UR MEDICINE | STRONG MEMORIAL HOSPITAL

☐ Inpatient
☐ Outpatient
☐ ED

PATIENT CARE AGREEMENT
SMH 660 MR

700

RR DONNELLEY

By signing below, I agree to the following for all care provided by Strong or by my treating professionals:

1. **Treatment Authorization.** If I am the patient, I consent to procedures and care, including photographs or recordings, my treating professionals recommend for me. If I am signing for a patient who is unable to consent, I consent to procedures and care, including photographs or recordings, the patient's professionals recommend. If asked, I will document that I am authorized to consent for the patient.
2. **Release of Medical Information.** Strong and URMC professionals may use and disclose patient health information for treatment, payment and health care operations. I authorize release of this information to government agencies (such as Medicare and Medicaid), insurance carriers, health plans, utilization review agents, home care, assisted living, nursing homes and primary care providers.
3. **Financial Responsibility.** I will pay for all hospital and professional care provided. If the bill is not timely paid I will be liable for collection fees, legal fees, court costs and interest. The institution reserves the right to bring this matter to a collection agency for non-payment.
4. **Third Party Payors.** I will promptly provide information about potential health, workers compensation, no-fault and liability insurance. I authorize Strong and URMC professionals to bill payors for all care. I assign my claim for medical benefits and payment to Strong and URMC. If a claim deadline is missed because I did not provide timely information, I will pay for the care even if it would have been covered.
5. **Medicaid and Other Assistance.** If I cannot pay, Strong's financial counselors may help me qualify for Medicaid or other assistance. I will assist with the application and provide needed information. My application may be denied if I do not provide needed information in time.
6. **Financial Assistance.** Strong has a Financial Assistance program for eligible persons who do not have insurance or cannot pay their bills. To be considered for Financial Assistance, I may need to apply for Medicaid and meet other requirements. (Call (585) 784-8889 for more information).
7. **No Fault Assignment.** I HEREBY ASSIGN TO URMC AND STRONG ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW. THIS AGREEMENT SHALL BECOME NULL AND VOID IF AT ANY TIME IT IS DETERMINED THAT BENEFITS ARE NOT PAYABLE DUE TO THE FOLLOWING CIRCUMSTANCES: LACK OF COVERAGE, VIOLATION OF A POLICY CONDITION, OR DETERMINATION THAT THE TREATMENTS/SERVICES RENDERED ARE NOT RELATED TO SAID MOTOR VEHICLE ACCIDENT. ANY PAYMENT PURSUANT TO THIS ASSIGNMENT SHALL NOT EXCEED THE HEALTH CARE PROVIDER'S PERMISSIBLE CHARGES UNDER SAID ARTICLE 51. URMC AND STRONG CERTIFY THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE INJURED PARTY AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE INJURED PARTY FOR SERVICES PROVIDED DUE TO INJURIES SUSTAINED IN RELATION TO THE AUTOMOBILE ACCIDENT.
8. **Cost Estimates.** Estimated cost of care can be obtained by calling (585) 758-7801 or (585) 758-7650. Hospital professionals and staff are not authorized to quote the cost of care or to negotiate rates.
9. **Personal Belongings.** Strong and URMC professionals are not responsible for damage or loss to personal belongings.
10. **Telephone Communications.** Strong, URMC, or their representatives may contact me or my representative by phone to deliver health care information and messages, such as appointment reminders, and to make inquiries regarding billing and payment. Strong and URMC may contact me or my representative at any phone number I supply, including any cell phone number, using an automatic telephone dialing system, an artificial voice and pre-recorded messages.
11. **Discharge.** I will cooperate fully with Strong's efforts to arrange a safe and timely discharge. I will provide needed financial and personal information required for discharge planning and will apply for Medicaid or other assistance needed to pay for post hospital care and to facilitate discharge.
12. **Caregiver (INPATIENTS ONLY) Designation.** I understand that I may designate a caregiver or caregivers to be included in my discharge planning. If I identify a caregiver, I understand that my caregiver will receive information and instruction about my post-discharge care.

☐ I designate _____ (Name) _____ (Relationship to me)

_____ (Address) _____ (Phone Number)

☐ I do not wish to designate a caregiver at this time.
☐ Patient is unable to designate a caregiver at this time.

