pulling up**

**Zippers, holding a cup, holding a pen, combing your hair, bathing, house work, etc.) or social activities?** □ Yes □ No

**17.** **Are you having trouble with any aspects of eating/feeding, such as swallowing?** □ Yes □ No

**~~~~~~ *If you are currently experiencing pain, please answer questions below. ~~~~~~***

**18.** **How often do you experience your symptoms?**

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)

□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

**19.** **How would you describe the type of pain? (Check all that apply)**

□ Sharp □ Numb □ Dull □ Tingly □ Diffuse □ Sharp with motion □ Achy

□ Shooting with motion □ Burning □ Stabbing with motion □ Shooting

□ Electric like with motion □ Stiff □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**20.** **How are your symptoms changing with time?**

□ Getting Worse □ Staying the Same □ Getting Better

**21.** **Using a scale from 0-10 (10 being the worst), how would you rate your pain?**

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

**22.** **Indicate on the drawings below where you have pain/symptoms**.

**(Right side) (Back side) (Front side) (Left Side)**

****



**23. How much has the problem interfered with your work or social activities?**

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extreme

***~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~***

*My signature indicates that the above information is accurate to the best of my knowledge and I understand that it is my responsibility to inform my provider of any changes in the above information.*

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| *Office Use Only* | Reviewed by:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Consent for Service**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby request that a person authorized by the People Inc. Rehabilitative Health Services perform examinations or test(s) and provide appropriate treatment when indicated.

Referral will be made for further diagnosis and/or treatment where indicated. I understand that if follow-up is needed, I will assume the responsibility for such follow-up.

I am aware that information on DO NOT RESUSCITATE ORDERS and HEALTH CARE PROXY is available upon request.

I authorize payment of medical benefits to the undersigned physician or supplier for services rendered.

I have read the patient Bill of Rights and all of the above.

**Assignment of Benefits**

We will bill the appropriate insurance companies for the services covered by your individual plan(s). You will; be responsible for and deductible or insurance balance. We will bill you for any remaining balance after your insurance has paid its portion of the bill. Self-pay patients are responsible for their balances in their entirety.

**YOUR INSURANCE CARD IS REQUIRED AT THE TIME OF EACH VISIT. INSURANCE CO-PAYMENTS ARE DUE AT THE TIME OF EACH VISIT.**

If you do not have insurance coverage, we will gladly discuss our fee schedule.

**PAYMENT IS EXPECTED AT THE TIME OF YOUR VISIT**

Please notify our office immediately if your insurance coverage changes.

I hereby assign all medical benefits to include all Medicare, Medicaid, Community Blue, Blue Cross/ Blue Shield, Independent Health, Univera, and/or other health plans to People Inc. Rehabilitative Health Services.

This assignment remains in effect until revoked by me in writing. I understand than I am financially responsible for all charges if not paid by said insurance.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed Date Witness Date

Notice of Privacy Practices

**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.**

Provider uses your Protected Health Information for your treatment, to obtain payment for our services and for our operational purposes, such as improving the quality of care we provide to you. We are committed to maintaining your confidentiality and protecting your health information. We are required by law to provide you with this Notice, which describes our health information privacy and those of affiliated health care providers.

This Notice applies to all information and records related to your care that our Provider workforce members and Business Associates have received or created. It also applies to health care professionals, such as physicians, and organizations that provide care to you from the various Provider Departments. It informs you about the possible uses and disclosures of your Protected Health Information and describes your rights and our obligations regarding your Protected Health Information.

***We are required by law to:***

* Maintain the privacy of your Protected Health Information;
* Provide to you this detailed Notice of our legal duties and privacy practices relating to your Protected Heath Information; and
* Abide by the terms of the Notice that are currently in effect. We reserve the right to change the terms of this Notice, and will notify you or your personal representative if we make any material changes to the Notice.

# **I. WITH YOUR CONSENT, WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**

We are required by New York State Law to obtain a signed Consent *(Attachment A-3)* allowing us to use and disclose your Protected Health Information or Private Information (collectively referred to as “Protected Health Information”) to others to provide you with treatment, obtain payment for our services, and run our health care operations. Here are examples of how we may use and disclose your health care information.

**FOR TREATMENT:** Our staff and affiliated health care professionals may review and record information in your record about your treatment and care. We will use and disclose this health information to health care professionals in order to treat and care for you. For example, a physician may consult with another physician located at another location to determine how to best diagnose and treat you.

