HUDSON HEADWATERS
HADLEY-LUZERNE STUDENT HEALTH

STUART M. TOWNSEND
ELEMENTARY SCHOOL

PO BOX 200
27 HYLAND DRIVE
LAKE LUZERNE, NY 12846-0200

518-824-2580
FAX: 518-824-2579

WWW.HHHN.ORG

Dear Parent/Guardian,

Hudson Headwaters Health Network has been providing care to children and teens in the North Country for over three decades. We are thrilled to now be partnering with the Hadley-Luzerne School District to bring high-quality primary care to students at the new school-based health center, Hadley-Luzerne Student Health. We'd like to share some information, so you and your child know what to expect.

Opening and Hours of Operation:
The health center is open every day that school is in session from 8:00 a.m. to 2:00 p.m. You will be able to reach a member of our pediatric health care team by phone until 5:00 p.m.

Services:
Primary care services provided to students may include annual physicals, sports physicals, illness or injury referred by the school nurse, vaccinations, chronic disease management, women's health or other care not routinely provided by the district's nurse.

Consent and Participation:
All students in the Hadley-Luzerne School District (including **both** Hadley-Luzerne Junior/Senior High School and the Stuart M. Townsend Elementary School) are eligible to enroll in the school-based health program.

To receive services, parents must complete the enclosed enrollment forms. Additionally, these forms are available at the school or online at www.hhhn.org. Enrollment in the program can be completed at any time.

All parents are encouraged to enroll their child in the program, even if they already have a primary care provider. Enrolling your child gives you the option of using the school-based health center if needed. The school-based health center team will work with your family doctor to provide back-up care when necessary and to help monitor chronic conditions.

Eligibility, Insurance, Payment:
There are no income or insurance requirements to participate in this program. Services are provided with **no out of pocket costs** to families. If your child has insurance, we will bill your insurance company if applicable. Should your child need additional services **outside** of Hadley-Luzerne Student Health, we offer financial and billing assistance through budget agreements, a Sliding Fee discount for medical, dental and other services, and RX Assist for financial assistance with ongoing prescription needs. For more information about our financial assistance programs please call 518-824-8640 or visit our website.

Appointments:
Students may access services from the health center through direction from the school nurse if they are enrolled in the program. Parents will also be able to schedule appointments for their children at this location.

(over)

If your child becomes ill at school, the school nurse will determine if it is necessary for your child to receive care. We will always attempt to contact you by phone if your child is seen for an acute illness or injury and will send home a written explanation of the care given and the necessary follow-up. Medications and prescriptions will not be sent home with your child. Prescriptions will be sent to the pharmacy of your choice.

If your child is ill, **please do not** send him/her to school. If you would like your child to be seen at Hadley-Luzerne Student Health, please call and make an appointment for your child to be seen. Parents are always welcome to come to their child's appointment. If you are unable to attend the appointment, we can see your child during the school day and call you before and after their appointment.

If needed, transportation from the Hadley-Luzerne Junior/Senior High School to Hadley-Luzerne Student Health will be provided by the school.

After Hours/Urgent Care:
When school is not in session and your child is ill, please contact your child's primary care provider. If you do not have a primary care provider for your child, please contact our Pediatric and Adolescent Health office at 518-798-6400.

Hudson Headwaters also offers **urgent care** for health concerns that arise suddenly but are not life-threatening at two of our facilities, the Health Center on Broad Street in Glens Falls and the Warrensburg Health Center seven days a week with evening hours. Please visit our website for more information.

Patient Portal:
As a parent or legal guardian, you can manage your child or teen's personal health information on our secure online health portal. Our portal allows you to access medical information you need like medications, immunizations, and appointment summaries from the convenience of your computer or mobile device. To register, select "yes" on the enrollment form and share your email address. You may also register for the patient portal by calling the health center.

