Patient's Demographics:

Primary Facility: _____ **Primary Doctor:** _____

Last Name: _____ **First Name:** _____

DOB: ____/_____/_____**Sex:** _____ SSN#: _____-_____-_____ **Language:** _____

Ethnicity: (*check one*)
___Non-Hispanic
___Hispanic
___Unreported/Refused

Race: (*check one*)
___American Indian
___Black/African American
___White
___Pacific Islander
___Alaskan Native
___Asian
___Native Hawaiian
___Other
___Unreported/Refused

Mailing Address: _____

Apt #: _____**City:** _____ **State:** _____ **ZIP:** _____

Physical Address (if different from mailing): _____

Apt #: _____**City:** _____ **State:** _____ **ZIP:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email Address:** _____

Marital: (*check one*)
___Single
___Married
___Widowed
___Divorced
___Separated
___Partner

Student: (*check one*)
___Full Time
___Part Time
___Not a Student

Employment: (*check one*)
___Full Time
___Part Time
___Retired
___Active Duty
___Self Employed

Employer Name: _____
School Name: _____

Parent/Guardian Information:

Mother's Name: _____ **DOB:** _____/_____/_____
Address: _____ **Phone:** _____

Father's Name: _____**DOB:** _____/_____/_____
Address: _____ **Phone:** _____

Guardian's Name: _____**DOB:** _____/_____/_____
Address: _____ **Phone:** _____
Relationship to Patient: _____

Emergency Contact:

Name: _____ **Relationship:** _____
Address: _____ **Phone:** _____

Pharmacy Information:

Name: _____ **Address:** _____
City: _____ **ZIP:** _____ **Phone:** _____

Insurance Information:

Primary Plan Name: _____ **Policy Number:** _____
Primary Care Provider on Insurance Card: _____

Secondary Plan Name: _____ **Policy Number:** _____
Primary Care Provider on Insurance Card: _____

Responsible Party Information:
Name: _____ **Address:** _____
City: _____ **ZIP:** _____ **Phone:** _____
Relationship to Patient: _____

Please indicate your preferences below to be contacted:

Would you like access to our patient portal?	[___] Yes	[___] No	
Preferred telephone number:	[___] Home	[___] Cell	[___] Work
Ok to leave Message:	[___] Home	[___] Cell	[___] Work
Best time of day to reach you:	[___] Morning	[___] Noon	[___] Evening
Preferred Language	[___] English	[___] Spanish	[___] Other: _____

The following questions assist the health center to receive funding to make sure that your care is affordable and may help reduce the cost of your healthcare

Are you: (Please check all that apply)

___Migrant Worker

Are you currently working in agriculture or farm work?	[___] Yes [___] No
Was your income mostly the result of farm work last year?	[___] Yes [___] No
Is your family's income mostly from farm work?	[___] Yes [___] No
Do you move around in search of farm work?	[___] Yes [___] No

___Seasonal Worker

Will you return to your home state/country after the growing season?	[___] Yes [___] No

___Homeless/Living in Shelter

Do you live in a shelter or weekly/monthly rental?	[___] Yes [___] No
Within the last year?	[___] Yes [___] No
Do you share a single family housing with one or more families?	[___] Yes [___] No
Or with more than 3 unrelated people?	[___] Yes [___] No
With in the last year?	[___] Yes [___] No
Are you currently living with family or friends while looking for housing?	[___] Yes [___] No

___In Public Housing

Do you currently live in public housing?	[___] Yes [___] No
With in the last year?	[___] Yes [___] No
Do you currently live in senior housing?	[___] Yes [___] No
With in the lat year?	[___] Yes [___] No
Do you receive Section 8 housing benefits?	[___] Yes [___] No
With in the last year?	[___] Yes [___] No

___Veteran
___HRHC Employee
___Board Member

How did you hear about us? (Please check one).

___Referred by
[__] Employee [__] Patient [__] Community agent

___ Advertisement
[__] Newspaper [__] Flyer/Poster [__] Website [__] HRHC Event

___ Other
Please describe: _____

HUDSON RIVER HEALTHCARE CONSENT FORM

Consent to Treatment. I authorize Hudson River HealthCare, Inc. ("HRHCare"), and its medical, nursing and other professional staff members, to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as, in the judgment of HRHCare's medical personnel, is deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination. I understand that no guarantees have been made to me as to the results or effectiveness of treatments or examinations performed by HRHCare personnel.

