NYSHA INC.
NEW YORK STATE HAMASPIK ASSOCIATION
293-295 Division Ave • Brooklyn NY 11211
Tel 1-877-26-NYSHA (69742) • www.nyshainc.org

MEMBER AGENCIES:
Hamaspik of Orange County • 845-774-8400
Hamaspik of Rockland County • 845-356-8400
Hamaspik of Kings County • 718-387-8400

Patient Authorization and Responsibilities

1. RELEASE OF INFORMATION: I hereby authorize NYSHA Inc. and the physicians, staff, to use and disclose my medical and other information acquired in the course of my examination and/or treatment for all purposes necessary for treatment, payment and health care operations, including but not limited to insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care. ☐

I also acknowledge that I have received NYSHA Inc's Notice of Privacy Practices. ☐

I authorize NYSHA Inc. personnel to communication by mail, answering machine message, and/or email according to the information I have provided in my patient registration information. ☐

2. ASSIGNMENT OF INSURANCE: I hereby authorize my insurance benefits to be paid directly to NYSHA Inc. for any services rendered to me by NYSHA Inc. I understand I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf. ☐

3. FINANCIAL LIABILITY: I hereby agree to pay all charges due (or to become due) to NYSHA Inc. for care and treatment, including co-payments and deductibles as provided under my plan. Benefits, if any, paid by a third party, will be credited on account. I understand that I will be responsible for any charges not covered by my health insurance company for whatever reason. ☐

4. INFORMED CONSENT. I have reviewed the attached "Application Form" and confirm that all information recorded is true and accurate to the best of my knowledge. ☐

I hereby authorize NYSHA Inc. its clinical departments or divisions, and its staff, to provide clinical care and to administer routine evaluations and procedures in the judgment of any NYSHA Inc. qualified clinician's and/or physician's recommendation. ☐

I acknowledge that no guarantees or assurances have been made to me concerning the results of findings intended from the treatments or examination in the NYSHA Clinic. ☐

I have received NYSHA Inc.'s Patients Rights and Responsibilities document, read it and fully understand my rights and responsibilities as a patient of NYSHA Inc. ☐

I also acknowledge that I have received NYSHA Inc's Operational Information Sheet and Grievance Procedures. ☐

6. CANCELED OR NO-SHOW APPOINTMENTS. I understand that I may incur a cancelation fee if I do not provide 24 hour notice of cancelation, or if I do not keep my appointment and have not canceled. Excessive abuse of scheduled appointments may result in discharge from the practice. ☐

7. DUPLICATION OF SERVICES. I hereby acknowledge that the services I am requesting to receive from NYSHA Inc., I am currently not receiving from any other provider. I understand that most health insurance plans do not allow me to receive the same service(s) from two providers at the same time. In the future, if I want to receive such services from a different provider I will inform NYSHA Inc. prior to receiving services from the other provider. ☐

____
Patient Name

I have read, understand, and agree to all the provisions stated above

_______________________________ _______________________________
Signature of Patient or Guardian Date

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Intake Packet

Operational Information Sheet

Welcome to the NYSHA Article 16 Clinic! For your records here is some useful information about our services:

- Our main phone number is (718) 302-3333, please listen to prompts to be directed to the party you want.

- We are located at:

Main Office:	Satellite:
293 Division Avenue	1 Hamaspik Way
Brooklyn, New York, 11211	Monroe, NY 10950

- Our clinic is open Sunday through Thursday 9:00am till 4:00pm, and Friday 9:00am till 12:00pm. Before and after-hours, weekends and holidays may be available by appointment only.

  Please note: During severe weather conditions, such as winter storms, NYSHA Article 16 Clinic may not operate in order to insure your safety as well as our staff. At these times, please call our main number before leaving home in order to make sure that our clinic is open.

- We are a non-emergency center. In of an emergency please call 9-1-1 or Hatzolah at 718-387-1750. If your matter is urgent, during our hours of operation please call our main number and dial “302” for the operator. After-hours and on holidays, please call our emergency 24-hour hotline at 1-877-928-9000.