Meet the Hadley-Luzerne Student Health Team:
Our team of experienced pediatric providers and nurse, Arlinda Allen, will work closely with the school nurse, Annie Horn to make sure your child receives the high-quality healthcare they need. Our team is available should you have any questions or concerns. We look forward to caring for the students of the Hadley-Luzerne School District.

Irene Flatau, M.D.
Pediatrician

Samantha Herman, PNP
Pediatric Nurse Practitioner

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Hadley-Luzerne Student Health Enrollment and Consent Form

Please complete the front and back of this form and return to the health center.

Student and Guardian Information:

Student's Name: _____ **Date of Birth**: _____ /_____ /_____ **Grade:** _____

Social Security #: _____ **Gender Identity:** ☐Female ☐Male ☐Other, please specify: _____

Preferred Language: _____ **Ethnicity:** ☐Hispanic/Latino ☐Not Hispanic or Latino ☐Refuse to Report

Race: ☐Native-Hawaiian ☐Black/African American ☐White American ☐Indian/Alaska Native ☐Asian
☐Unreported/Refuse to Report ☐Other _____

Student Address: _____

Parent/Guardian First and Last Name: _____ **Relationship to Student:** _____

Phone #: _____ **Cell #:** _____ **Work #:** _____

E-Mail Address: _____ **Would you like to register for our patient portal? YES NO**

Who is your child's primary care provider? ☐Hudson Headwaters Health Network

Practice Name: _____ Provider Name: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

Emergency Contact:

Name: _____ Relationship to Student: _____

Home Phone #: _____ Cell Phone #: _____

Insurance Information:

Does your child have health insurance: **YES NO**

If your child does not have health insurance, would you like to be contacted by an enrollment specialist from Adirondack Health Institute who can assist you with obtaining free or low-cost health insurance? YES NO

Insurance Company: _____ Phone #: _____

Address to submit claim to: _____

Policy/ID #: _____ Group #: _____

Name of Policy holder: _____ Date of Birth: _____

Social Security #: _____ Employer: _____

(*over*)

HUDSON HEADWATERS
HADLEY-LUZERNE STUDENT HEALTH

Consent for Health Services

I give my consent for my child to receive applicable medical services provided by the staff of Hudson Headwaters Health Network Hadley-Luzerne Student Health, including;

- Comprehensive physical exams, including those for school sports
- Lab test when necessary to detect illness or infection (ie: strep throat)
- Immunizations
- First aid and assessment of acute illness, injuries and emergency care
- Prescriptions and medication administration when necessary
- Referrals to an outside agency for services not provided at Hadley-Luzerne Student Health
- Health Education Counseling

I give consent for, _____to receive the above healthcare services provided by the professional staff of Hudson Headwaters Health Network Hadley-Luzerne Student Health.

I further give consent to the staff of Hadley-Luzerne Student Health to examine my child's full medical and school records including any information that may assist them in helping my child. In addition, if necessary, you may contact our family physician or any other healthcare provider to share information regarding my child's treatment.

I also authorize the release of any medical information necessary to process any insurance claim to my designated insurance carrier and made payable directly to Hudson Headwaters Health Network Hadley-Luzerne Student Health.

I understand that when necessary every effort will be made to contact me prior to any treatment that requires parental consent according to New York State Law. New York State law does not require parental consent for treatment or advise about drug abuse, alcoholism, sexually transmitted disease, reproductive health or outpatient mental health services.

All care provided will be in collaboration with your child's Primary Care Provider.

The staff of Hadley-Luzerne Student Health considers parental involvement very important. Accordingly, the staff will encourage every student to involve his/her parents or guardian in counseling and medical care decisions. We encourage parents to visit or call the center at any time.

Date: _____ Signature: _____

Print Name: _____

Relationship to student: _____

Please complete the front and back of this form and return to the health center.