****

_____ (Signature) _____ (Date) _____ (Time) _____ (Relationship to Patient (Parent, Guardian, Spouse, Self, etc))

No signature was obtained due to:
☐ Patient's condition/capacity ☐ No representative ☐ Refused to sign

Patients have the right, consistent with applicable laws, to:

1. Understand and use these rights. If for any reason they do not understand or they need help, the hospital MUST provide assistance, including an interpreter.
2. Receive treatment without discrimination as to age, race, color, religion, gender, gender identity and expression, national origin, disability, sexual orientation, or source of payment.
3. Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
4. Receive emergency care if they need it.
5. Be informed of the name and position of the doctor who will be in charge of their care in the hospital.
6. Know the names, positions, and functions of any hospital staff involved in their care and refuse their treatment, examination, or observation.
7. A no smoking room. (SMH is a smoke and tobacco free institution)
8. Receive complete information about their diagnosis, treatment, and prognosis.
9. Receive all the information they need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
10. Receive all the information they need to give informed consent for an order not to resuscitate. They also have the right to designate an individual to give this consent for them if they are too ill to do so. If they would like additional information, a copy of the pamphlet "Do Not Resuscitate Orders – A Guide for Patients and Families" should be provided.
11. Refuse treatment and be told what effect this may have on their health.
12. Refuse to take part in research. In deciding whether or not to participate, they have the right to a full explanation.
13. Privacy while in the hospital and confidentiality of all information and records regarding their care.
14. Participate in all decisions about their treatment and discharge from the hospital. The hospital must provide them with a written discharge plan and written description of how they can appeal their discharge.
15. Review their medical records and obtain copies of their medical records, (for which the hospital can charge a reasonable fee). They cannot be denied a copy solely because they cannot afford to pay.
16. Receive an itemized bill and explanation of all charges.
17. Formulate advance directives and appoint a health care proxy.
18. Participate in the consideration of ethical issues that arise in their care.
19. Authorize those family members and other adults who will be given priority to visit consistent with their ability to receive visitors.
20. Make known their wishes in regard to anatomical gifts. Patients may document their wishes in their health care proxy or on a donor card, available from the hospital.
21. Receive timely assessment and treatment of pain, including education about how to manage their pain.
22. The right to be free from financial or other exploitation and have access to legal entities for appropriate representation, self-help services and advocacy support services.
23. Complain without fears of reprisal about the care and services they are receiving and to have the hospital respond to them and, if they request it, a written response. They should first speak to the nurse or doctor caring for them and if they are not satisfied with the hospital's response, they can request review by The Grievance Committee or complain to the New York State Department of Health. The hospital must provide them with the Department of Health phone number. If concerns cannot be resolved through the hospital or Department of Health patients may contact The Joint Commission at 1-800-994-6610 or via e-mail at complaint@jointcommission.org.

Patients have the responsibility to:

1. To the best of their knowledge, provide accurate and complete information about their present symptoms, past illnesses, hospitalizations, medications and other matters relating to their health.
2. Provide upon admission a copy of their health care proxy or any other advance directives or power of attorney forms, if they have them.
3. Report any changes in their condition or anything that appears unsafe to their nurse or doctor.
4. Ask questions if they do not clearly understand the proposed plan of care and what is expected of them.
5. Follow the treatment plan that the patient and their doctor have developed. This may include following the instructions of nurses and other health care staff who are involved in their care. Accept the consequences if they do not follow the treatment plan.
6. Keep appointments. When they are unable to do so for any reason, notify the office appointment center in advance
7. Provide accurate insurance information and promptly pay balances not covered by their insurance.
8. Treat other patients and staff with consideration and respect.
9. Be considerate of the rights of other patients and the hospital staff by assisting with the control of noise and the number of visitors to the hospital.
10. Be respectful of the property of other persons and of the hospital.
11. Be aware that the following items and behaviors are prohibited at the hospital: alcoholic beverages, disruptive or violent behaviors, weapons, smoking, street drugs, electronic cigarettes, tobacco.