- For **EMERGENCIES** please call **911**. Or you can contact your Primary Care Physician or utilize the appropriate emergency services available in your area.

- We provide the following services: physical therapy, occupational therapy, speech language pathology, social work, psychology, psychiatry, nutrient and nursing. Please call our main number for availability.

- Your treatment coordinator is Surie Werzberger. She will coordinate the provision of all treatments and therapies as prescribed. She may check on maintenance of appointment, obtain information to address recipient questions, transmit information to the referral source, outside case manager or other appropriate parties. She will also review your clinical record to ensure compliance with regulations and evaluate your satisfaction with services. Your Treatment Coordinator functions as the liaison between you, your clinician and outside providers. Please do not hesitate to contact her with any questions, concerns or comments at (718) 302-3333 extension 301.

Thank you for choosing the NYSHA Article 16 Clinic.

Notice of Privacy Practices

Effective December 1, 2010

THIS NOTICE DESCRIBES HOW MEDICAL AND/OR CLINICAL INFORMATION ABOUT INDIVIDUALS RECEIVING SERVICES FROM NYSHA MAY BE USED AND DISCLOSED, AND HOW SERVICE RECIPIENTS, THEIR GUARDIANS AND/OR THEIR PERSONAL REPRESENTATIVES, CAN GET ACCESS TO THIS INFORMATION.

Guardians and personal representatives should be aware that the word “you” in this notice refers to NYSHA service recipients. The word “we” in this notice refers to the NYSHA Article 16 Clinic or any of our staff.

Please review this notice carefully. You also have rights regarding your health and/or clinical information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms “information” and “health and/or clinical information” in this notice include any information that we maintain that reasonably can be used to identify you as a recipient of services from NYSHA.

We have the right to change our privacy practices and the terms of this notice. If we make any material change to our privacy practices, we will provide a revised notice by direct mail to you reflecting the change within 60 days of the change and we will post the revised copy at our facility’s reception area.

HOW NYSHA USES OR DISCLOSES INFORMATION

1. We must use and disclose your health and/or clinical information to you or to someone who has the legal right to act for you to administer your rights as described in this notice.

2. We have the right to use and disclose your health and/or clinical information for the following reasons:

For Treatment. We may use and disclose your health and/or clinical information to aid in your treatment or the coordination of your care. For example, we may disclose your information to your physicians or to entities providing other clinical services to you.

For Payment. We may use and disclose your health and/or clinical information so that we can obtain payment for our services. For example, we may disclose your information to your health insurance company or to OPWDD. We may also disclose your information with other service providers or payors for their payment activities.

For Operations. We may use and disclose your information to others as necessary to operate and manage our normal business operations. For example, we may disclose your information with another company that performs business services for us. In these cases, we will have a written contract to ensure that this company also protects the privacy of your information.

Fundraising. We may use or disclose your demographic information, including information about your age and gender, and where you live or work, and the dates that you received treatment or services, in order to contact you to raise money to help us operate. We may also share this information with a charitable foundation that will contact you to raise money on our behalf. If you do not want to be contacted for these fundraising efforts, you have the right to opt out, effectively revoking any prior authorizations. To opt out, please contact NYSHA's Privacy Officer by phone or by mail at the address using the contact information below.

To Business Associates. We may use or disclose your information to business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required to protect the privacy of your information and are subject to federal privacy laws.

For Data Breach Notification Purposes. We may use or disclose your information to provide legally-required notices of unauthorized acquisition, access or disclosures of your health and/or clinical information.

For a Facility Directory. NYSHA does not maintain a Facility Directory.

For Public Need. We may use or disclose your health and/or clinical information in order to meet important public needs:

As Required By Law. We may use or disclose your health and/or clinical information if we are required by law to do so.

For Public Health Activities. We may use or disclose your health and/or clinical information for reporting or preventing disease outbreaks.