HUDSON HEADWATERS HEALTH NETWORK

Today's Date: ____ / ____ / _____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: ____ / ____ / _____
Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other _____
Gender Identity: ☐ Female ☐ Male ☐ Non-conforming (neither exclusively female or male)
☐ Transgender Female/Male-to-Female ☐ Transgender Male/Female-to-Male
☐ Choose not to answer ☐ Other _____

Please take a few moments to answer these questions about your past medical history. This will help us to serve you better. This information will be kept **CONFIDENTIAL**. Thank you.

ALLERGIES: Please list any medication allergies, reactions, and other allergies.

_____
_____
_____
_____

MEDICATIONS: Please list any prescription, over-the-counter medications, herbals and/or vitamins you are taking. Include dose, frequency and prescribing provider.

_____
_____
_____
_____

IMMUNIZATIONS/VACCINES: Please include a copy of child's immunization and vaccination history including facility, provider and date.

MEDICAL ILLNESSES: Please list any hospitalizations or medical illnesses. Note year.

_____
_____
_____
_____

SURGERY: Please list any operations you have had. Note year and provider name.

_____
_____
_____
_____

Continue to Page 2 →

Name: _____
Date of Birth: ____ / ____ / _____

SOCIAL HISTORY:

Parents' Name(s): _____

Parents' Marital Status: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced ☐ Other _____

Home situation: ☐ Both parents ☐ Mother ☐ Father ☐ Relatives ☐ Adoptive parents
☐ Foster parents ☐ Other _____

Do you have siblings? ☐ Yes ☐ No If yes, names and date of birth: _____
_____

Do you have pets? ☐ Yes ☐ No

Date of Last Dental Visit: ____ / ____ / _____ Date of Last Eye Exam: ____ / ____ / _____

How much caffeine or sweetened drinks do you consume per day? _____

Diet: ☐ Regular ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Diabetic ☐ Other _____

Do you exercise/play sports regularly? ☐ Yes ☐ No If yes, what sports or hobbies? _____

How much screen time do you have per day? _____

Do you use sunscreen routinely? ☐ Yes ☐ No

Are you currently employed? ☐ Yes ☐ No Year in school: _____

Are there smoke and carbon monoxide detectors in your home? ☐ Yes ☐ No ☐ Unknown

Are there guns in your home? ☐ Yes ☐ No ☐ Unknown If yes, are they secure? ☐ Yes ☐ No

Sexual Orientation: ☐ Homosexual ☐ Heterosexual ☐ Bisexual ☐ Other _____
☐ Choose not to answer

Are you sexually active? ☐ Yes ☐ No Contraception? ☐ Yes ☐ No Condoms? ☐ Yes ☐ No

Assigned sex at birth: ☐ Male ☐ Female ☐ Choose not to answer ☐ Unknown

Do you live with someone who smokes? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No If yes, what type (smoke, chew, vape)? _____

If yes, how many packs per day? _____

If not currently a smoker, did you smoke in the past? ☐ Yes ☐ No

If yes, what age did you start? _____ What age did you quit? _____

Do you vape? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per day? _____

Do you use recreational(street) drugs? ☐ Yes ☐ No If yes, what? _____

Do you use marijuana(pot)? ☐ Yes ☐ No

FAMILY HISTORY: Please note their health status and age, or age at death and cause.

Mother: _____

Father: _____

Siblings: _____

Children: _____

PREVIOUS PEDIATRICIAN/PRIMARY CARE PROVIDER: Include facility address and phone number.

_____

_____

OTHER DOCTORS YOUR SEE: Include reason, facility address and phone number.

_____

_____

_____

_____

HUDSON HEADWATERS HEALTH NETWORK

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name	Date of Birth	Phone Number

Street Address	City	State	Zip Code

A) I hereby authorize records FROM:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

B) To be released TO:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

C) Information disclosed: *(please select one)*

☐ Medical information ☐ Dental information

- -

☐ Entire record set

☐ Date range: _____ to _____

☐ Other: _____

D) Special Considerations:

To include the following information, please initial below. If not initialed, this information will not be disclosed.