Release of Information. I authorize HRHCare to use and disclose my health information for the following purposes: (1) to provide for, arrange or coordinate my health care treatment; (2) to enable HRHCare to obtain payment for the services it provides to me; and (3) to permit HRHCare to carry out ordinary health care and business operations such as quality assurance, service planning and general administration.

I am aware that this authorization to use and disclose information may include information regarding:

- HIV or AIDS
- Alcohol or drug abuse
- Mental illness or any mental health condition
- Sexually transmitted diseases
- Family planning, pregnancy and abortion
- Genetic tests or genetic diseases

I am aware that Hudson River HealthCare may share information with my other medical providers for medical treatment or with a third party for financial payment through electronic means.

Assignment of Benefits. I assign to HRHCare all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers and other third parties who are financially liable for the medical care and treatment provided by HRHCare.

Financial Obligations. I agree, that, except as may be limited by law or HRHCare's agreements with third party payers, in the event of non-payment by a third party for which I have provided an assignment of benefits, I am obligated to pay all amounts due for services provided at HRHCare facilities in accordance with the rates and terms of HRHCare in effect on the date of service. I also agree that I am responsible for any applicable copayments, coinsurance or deductibles.

I certify that I have read this form and that I am the patient or I am duly authorized by the patient as the patient's representative to execute this form and accept its terms.

Patient or Responsible Party Signature: _____

Nature of Relationship to Patient (if patient not signing): _____

Date: _____

Reports to NYS Immunization Information System. I hereby authorize HRHCare to report any immunizations that its medical staff administer to me to the New York State Immunization Information System.

Signature of Patient Date

Acknowledgement of Receipt of Notice of Privacy Practices. I acknowledge that I have been provided a copy of the Hudson River Healthcare (HRHCare) Notice of Privacy Practices, which describes how health information about me may be used and disclosed by HRHCare and how I may obtain access to and control the use and disclosure of this information.

Signature of Patient Date

RHIO CONSENT FORM

Hudson River HealthCare, Inc

In this Consent Form, you can choose whether to allow Hudson River HealthCare to obtain access to your medical records through a computer network operated by THINC, which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Hudson River HealthCare to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, Hudson River HealthCare's staff involved in my care may see and get access to all of my medical records through THINC."

If you check the **"I DENY CONSENT"** box below, you are saying "No, Hudson River HealthCare may not be given access to my medical records through THINC for any purpose."

THINC is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask Hudson River HealthCare for it, or go to the website www.ehealth4ny.org.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices.

- ☐ **I GIVE CONSENT for Hudson River HealthCare to access ALL of** my electronic health information through THINC in connection with providing me any health care services, including emergency care.
- ☐ **I DENY CONSENT for Hudson River HealthCare to access** my electronic health information through THINC for any purpose, *even in a medical emergency*.

  NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through THINC.

_____	_____
Print Name of Patient	Patient Date of Birth
_____	_____
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 patient information in THINC and the consent process:

1. **How Your Information Will be Used**. Your electronic health information will be used by Hudson River HealthCare **only** to:

   - Provide you with medical treatment and related services
   - Check whether you have health insurance and what it covers
   - Evaluate and improve the quality of medical care provided to all patients.

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information about You Are Included**. If you give consent, Hudson River HealthCare may access ALL of your electronic health information available through the RHIO. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to 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 ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from [*Provider Organization OR RHIO, as applicable].* You can obtain an updated list of Information Sources at any time by checking the THINC's website at www.thinc.org or by calling 845-896-4726.

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve on [Name of Provider Organization']s medical staff who are involved in your medical care; health care providers who are covering or on call for Hudson River HealthCare's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **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 Hudson River HealthCare at: 914.734.8800; or visit THINC's website: www.thinc.org; or call the NYS Department of Health at 877-690-2211.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by Hudson River HealthCare to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. THINC and persons who access this information through the THINC must comply with these requirements.

7. Effective Period. This Consent Form will remain in effect until the day you withdraw your consent.

8. Withdrawing Your Consent. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to [*Provider Organization or RHIO, as applicable]*. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms on THINC's website at www.thinc.org, or by calling 845-896-4726. **Note: Organizations that access your health information through THINC while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.**

9. Copy of Form. You are entitled to get a copy of this Consent Form after you sign it**.**