For Reporting Victims of Abuse, Neglect Or Domestic Violence. We may use or disclose your health and/or clinical information to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence, such as social service or protective service agencies.

For Health Oversight Activities. We may use or disclose your health and/or clinical information to a health oversight agency for activities authorized by law, such as licensure, governmental audits, and fraud and abuse investigations.

For Product Monitoring, Repair and Recall. NYSHA may use or disclose your information to a person or company that is required by the Food and Drug Administration to: (1) report or track product defects or problems; (2) repair, replace, or recall defective or dangerous products; or (3) monitor the performance of a product after it has been approved for use by the general public.

For Judicial and Administrative Proceedings. We may use or disclose your health and/or clinical information in response to a court order, search warrant or subpoena.

For Law Enforcement Purposes. We may use or disclose your information to law enforcement officials for purposes such as providing limited information to locate a missing person or report a crime.

To Avert a Serious Threat to Health or Safety. We may use or disclose your information when necessary to prevent a serious threat to your health or safety of you, another person or the public.

For Specialized Government Functions. We may use or disclose your information for specialized government functions such as the military and veterans activities, national security and intelligence activities and protective services to the President or others.

To Correctional Institutions and Law Enforcement Authorities. We may use or disclose your information if you are an inmate or you are detained by law enforcement authorities if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined or to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

For Workers' Compensation. We may use or disclose your information to the extent necessary to comply with state workers compensation laws that govern job-related injuries or illness.

For Research Purposes. We may use or disclose your information for research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.

To Provide Information Regarding Decedents. We may use or disclose your information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also use or disclose information to funeral directors as necessary to carry out their duties.

For Organ and Tissue Donation Purposes. We may use or disclose your information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation under applicable laws.

3. Restrictions on Use and Disclosure. New York State law requires special privacy protections that restrict the use and disclosure of:

Psychotherapy Notes. We are restricted from disclosing psychotherapy notes that are maintained separate from your clinical record. Without your general written consent, psychotherapy notes may be used and disclosed only in the following situations:

• The mental hygiene professional who created the notes may disclose them as required by law;

• The mental hygiene professional who created the notes may disclose the notes to appropriate government authorities when necessary to avert a serious and imminent threat to the health or safety of you or another person;

• The mental hygiene professional who created the notes may disclose them to the United States Department of Health and Human Services when that agency requests them in order to investigate the mental hygiene professional's compliance with Federal privacy and confidentiality laws and regulations; and

• The mental hygiene professional who created the notes may disclose them to medical examiners and coroners, if necessary to determine your cause of death.

HIV-Related Information. We are restricted from disclosing HIV-Related Information about you without your general written consent. Without your general written consent, HIV-Related Information may be used and disclosed only in the following situations:

• The disclosure is to a person who is authorized under applicable law to make health care decisions on your behalf and the information disclosed is relevant to that person fulfilling such a role;

• The disclosure is to another health care provider or payor for treatment or payment purposes;

• The disclosure is to an external agent who needs the information to provide you with direct care or treatment, to process billing or reimbursement records, or to monitor or evaluate the quality of care provided;

• The disclosure is required by law or court order;

• The disclosure is to an organization that procures body parts for transplantation;

• You receive services under a program monitored or supervised by a federal, New York State, or local government agency and the disclosure is made to such government agency or other employee or agent of the agency when reasonably necessary for the supervision, monitoring, administration or provision of the program's services;

• The disclosure to a health officer;

• The disclosure is required for public health purposes;

• If you are an inmate at a correctional facility and disclosure of confidential HIV-related information to the medical director of such facility is necessary for the director to carry out his or her functions;

• If you are deceased, in which case disclosure may be made to a funeral director who has taken charge of your remains and who has access in the ordinary course of business to confidential HIV-related information on your death certificate; or

• The disclosure is made to report child abuse or neglect to appropriate New York State or local authorities.