_____ Alcohol/Drug treatment

_____ HIV/AIDS-related information

_____ Mental health treatment

E) Purpose of requested information: *(please select one)*

☐ At the request of the individual ☐ Transfer of care *(select reason)*

☐ Legal purposes ☐ Patient experience ☐ Other: _____

☐ Coordination of care ☐ Patient relocation

F) Delivery method: *(please select one)*

☐ US mail (Paper) ☐ US mail (CD) ☐ Pick up at: _____

☐ Encrypted email: _____ ☐ Fax to: _____

G) Authorization Expiration: Unless previously revoked by me in writing, this authorization will expire on the following date or event: _____ *Please note: If left blank, this authorization will expire upon the completion of the release of information outlined in this document.

H) If not the patient, name of person signing authorization:	I) Authority to sign on behalf of patient:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

This authorization may include disclosure of information relating to **ALCOHOL/DRUG TREATMENT**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **HIV RELATED INFORMATION** only if I place my initials on the appropriate line in the Special Considerations section. In the event the health information described above includes any of these types of information, and I initial the line in the Special Considerations, I specifically authorize release of such information to the person(s) indicated in Item B.

If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at **(212) 480-2493** or the New York City Commission of Human Rights at **(212) 306-7450**. These agencies are responsible for protecting my rights.

I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

Information disclosed under this authorization might be redisclosed by the recipient (except for the Special Considerations as noted above), and this redisclosure may no longer be protected by federal or state law.

HHHN reserves the right to charge the 'medical record stated fee structure' as set forth in the NYS Article 18 Public Health Law. By signing this authorization, I agree to pay HHHN for my records if applicable.

_____ _____ _____

Signature of Patient or Representative Authorized by Law | Print Name | Date

HUDSON HEADWATERS HEALTH NETWORK

☐ Patient or Legal Representative refused to sign/complete this document.

GENERAL CONSENT AND AGREEMENT

We have developed the following agreement to ensure a long and healthy relationship together. Please read the following information carefully. After you have read this consent and agreement, please sign your name indicating your acceptance of the terms of this agreement.

- I, _____, _____ agree to permit the providers and staff of
  (Patient's name) *(date of birth)*
- Hudson Headwaters Health Network (HHHN) to provide medical care to myself, child, or legal ward as applicable.
- I agree to permit laboratory and diagnostic tests, medical treatment (for example, medications, injections, drawing blood for tests, counseling, screening tests, health education and other diagnostic procedures), emergency care as necessary, and hospital services performed at the request of my provider or other providers assisting in my care. I understand that I have the right to refuse this treatment at any time.
- I understand that a medical record will be prepared and maintained about me by HHHN, and that I am able to view my medical record via the *Patient Portal*. I am also entitled to obtain a copy of my medical record by signing an *Authorization for Release of Health Information* form.
- I agree to abide by HHHN's *Patient Responsibilities* and understand that these responsibilities are posted in all health centers, online, and are physically available to me upon request. I understand that HHHN maintains the right to discontinue treatment for any violation of these responsibilities, such as failure to maintain a consistent appointment schedule or inappropriate behavior. In such cases, the patient or parent/guardian agrees to accept full responsibility for pursuing alternate medical care.
- I understand that some treatment and procedures may require an additional consent agreement to be completed.
- I understand that this consent is valid as long as I am an active patient of HHHN. I have the right to withdraw my consent at any time. I understand that refusal to sign this consent and agreement may prohibit my ability to access HHHN services.

By signing this document, you understand the agreement and consent in full, and you have had all of your questions answered to your satisfaction.