UNIVERSITY of ROCHESTER MEDICAL CENTER

& Affiliates

15

RR DONNELLEY

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____
(please print)

DOB: _____

Medical Record #: _____

I have been provided with the URMC & Affiliates Notice of Privacy Practices

Patient's Signature: _____ Date: _____

OR

Signature of personal representative: _____

Relationship to patient: _____ Date: _____

****

If signature not obtained, please indicate reason:

- ☐ Patient Declined
- ☐ Emergency Situation
- ☐ Other _____

Staff Member's Name (please print): _____

Department: _____

Date: _____

(Note: This document must be retained for 6 years in accordance with the HIPAA Privacy Rule)

SH 1293 MR
Rev. 4/16

UNIVERSITY of ROCHESTER MEDICAL CENTER

& Affiliates

640

Strong Memorial Hospital
Department or Practice _____
601 Elmwood Avenue, Box #: _____
Rochester, NY 14642
Phone: (585) _____ Fax: (585) _____

SH 48BH Authorization for Release/Disclosure of Medical and/or Behavioral Health Information

PLEASE PRINT:
Patient name: _____ Date of Birth: _____
Address: _____ Patient's phone#: ( ) _____
City/State/Zip: _____

This Authorization allows URMC & Affiliates to: (check one or both)

☐ **SEND** copies of your record to (or discuss your information with) the provider/person/facility below

☐ **RECEIVE** copies of your record from (or discuss your information with) the provider/person/facility below

_____ Name of Provider/ Person/Facility

_____ Address

_____ City, State, Zip Code

_____ Phone #/Fax # (include area code)

PURPOSE FOR THIS REQUEST: ☐ Healthcare or Appointment **(date)** _____ ☐ Insurance ☐ Other

TYPE OF RECORDS or INFORMATION REQUESTED: Check all that apply:

The records requested are to include: ☐ Mental Health Treatment Records ☐ Alcohol/Drug Treatment Records
(Release/disclosure of HIV-related information requires additional authorization on form NYS DOH2557 or OCA 960)

☐ **Inpatient admission(s)/date(s):** _____
(Check only **one** of the following 3 choices if requesting inpatient records)
- ☐ Treatment summary (includes discharge summary, history/physical, laboratory tests, x-ray reports, operative reports, pathology)
- ☐ Specific information or reports (describe): _____
- ☐ Other (describe): _____

☐ **Outpatient/Office visits--date(s):** _____ **and/or specific illness/injury:** _____.
(Check type of outpatient visit to be released)
☐ Clinic/doctor/dental visit ☐ Ambulatory Surgery visit ☐ Emergency Department Record
☐ Radiology report(s) ☐ Laboratory test results ☐ Immunizations ☐ Physical/occupational therapy record(s)
☐ Other (describe): _____

AUTHORIZATION VALID FOR: (If nothing is checked below, this authorization is valid for this request only.)
☐ This request only
☐ One year from the date of this authorization **OR** _____ (insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.
☐ This request **and** for medical records of any **future** treatment of the type described above until: _____(insert date)

I understand that:
- My right to healthcare treatment is not conditioned on this authorization, except in very limited circumstances (e.g. non-emergent mental health or chemical dependency treatment).
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed, except that chemical dependency treatment records protected by Federal Confidentiality Rules 42CFR Part 2 may not be disclosed without my written authorization unless otherwise provided for in the regulations.
- There may be a charge for the requested records.
- The medical records requested above may be faxed in cases of medical necessity.

Signature of Patient or Representative _____ Date _____

Relationship to Patient *(if Representative)* _____

290

ROCHESTER RHIO
Regional Health Information Organization

RHIO CONSENT FORM

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

PROVIDER: ***UNIVERSITY of ROCHESTER MEDICAL CENTER and AFFILIATES***

Patient Name	Date of Birth	Patient Medical Record Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans attached to this form to obtain access to my medical records through the health information exchange organization called Rochester RHIO. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Rochester RHIO is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Rochester RHIO's website at **www.RochesterRHIO.org**.