**FOR PAYMENT:** The Provider may use and disclose your Protected Health Information to others in order for the Provider to bill for your health care services and receive payment. For example, we may include your health information in our claim to your insurance company, Medicaid, or Medicare in order to receive payment for services provided to you. We may also disclose your health information to other health care providers so that they can receive payment for their services.

**FOR HEALTH CARE OPERATIONS:** We may use and disclose your Protected Health Information to others for the Provider’s business operations. For example, we may use Protected Health Information to evaluate the Provider’s services, including the performance of our staff, and to educate our staff.

**Appointment Reminders:** We may use and disclose your information to contact you as a reminder that you have an appointment for treatment or medical care.

# **WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR OTHER SPECIFIC PURPOSES**

**BUSINESS ASSOCIATES:** We may share your Protected Health Information with our vendors and agents who create, receive, maintain or transmit PHI for certain functions or activities on behalf of the Provider. These are called our “Business Associates”. To protect and safeguard your health information, we require our Business Associates and subcontractors to appropriately safeguard your information.

**FAMILY AND FRIENDS INVOLVED IN YOUR CARE:** Unless you object, we may disclose your Protected Health Information to a family member or close personal friend, including clergy, who is involved in your care or payment for that care.

**PERSONAL REPRESENTATIVE:** If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information. If you become deceased, we may disclose health information to an executor or administrator of your

estate to the extent that person is acting as your personal representative or to your next of kin, as permitted under state and federal law.

**DISASTER RELIEF:** We may disclose your Protected Health Information to an organization assisting in a disaster relief effort.

**PUBLIC HEALTH ACTIVITIES:** We may disclose your Protected Health Information for public health activities including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation and/or intervention. We may also disclose your information to notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition if a law permits us to do so.

**HEALTH OVERSIGHT ACTIVITIES:** We may disclose your Protected Health Information to health oversight agencies authorized by law to conduct audits, investigations, inspections and licensure

actions or other legal proceedings. These agencies provide oversight for the Medicare and Medicaid programs, among others.

**REPORTING VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE:** If we have reason to believe that you have been a victim of abuse, neglect or domestic violence, we may use and disclose your Protected Health Information to notify a government authority if required or authorized by law, or if you agree to the report.

**LAW ENFORCEMENT:** We may disclose your Protected Health Information for certain law enforcement purposes or other specialized governmental functions.

**JUDICIAL AND ADMINISTRATIVE PROCEEDINGS:** We may disclose your Protected Health Information in the course of certain judicial or administrative proceedings.

**RESEARCH:** We will request that you sign a written authorization before using your Protected Health Information or disclosing it to others for research purposes.

**CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTOS, ORGAN PROCUREMENT ORGANIZATIONS:** We may release your Protected Health Information to a coroner, medical examiner, funeral director or, if you are an organ donor, to an organization involved in the donation of organs and tissue.

**TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY:** We may use and disclose your Protected Health Information when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person. However, any disclosure would be made only to someone able to help prevent the threat.

**MILITARY AND VETERANS:** If you are, or were, a member of the armed forces, we may use and disclose your Protected Health Information as required by military command authorities. We may also use and disclose Protected Health Information about foreign military personnel as required by the appropriate foreign military authority.

**WORKERS’ COMPENSATION:** We may use or disclose your Protected Health Information to comply with laws relating to worker’s compensation or similar programs.

**NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES; PROTECTIVE SERVICES:** We may disclose Protected Health Information to authorized federal officials who are conducting national security and intelligence activities or as needed to provide protection to the President of the United States, or other important officials.

**AS REQUIRED BY LAW:** We will disclose your Protected Health Information when required by law to do so.

## YOUR AUTHORIZATION IS REQUIRED FOR OTHER USES OF YOUR PROTECTED HEALTH INFORMATION

We will use and disclose your Protected Health Information other than as described in this Notice or required by law only with your written Authorization. You may revoke your authorization to use or disclose Protected Health Information in writing, at any time. To revoke your Authorization, contact the appropriate Provider Staff. If you revoke your Authorization, then we will no longer use or disclose your Protected Health Information for the purposes covered by the Authorization, except where we have already relied on the Authorization.

**Fundraising [if applicable]**.

Provider may contact you or your personal representative to raise money for the Provider. We may also share your demographic information with a charitable foundation that may contact you or your personal representative to raise money on our behalf. In certain circumstances, you must provide us with your written authorization for our use of your information for fundraising and you also have the opportunity to opt out or restrict your receiving future fundraising communications. Your request to opt out of receiving future fundraising communication will revoke any prior authorizations and you will not receive any future communications.