_____	_____	_____
Signature of Patient or Representative Authorized by Law	Print Name	Date

HUDSON HEADWATERS HEALTH NETWORK

☐ Patient or Legal Representative refused to sign/complete this document.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, _____ hereby acknowledge that I have been offered a copy
(Patient's name) *(date of birth)*
of the Hudson Headwaters Health Network (HHHN) Notice of Privacy Practices. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how HHHN may use and/or disclose my personal health information both with and without my authorization. I further understand that HHHN reserves the right to change its privacy practices at any time. In the event of a change, a copy will be posted in a prominent location in the practice site, or upon my request, a copy will be sent to the address I have provided.

I understand that as part of my health care, HHHN originates and maintains paper and/or electronic records describing health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means to facilitate coordination of care among the health professionals, including referrals, who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for healthcare options of HHHN such as assessing quality of care and reviewing competence of healthcare professionals.

I understand that HHHN may send test results and correspondences associated with my care to the address I have provided. HHHN may also leave messages at the telephone numbers I have provided either to confirm appointments or to request I call on medical, dental, or billing items.

If you require a restriction on the above, please see a staff member at the front desk.

_____	_____	_____
Signature of Patient or Representative Authorized by Law	Print Name	Date

HUDSON HEADWATERS HEALTH NETWORK

☐ Patient or Legal Representative refused to sign/complete this document.

ASSIGNMENT OF BENEFITS

I, _____, _____ understand that my health information may be used
(Patient's name) *(date of birth)*
or disclosed for the purposes of treatment, payment, and operations in accordance with state and federal regulations for privacy and security. I understand that this may include disclosures of information to my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment directly to the Network for medical services rendered to myself and/or my dependents.

I request that payment of authorized medical benefits is made on my behalf directly to Hudson Headwaters Health Network (HHHN). I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by HHHN and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for products and services received.

I understand that refusal to sign this form prohibits Hudson Headwaters Health Network from billing my health care insurer and that I will be personally responsible for any charges associated with any service(s) rendered.

This assignment will remain in effect until revoked by me in writing and is not invalidated by any changes in my health care insurance plan or health care insurer. A photocopy of this assignment is to be considered as valid as an original.

_____	_____	_____
Signature of Patient or Representative Authorized by Law	Print Name	Date

HUDSON HEADWATERS
HEALTH NETWORK

☐ Patient or Legal Representative refused to sign/complete this document.

AUTHORIZATION TO RELEASE BILLING INFORMATION

I, _____, _____ authorize the release of any medical or other
(Patient's name) *(date of birth)*
information necessary to my health care insurer(s) in order to process any claims associated with services that I have received from Hudson Headwaters Health Network (HHHN). [1]

Furthermore, I authorize payment of medical benefits to HHHN from my health care insurer(s) for any claims associated with services that I have received from HHHN. [2]

I understand that my refusal to sign this form may prevent my health care insurer(s) from paying HHHN for my services. I understand that I will be personally responsible for any charges associated with any service(s) rendered if this occurs.

_____	_____	_____
Signature of Patient or Representative Authorized by Law	Print Name	Date

[1] This is a requirement of CMS 1500 form, box 12.
[2] This is a requirement of CMS 1500 form, box 13.

HUDSON HEADWATERS HEALTH NETWORK

☐ Patient or Legal Representative refused to sign/complete this document.

RELEASE OF MEDICAL INFORMATION

I, _____, _____ give Hudson Headwaters Health Network (HHHN)
(Patient's name) *(date of birth)*

permission to disclose to a relative or friend my location and general condition, or other information directly relevant to that person's involvement in my care[1], to those I have named below:

_____ _____
(First and last name) *(Relationship to patient)*

☐ Primary care
☐ OB/GYN
☐ Specialty care: _____
☐ **All information**

_____ _____
(First and last name) *(Relationship to patient)*

☐ Primary care
☐ OB/GYN
☐ Specialty care: _____
☐ **All information**

_____ _____
(First and last name) *(Relationship to patient)*

☐ Primary care
☐ OB/GYN
☐ Specialty care: _____
☐ **All information**

_____ _____
(First and last name) *(Relationship to patient)*

☐ Primary care
☐ OB/GYN
☐ Specialty care: _____
☐ **All information**

I understand that this document **does not** expire and is considered to be in effect unless I update or revoke it in writing. Furthermore, this document only applies to medical-related information and does not include the release of dental information.