Alcohol and Substance Abuse Treatment Information and Genetic Information. Special privacy protections apply to alcohol and substance abuse treatment information and genetic information. Some parts of the general Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you will be provided with separate notices explaining how the information will be protected. To obtain copies if these other notices, please contact NYSHA's Privacy Officer by phone or by mail using the contact information provided below.

Except for uses and disclosures described and limited as set forth in this notice, we will not use or disclose your health and/or clinical information without written authorization from you. Once you give us authorization to release your health and/or clinical information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing except if we have already acted based on your authorization. To revoke an authorization, please contact NYSHA's Privacy Officer by phone or by mail using the contact information provided below.

YOUR RIGHTS.

Following are your rights with respect to your health and/or clinical information:

1. To Choose a Personal Representative. You have the right to name a personal representative who may act on your behalf to control the privacy of your health and/or clinical information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

2. To Inspect and Copy Records. You have the right to inspect and obtain a copy of any of your health and/or clinical information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. If you request a copy of the information, we may charge a reasonable fee. Under certain limited circumstances, we may deny your request to inspect or obtain a copy of your health and/or clinical information. If we deny your request, you have a right to have the denial reviewed. To inspect or obtain a copy of your health information, please submit your request in writing to NYSHA's Privacy Officer, at the address provided below.

3. To Request an Amendment of Records. If you believe that your health information is incorrect or incomplete, you may request that we amend the information. To request an amendment, please write to NYSHA's Privacy Officer, at the address below. Your request should include the reasons why you think we should amend the record. If we deny your request, you may have a statement of your disagreement added to your health and/or clinical information.

4. To Request an Accounting of Disclosures. You have a right to request an accounting of certain disclosures of your health and/or clinical information made by us during the six years prior to your request. This accounting will not include:

• Disclosures we made to you or pursuant to your authorization;

• Disclosures we made for treatment, payment or health care operations;

• Disclosures made to federal officials for national security and intelligence activities;

• Disclosures for purposes of research, public health, our normal business operations or of limited portions of your health information that do not directly identify you; or

• Disclosures about inmates to correctional institutions or law enforcement officers.

To request this accounting list, please write to NYSHA's Privacy Officer, at the address below.

5. To Request a Paper Copy of this Notice. You may ask for a paper copy of this notice at any time. Even if you have previously agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To request a paper copy of this notice please contact NYSHA's Privacy Officer at the address provided below.

6. To Request Restrictions. You have the right to request that we restrict the way we use and disclose your health and/or clinical information for treatment, payment or business operations. You may also request that we limit how we disclose information about you to your family or others involved in your care. While we are not required to agree to these restrictions, we will try to honor your request within the limits of our policies. We are required to comply with your request if the information is to be sent to a health plan for payment or operations purposes and the disclosure relates to products or services that were paid for solely out of pocket (unless otherwise required by law).

7. To Request Confidential Communications. You have the right to request that we communicate confidential information by alternative means or at alternative locations. We will accommodate reasonable requests. Please submit your request in writing to NYSHA's Privacy Officer at the address provided below. Please specify in writing how or where you wish to be contacted.

Exercising your Rights

1. Contact Us. If you have any questions about this notice or wish to exercise any of your rights, or if you wish to submit any written request, please contact NYSHA's Privacy Officer:

NYSHA Inc.

Att: Joel Brecher, HIPAA Privacy Officer

293 Division Avenue, Brooklyn, NY 11211

(718) 302-3333

2. File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above. You may also notify the New York State Division of Human Rights at (212) 480-2493 Secretary of the Department of Health and Human Services or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting your rights. We will not take any action against you for filing a complaint.

PATIENTS RIGHTS AND RESPONSIBILITIES

YOUR RIGHTS

1. No person shall be deprived of any civil or legal right solely because of a diagnosis of developmental disability or other handicap.

2. You have the right to receive services with respect and dignity without regard to your age, race, color, sexual orientation, creed, religion, marital status, gender, ethnic background or health condition. In addition, there shall be no discrimination for these or any other reasons.