**Marketing [if applicable]**.

In most circumstances, Provider is required by law to receive your written authorization before we use or disclose your health information for marketing purposes. Under no circumstances will we sell our individual lists or your health information to a third party without your written authorization.

**Psychotherapy Notes [if applicable]**.

In most circumstances, Provider is required by law to obtain your written authorization before we use or disclose psychotherapy notes.

**IV. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

You have the following rights with respect to your health information. If you wish to exercise any of these rights, you should make your request to the appropriate Provider Staff.

**RIGHT OF ACCESS TO PROTECTED HEALTH INFORMATION:**  You have the right to request, either orally or in writing to inspect and obtain a copy of your Protected Health Information, subject to some limited exceptions. If available, you have the right to access your information in electronic format. We must allow you to inspect your records within 10 days of your request. If you request copies of the records, we must furnish you a copy within 30 days of that request if the records are maintained on site and within 60 days if maintained off site. We may charge a reasonable fee for our costs in copying and mailing your requested information or provision of information in electronic format.

In certain limited circumstances, we may deny your request to inspect or receive copies. If we deny access to your Protected Health Information, we will provide you with a summary of the information, and you have a right to request review of the denial. We will provide you with information on how to request a review of our denial and how to file a complaint with us or the Secretary of the Department of Health and Human Services.

**RIGHT TO REQUEST RESTRICTIONS:** You have the right to request restrictions on the way we use and disclose your Protected Health Information for our treatment, payment or health care operations. You also have the right to request restrictions on our disclosures of your Protected Health Information to a family member, friend or other person who is involved in your care or the payment for your care.

We are not required to agree to your requested restriction, and in some cases, the law may not permit us to accept your restriction. However, if we do agree to accept your restriction then we will comply with your restriction EXCEPT IF: (1) you are being transferred to another health care institution; (2) the release of records is required by law, or (3) the release of information is needed to provide you emergency treatment. If your restriction applies to disclosure of information to a health plan for payment or health care operations purposes and is not otherwise required by law, and where you paid out of pocket, in full, for items or services, we are required to honor that request.

**RIGHT TO RECEIVE NOTICE OF A BREACH:** We will notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. A “Breach” means the unauthorized access, acquisition, use, or disclosure of Protected Health Information which compromises the security or privacy of Protected

Health Information, except: (1) an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information; (2) any unintentional acquisition, access, or use of PHI by an employee or individual acting under the authority of a covered entity or business associate (a) was made in good faith and within the course and scope of the employment or other professional relationship of such employee, or individual, respectively, with the covered entity or business associate; and (b) such information is not further acquired, accessed, or used or disclosed by any person; or (3) any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by a covered entity or business associate to another similarly situated individual at the same facility provided that any such information received as a result of such disclosure is not further acquired, accessed, used, or disclosed without authorization. The Provider must notify you of any breach unless we can demonstrate, based on a risk assessment, that there is a low probability that the PHI has been compromised.

“Unsecured Protected Health Information” is information that is not secured through the use of a technology or methodology identified by the U.S. Department of Health and Human Services to

render the Protected Health Information unusable, unreadable and undecipherable to unauthorized users. The notice is required to include the following information:

* a brief description of the breach, including the date of the breach and the date of its discovery, if known;
* a description of the type of Unsecured Protected Health Information involved in the breach;
* steps you should take to protect yourself from potential harm resulting from the breach;
* a brief description of action we are taking to investigate the breach, mitigate losses, and protect against further breaches; and
* contact information, including a toll-free number, e-mail address, Website or postal address to permit you to ask questions or obtain additional information.

In the event the breach involves 10 or more individuals whose contact information is out of date, we will post a notice of the breach on the home page of our web site or in a major print or broadcast media. If the breach involves more than 500 individuals in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 individuals, we are required to immediately notify the Secretary of Health and Human Services. We are also required to submit an annual report to the Secretary of a breach that involved less than 500 individuals during the year and will maintain a written log of breaches involving less than 500 individuals. Notification to the Secretary will occur within 60 days of the end of the calendar year in which the breach was discovered.

**RIGHT TO AN ACCOUNTING OF DISCLOSURES:** You have the right to request an “accounting” of our disclosures of your Protected Health Information. This is a listing of certain

disclosures of your Protected Health Information made by the Provider or by others on our behalf, but does not include disclosures made for treatment, payment and health care operations or certain other purposes unless the records are maintained in an Electronic Health Record. Records maintained in an Electronic Health Record will include disclosures made for treatment, payment, health care operations and other purposes.