I understand that my refusal to sign this form and/or refusal to designate a person above prohibits HHHN from disclosing my general condition (i.e., upcoming appointment date) to anyone besides myself.

_____ _____ _____
Signature of Patient or Representative Authorized by Law | Print Name | Date

[1] This **does not** include information relating to family planning services (i.e. birth control, contraception), sexually transmitted infection testing or treatment, and HIV testing or treatment for patients under the age of 18. This information is only released directly to the patient.

HUDSON HEADWATERS HEALTH NETWORK

☐ Patient or Legal Representative refused to sign/complete this document.

DETERMINATION OF FAMILY SIZE AND INCOME

The Network serves all patients and does not deny services based on patients' ability to pay. The Network also offers discounted fees for patients who qualify for our sliding fee program. Because the Network receives funding from the Federal Government to offer these services, we are required to collect income range information for all patients.

Please determine family size and check the appropriate income category box.

FAMILY SIZE	CATEGORY 1: ☐	CATEGORY 2: ☐	CATEGORY 3: ☐	CATEGORY 4: ☐
1	$0-15,060	$15,061-22,590	$22,591-30,120	$30,121
2	$0-20,440	$20,441-30,660	$30,661-40,880	$40,881
3	$0-25,820	$25,821-38,730	$38,731-51,640	$51,641
4	$0-31,200	$31,201-46,800	$46,801-62,400	$62,401
5	$0-36,580	$36,581-54,870	$54,871-73,160	$73,161
6	$0-41,960	$41,961-62,940	$62,941-83,920	$83,921
7	$0-47,340	$47,341-71,010	$71,011-94,680	$94,681
8	$0-52,720	$52,721-79,080	$79,081-105,440	$105,441

Please note: this table is based on Federal Poverty Guidelines (FPG) which are released every year. This form must be **updated** and **completed** annually in accordance with Uniform Data System requirements.

_____ _____ _____

Signature of Patient or Representative Authorized by Law | Print Name | Date

HUDSON HEADWATERS HEALTH NETWORK

PATIENT BILL OF RIGHTS

At Hudson Headwaters, we are dedicated to providing the best care, and access to that care, for everyone in our community.

As a patient in a Clinic in New York State, you have the right, consistent with law, to:

1. Receive service(s) without regard to age, race, color, sexual orientation, marital status, religion, sex, national origin or sponsor;
2. Be treated with consideration, respect and dignity including privacy intreatment;
3. Be informed of the services available at the health center;
4. Be informed of the provisions for off-hour emergency coverage;
5. Be informed of and receive an estimate of the charges for services, view a list of the health plans and the hospitals that the center participates with; eligibility for third-party reimbursement 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 health care practitioner, or the health care 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 physician information necessary to give informed consent prior to the start of any nonemergency procedure or treatment or both. An informed consent shall include, as a 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 center response, the patient may complain to the New York State Department of Health;
13. Privacy and confidentiality of all information and records pertaining to the patient's treatment;
14. Approve or refuse the release or disclosure of the contents of his/her medical record to any health-care practitioner and/or healthcare facility except as required by law or third-party payment contract;
15. Access to his/her medical record per Section 18 of the Public Health Law, and Subpart 50-3.
16. Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors;
17. When applicable, make known your wishes regarding anatomical gifts. Persons sixteen years of age or older may document their consent to donate their organs, eye and/or tissues, upon their death, by enrolling in the NYS Donate Life Registry or by documenting their authorization for organ and/or tissue donation in writing in several ways (such as health care proxy, will, donation card, or other signed paper). The health care proxy is available from the center;
18. View a list of the health plans and the hospitals that the center participates with; and
19. Receive an estimate of the amount that you will be billed after services are rendered.