3. You have the right to receive clinically appropriate, safe and skillful care and treatment that is suited to your needs with full respect for your dignity and personal integrity.

4. You have the right to an individualized plan of treatment services and to participate to the fullest extent consistent with your capacity in the establishment and revision of that plan.

5. Participation in treatment is voluntary and you are presumed to have the capacity to consent to such treatment. While your full participation in treatment is a central goal, your objection to your treatment plan, or disagreement with any portion thereof, shall not, in and of itself, result in your termination from the program unless such objection renders your continued participation in the program clinically inappropriate or would endanger the safety of you or others.

6. You have the right to privacy and confidentiality of all information and records pertaining to your treatment at the Clinic and access to such information, in accordance with applicable laws.

   You have the right to be informed of the provider’s patient grievance policies and procedures, and to initiate any question, complaint or objection accordingly.

7. At our facility, in addition to the above, you are provided: A safe and sanitary environment; Freedom from physical or psychological abuse; Freedom from corporal punishment; Freedom from unnecessary use or mechanical restraining devices; Freedom from unnecessary or excessive medication; Protection from commercial or other exploitation;

8. The opportunity to participate in the development and modification of a written, individualized Treatment Plan which has as its goal the maximization of a person’s abilities to cope with his or her environment and which fosters social competency and which enables the individual to live as independently as possible. Such rights also include:

   a. The opportunity to participate in the development and modification of an individualized Treatment Plan, unless constrained by the person’s ability to do so;

   b. The opportunity to object to any provision within an individualized Treatment Plan, and the opportunity to appeal any decision made in relation to his or her objection to the plan with which the person disagrees and;

c. The provision for meaningful and productive activities within the person's capacity, although some risk may be involved, and which take into account his or her interests.

9. You have the right to receive services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity;

10. You have the right to receive appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s) or guardian(s), or correspondent to participate in the choice of clinicians; or the opportunity to obtain a second medical opinion;

11. Access to clinically sound instructions on the topic of sexuality and family planning services and information about the existence of these services, including access to medication or devices to regulate conception when clinically indicated. This right includes:

    a. Freedom to express sexuality as limited by one's consensual ability to do so, provided such expressions do not infringe on the rights of others;

    b. The right to make decisions regarding conception and pregnancy pursuant to the mandates of applicable State and Federal law;

    c. The right of facilities to reasonably limit the expression of sexuality including time and location thereof, in accordance with a plan for effective facility management;

12. Observance and participation in the religion of your choice, through the means of your choice, including the right of choice not to participate;

13. freedom from discrimination, abuse or any adverse action based on his or her status as one who is the subject of an HIV-related test or who has been diagnosed as having HIV infection, AIDS or HIV-related illness;

14. The receipt of information on or prior to admission regarding the supplies and services that the facility will provide or for which additional charges will be made and timely notification of any changes thereafter;

15. The opportunity, either personally or through parent(s), guardian(s), or correspondent, to express without fear of reprisal: grievances, concerns, and suggestions to the chief executive officer of the facility; the commissioner of OPWDD and the Commission on Quality of Care and Advocacy for Persons with Disabilities.

16. the opportunity to receive visitors at reasonable times; to have privacy when visited, provided such visits avoid infringement on the rights of others, and to communicate freely with anyone within or outside the facility.

17. The opportunity to make, or have made on his or her behalf, an informed decision regarding cardiopulmonary resuscitation and the opportunity to create a health care proxy.

YOUR RESPONSIBILITIES

1. Implementation of many of the above rights entails inherent risks. To the extent reasonable, foreseeable, and appropriate, under the circumstances, such risks shall be described to individuals and/or their parents, guardians, or correspondents. However, individuals assume responsibility for those risks typically associated with participation in normal activities; to the extent the person's abilities permit such participation.

2. Provide complete information about present and past illnesses, hospitalizations, medications and other matters including diagnostic exams, assessments, reports and/or special studies relevant to your treatment and to do so to the best of your ability. Answer medical and social history questions posed by your clinician with honesty.