You must submit a request in writing, stating a time period beginning after April 13, 2003 that is within six years from the date of your request. Where an Electronic Health Record is used, we will provide you with an accounting of disclosures for a 3-year period. You are entitled to one free accounting within one 12-month period. For additional requests, we may charge you our costs.

We will usually respond to your request within 60 days. Occasionally, we may need additional time to prepare the accounting. If so, we will notify you of our delay, the reason for the delay, and the date when you can expect the accounting.

**RIGHT TO REQUEST AMENDMENT:** If you think that your Protected Health Information is not accurate or complete, then you have the right to request that the Provider amend such information for as long as the information is kept in our records. Your request must be in writing and state the reason for the requested amendment. We will usually respond within 60 days, but will notify you within 60 days if we need additional time to respond, the reason for the delay and when you can expect our response. We may deny your request for amendment, and if we do so, we will give you a written denial including the reasons for the denial and an explanation of your right to submit a written statement disagreeing with the denial.

**RIGHT TO A PAPER COPY OF THIS NOTICE:** It is the Provider policy to provide you with a paper copy of this notice.

**RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS:** You have the right to request that we communicate with you concerning personal health matters in a certain manner or at a certain location. For example, you can request that we speak to you only at certain private locations. We will accommodate your reasonable requests.

**V. COMPLAINTS**

If you believe that your privacy rights have been violated, then you may file a complaint in writing with Provider or with the Office of Civil Rights in the U.S. Department of Health and Human Services. To file a complaint with the Provider, contact:

People Inc.

Corporate Compliance Officer

1219 North Forest Road

Williamsville, NY 14221

No one will retaliate or take action against you for filing a complaint.

**VI. CHANGES TO THIS NOTICE**

We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice. We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all Protected Health Information already received and maintained by the Provider as well as for all Protected Health Information we receive in the future. We will post a copy of the current Notice in the appropriate Provider Department. In addition, we will provide a copy of the revised Notice to all individuals receiving our services.

If you have any questions about this Notice or would like further information concerning your privacy rights, then please contact:

People Inc.

Corporate Compliance Officer

1219 North Forest road

Williamsville, NY 14221

# **INDIVIDUAL’S WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**



**Name:**

**I acknowledge that I have received a copy of the Provider’s Notice of Privacy Practices and have been advised of how the Provider [and the other named individuals and organizations listed in the Notice] will handle my Protected Health Information. I have also been advised of my rights to obtain access to and control my Protected Health Information. I understand that I may receive other notices which describe how the Provider will handle specialized forms of Protected Health Information such as HIV/AIDS-related, alcohol and drug abuse, and genetic information and psychotherapy notes.**

|  |
| --- |
| SIGNATURE  I have received a copy of the Provider’s Notice of Privacy Practices. I have had an opportunity to ask questions about the Notice and the use or disclosure of my Protected Health Information.  Signature of Individual or Personal Representative:  Print Name of Individual or Personal Representative:  Description of Individual Representative’s Authority:  Date:  CONTACT INFORMATION  Contact information of the personal representative who signed this form:  Address:      Telephone: (Daytime) (Evening) |
| For Provider Use Only Date Notice Provided  Name of Staff Member\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |



Consent to Use and Disclose Protected Health Information for

Treatment, Payment and Health Care Operations

**Section A:**

Individual Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Individual ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the use and disclosure of my Protected Health Information by the Provider listed below and by the Provider's staff and Business Associates for purposes of treatment, payment and health care operations.

Name of Provider Using and Disclosing the Information:

Provider Address: People Inc. Rehabilitative Services

800 Hertel Avenue, Suite 101

Buffalo, New York 14207

**Section B:** Important Information Regarding Consent:

1. I understand New York laws require my consent before the Provider may use or disclose my Protected Health Information for treatment, payment or health care operations.

2. I understand that this information may be used or disclosed by the Provider to:

* + - Plan my care and treatment;
    - Communicate among various health care professionals who are involved in my care or treatment;
    - Obtain payment for care provided by the Provider or for the payment of activities of another health care provider or entity;
    - Provide information to my health insurance company or plan;
    - Obtain payment from my health insurance company or plan; and

review the quality of my care.

3. I understand that my signature on the consent is required in order for me to receive care from the Provider and that the Provider may condition my treatment on obtaining my consent for use and disclosure of my Protected Health Information for treatment, payment and health care operations.

4. I understand that further information on the Provider's uses and disclosures of my Protected Health Information for treatment, payment and health care operations is included in the Provider's Notice of Privacy Practices which I have received.