HUDSON HEADWATERS HEALTH NETWORK

PATIENT RESPONSIBILITIES

To provide safe and comprehensive services, Hudson Headwaters asks its patients to adhere to the following responsibilities:

Health Center Rules and Regulations:

1. Inform the Health Center personnel of any changes in your medical or dental treatment or condition.
2. Supply accurate and complete information whenever possible to your provider regarding all factors and changes affecting your health status.
3. Cooperate with those providing care.
4. Avoid discrimination in any form against Health Center personnel and other patients and visitors.
5. Ask questions if you do not fully understand your care.
6. Inform the Health Center staff if you need to cancel a scheduled visit, preferably 24 hours prior to the visit.
7. Provide the Health Center with the name, address and phone number of the person to contact in case of emergency.
8. Inform the Health Center of any changes affecting your financial status and/or need for service.
9. Arrive at the Health Center in advance of your appointment, as directed, so all necessary papers can be completed with the patient or designee prior to the visit with the provider.
10. Understand that arriving considerably late for an appointment means the provider may not be able to see you. It will be considered a missed appointment and it may be rescheduled.
11. Observe all rules and regulations of the Health Center, particularly those relating to safety. The Health Center has an obligation to make this information known to you.

Respect and Consideration:

12. Be considerate of the rights and privacy of staff and other patients by assisting in the control of noise and refraining from the use of recording devices in the health center.
13. Be courteous to staff & other patients and refrain from being verbally or physically abusive. Threatening statements or behavior towards staff or other patients may result in you no longer receiving services from the Network.
14. Follow the Network's No Smoking, No Vaping, & No Weapons Policy.
15. Be respectful of the property of other persons and of Hudson Headwaters Health Network.

Compliance with Instructions:

16. Follow the mutually agreed upon prescribed course of treatment. This may include following instructions of the nurse or other personnel as they carry out your coordinated plan of care.

Provision of Information:

17. Communicate, to the best of your knowledge, an accurate and complete medical history to the providers and others providing health care services.
18. Report any changes in your condition promptly to the provider, nurses and others providing health care services.
19. Make it known whether you clearly understand explanations or instructions given and for stating your inability to follow completely any instruction given.

Payment of Services:

20. Provide all necessary information including insurance card and policy number to assure timely processing of your bill and to make appropriate arrangements for the payment of your bills. You are also responsible for understanding the limitations of your insurance coverage and you must present any co-pay or other personal obligations at the time service is rendered.

HUDSON HEADWATERS HEALTH NETWORK

NOTICE OF PRIVACY PRACTICES

Your Rights

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

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures. We'll provide one accounting a year for free but will charge a reasonable fee for requests beyond that.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- If you feel your privacy rights have been violated, you may file a complaint to:

  HHHN Privacy Officer
  (518) 409-8642
  PatientConcerns@hhhn.org

- You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints**
- You will not be penalized or retaliated against for filing a complaint.

Your Choices

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

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We use or share your health information in the following ways.

To Treat You

- We can use your health information and share it with other professionals who are treating you.
  Example: A doctor treating you for an injury asks another doctor about your overall health condition.

To Run Our Organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  Example: We use health information about you to manage your treatment and services.

To Bill You For Services

- We can use and share your health information to bill and get payment from health plans or other entities.
  Example: We give information about you to your health insurance plan so it will pay for your services.

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

Help with public health and safety issues

- We can share health information for certain situations such as: Preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you in regard to workers' compensation claims, law enforcement purposes, health oversight agencies and special government functions such as military, national security and presidential protective services.

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Participation in Accountable Care Organizations

- We can share health information about you within an Accountable Care Organization, such as Adirondacks ACO.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time in writing.
- We will not share substance abuse treatment records, HIV status or behavioral health records without your written permission.

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

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