3. Provide accurate information needed for processing your insurance coverage and update NYSHA should any change occur.

4. Conduct yourself with respect for other NYSHA Inc. patients and for NYSHA Inc. staff members. Respect the rights and property of others and treat property with care and regard. Refrain from smoking on the premises. Refrain from bringing dangerous objects or substances to the clinic.

5. Come to appointments free of illegal drugs and alcohol.

6. Report safety concerns immediately to your clinician, treatment coordinator or to the person at the front desk.

7. Evacuate the building in an orderly fashion during an emergency.

8. Ask questions if you do not understand directions or procedures.

9. Know your rights and speak up when your rights are violated.

10. Be an active participant in your healthcare by following the instructions and guidance of your clinican(s) and ask questions about those health related matters that you need help understanding. Accordingly, you must accept medical consequences if you do not follow the care, service, or treatment plan provided to you.

11. Be responsible for payment of all services, either through your third party payers (insurance company) or by personally making payment for any service(s) that are not covered by your insurance policy(s).

12. All patients have the responsibility to attend scheduled appointments regularly and avoid unnecessary absences. You must notify the center when unable to attend or if you are running late for an appointment.

    PLEASE NOTE: Please notify us at least 24 hours before the scheduled appointment. Individuals who cancel appointments over and over or who do not show up for more than three consecutive

appointments may be terminated from services and/or referred to another center. Absences without notification of over 2 weeks may result in cancellation of your scheduled appointment time.

PATIENT GRIEVANCE PROCEDURE

It is NYSHA's policy to ensure that all service recipients and their families, representatives and legal guardians recognize their rights to register complaints and to have a clear understanding of the recommended procedure for resolution of complaints.

NYSHA shall, upon admission and as changes occur, inform individuals and help them understand the rights to which they are entitled, how such rights might be exercised, and the obligation they incur upon admission to, and participation in, the relevant NYSHA program.

While grievances may be brought to the attention of the regulatory agency at any time, NYSHA recommends the following informal resolution process:

The procedure for consideration of grievance and complaints:

1. The patient and/or advocate, authorized representative, next of kin, guardian or surrogate shall first attempt to address and settle the matter with the patient's treatment coordinator.
2. If the matter is not satisfactorily resolved at that level, the patient and/or advocate, authorized representative, next of kin, guardian or surrogate shall attempt to resolve the matter with the Clinic Director.

   Joel Brecher, 293 Division Avenue, Brooklyn, NY 11211. (718) 302-3333 ext. 303
3. If the matter is not satisfactorily resolved at that level, patient and/or advocate, authorized representative, next of kin, guardian or surrogate shall submit the matter in writing to the Executive Director of NYSHA, Inc.

   Joel Freund, 295 Division Avenue, Brooklyn, NY 11211. (718) 387-8400 ext. 106
4. If the matter is not resolved or no action within the patient's sense of reasonable time is forthcoming from the Executive Director, the patient and/or advocate, authorized representative, guardian or surrogate may present the issue in writing to persons of his/her choice outside the agency:

Donna Limiti, Director	Courtney Burke, Commissioner	Bureau of Quality Assurance
Brooklyn DDSO	OPWDD	NY State CQC/APD
888 Fountain Avenue	44 Holland Avenue	401 State Street
Brooklyn, NY 11208	Albany, NY 12229	Schenectady, NY 12305-2397
(718) 642-6000	(518) 473-1997	1-800-624-4143

5. No person shall be denied the opportunity to participate in any hearings related to the objection.
6. Every effort feasible shall be made to maintain the person in at least his or her current level of programming. While an objection to placement or discharge is undergoing administrative review, relocation or discharge shall only take place with the Commissioner's approval.
7. Treatment may be given, other than treatment for which informed consent is required, to a person, despite objection, in a situation where the treatment is deemed necessary to avoid serious harm to life or limb of that person or others, at the discretion of the Medical Director and in accordance with agency/facility policies and procedures.