**SIGNATURE**

I have read and understand the terms of this consent. I have had an opportunity to ask questions about the disclosure of my Protected Health Information.

Signature of Individual or Personal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Individual or Personal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Personal Representative's Authority: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONTACT INFORMATION**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Daytime) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Evening)

For Provider Use Only

Date Provider Obtained Consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Title of Person Obtaining Consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Action Taken by Provider on Consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient Policy for Cancellations and “No-Show” Appointments**

Cancellation of an Appointment

In order to be respectful of the medical needs of other, please be courteous and call the People Inc. Rehabilitative Health Services promptly if you are unable to attend an appointment. The time will be reallocated whenever possible to someone who is in urgent need of care.

If it is necessary to cancel a scheduled appointment, we require that you call the People Inc. Rehabilitative Health Services a minimum of twenty-four (24) hours in advance of the scheduled appointment time. Late cancellations will be considered as a “no-show”.

No-Show Policy

A “no-show” is someone who misses an appointment without cancelling it twenty-four (24) hours in advance. No-shows inconvenience those individuals who need access to medical care or services in a timely manner.

**In the case of a no-show for an Initial Appointment, another appointment will not be scheduled for the patient at People Inc. Rehabilitative Health Services.**

With respect to established patients, three (3) “no-shows” will result in the patient being discharged from the People Inc. Rehabilitative Health Services. In those cases, a letter will be sent to the patient offering thirty (30) additional days of services; by appointment only.

Your signature below indicates that you understand and will comply with this policy.

Patient Name (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_



**Patient Responsibilities**

**The patient (or his/her parents, guardian, or surrogate) is responsible:**

1) To provide a complete and accurate medical history including past illnesses, hospitalizations, medications, family history of illness and any other matters relating to your present health.

2) To report any unexpected problem or change in your condition to the nurses or medical staff in the health center.

3) To provide a copy of your advanced directive, if you have one, to the People Inc. Rehabilitative Health Services.

4) To be committed to your own wellness by discussing and participating in your treatment plan with your provider. Ask questions if you do not understand what your nurse or doctor is saying. This is for all tests, procedures, medications and treatment plans. Once agreed upon, follow the treatment plan carefully.

5) To be respectful of the property of other persons and the property of this facility. Verbal or physical threats of any nature will not be tolerated and may result in all services being terminated.

6) To keep all scheduled appointments or give 24-hours’ notice to reschedule or cancel an appointment. If notice is not given, the appointment will be considered a “NO-SHOW”. A pattern of “NO SHOW” appointments will result in discharge from the People Inc. Rehabilitative Health Services.

*NOTE: People Inc. Rehabilitative Health Services is not a walk-in clinic and all visits are by appointment only.*

7) To notify the People Inc. Rehabilitative Health Services of any change in your address, telephone number, emergency contact, or health insurance information.

8) To notify staff of any complaint or concern about your care or treatment.

9) To address your financial obligations to the Health Center in a prompt manner.

***Patients’ Bill of Rights***

As a patient of People Inc. Rehabilitative Health Services located in New York State, you have the right, consistent with law, to:

1. receive service(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or sponsor;
2. be treated with consideration, respect, and dignity including privacy in treatment;
3. be informed of the services available at the center;
4. be informed of the provisions for off-hour emergency coverage;
5. be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care;
6. receive an itemized copy of his/her account statement, upon request;
7. obtain from his/her healthcare practitioner, or the practitioner’s delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand;
8. receive from his/her practitioner information necessary to give informed consent prior to the start of any nonemergency procedure or treatment or both. An informed consent shall include, at minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision;
9. refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action;
10. refuse to participate in experimental research;
11. voice grievances and recommend changes in policies and services to the center’s staff, the operator, and the New York State Department of Health without fear of reprisal;
12. express complaints about the care and services provided and to have the center investigate such complaints. The center is responsible for providing the patient or his/her designee with a written response within 30 days, if requested by the patient, indicating the findings of the investigation. The center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the response, the patient may complain to the New York State Department of Health’s Office of Health Systems Management;
13. privacy and confidentiality of all information pertaining to the patient’s treatment
14. approve or refuse the release or disclosure of the contents of his/her medical record to any healthcare practitioner and/or healthcare facility except as required by law or third party payment contract;
15. access his/her medical record pursuant to the provisions of section 18 of the Public Health Law, and Subpart 50-3 of this title;
16. authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors; and
17. make known your wishes in regard to anatomical gifts. You may document your wishes in your healthcare proxy on a donor card, available from the center.