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

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

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

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

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

My questions about this form have been answered and I have been provided a copy of this form unless I refuse it.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through Rochester RHIO and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
    - **Treatment Services.** Provide you with medical treatment and related services.
    - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
    - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
    - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization(s) and/or Health Plan(s) listed may access ALL of your electronic health information available through Rochester RHIO. This includes information created before and after the date this form is signed. Your health records may include 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 include sensitive health conditions, including but not limited to:
    - Alcohol or drug use problems
    - Birth control and abortion (family planning)
    - Genetic (inherited) diseases or tests
    - HIV/AIDS
    - Mental health conditions
    - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from the named Provider Organization(s) or Rochester RHIO. You can obtain an updated list at any time by checking Rochester RHIO's website at www.RochesterRHIO.org or by calling 1-877-865-RHIO(7446).

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. If there is an emergency, doctors and other staff members will be able to use the Rochester RHIO to see the health information of patients who are minors.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Rochester RHIO for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the URMC Integrity Hotline at 585-756-8888, or toll free at 1-866-567-4202; or visit Rochester RHIO's website: www.RochesterRHIO.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as Rochester RHIO ceases operation (or until 50 years after your death whichever occurs first). If Rochester RHIO merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Organizations that access your health information through Rochester RHIO while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.

HIGHLAND HOSPITAL
STRONG MEMORIAL HOSPITAL

TELEHEALTH CONSENT

SH 419TELE MR

419

This consent is for all telehealth services provided for the following condition(s): _____.

1. I understand that my health care provider wishes me to engage in a telehealth appointment/consultation to evaluate my health condition.

2. My health care provider has explained to me that either video conferencing technology and/or electronic transmission of my health information such as radiologic images, photos and sounds will be used during this appointment/consultation and it will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand that there are risks associated with use of this technology such as interruptions, technical difficulties, and inability to obtain information sufficient for decision making about my health problem and that all possible precautions will be taken to minimize these risks. In addition, my health care provider or I can discontinue the telehealth visit if it is felt that the information obtained through the telemedicine connection is not adequate for diagnostic decision-making or for implementing management of my health problem. In that event, we will endeavor to facilitate access to a site where adequate care can be provided, such as a doctor's office or other source of in-person care.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the appointment/consultation and thus will have the right to request the following:

(a) Omitting specific details of my medical history/physical examination that are personally sensitive;
(b) Asking non-medical personnel to leave the telemedicine examination room; and/or
(c) Terminating the consultation at any time.

5. The alternatives to a telehealth appointment/consultation have been explained to me. In choosing to participate in a telehealth appointment/consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6. In an **emergent** consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

7. I understand that billing may occur from both my health care provider and the facility I am presenting at for my appointment.

8. I have had a direct conversation with my health care provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify that:

- I have read or had this form read and/or had this form explained to me
- I fully understand its contents including the risks and benefits of the telehealth appointment/consultation
- I have been given ample opportunity to ask questions and that all questions have been answered to my satisfaction.
- I consent to this telehealth appointment/consultation.
- I have been provided with the University of Rochester Medical Center and Affiliates Notice of Privacy Practices.

Patient/Parent/Guardian Signature	Date	Time

TO BE COMPLETED BY STAFF
No signature was obtained due to:

◎ Impractical, verbal consent given
◎ Patient's condition/capacity
◎ No representative

Staff Signature	Date	Time

Preferred Contact Information

This information is used by BHP staff to make sure we can get in contact with you about your appointments and care here. This information will remain in effect until notified differently by the patient or until the patient is discharged from BHP.

***Preferred phone number** (choose one)

- ☐ Cell:
- ☐ Work: **Can we leave a message?** Y / N
- ☐ Home:
- ☐ Other:

Other phone number (if applicable, choose one)

- ☐ Cell:
- ☐ Work: **Can we leave a message?** Y / N
- ☐ Home:
- ☐ Other:

*Required

BHP Referral Source

All information you provide is strictly confidential

How did you hear about our services?

- ☐ Co-worker
- ☐ Supervisor
- ☐ HR Business Partner
- ☐ Union Rep
- ☐ Reputation
- ☐ Orientation/Presentation
- ☐ Family Member
- ☐ Web page
- ☐ Attend BHP Previously
- ☐ EAP
- ☐ PCP
- ☐ Condition Mgmt. Program
- ☐ Brochure/Poster
- ☐ Lifestyle Mgmt. Program

Work Location:

- ☐ URMC
- ☐ Rochester Tech Park
- ☐ Other Offsite Location
- ☐ River Campus
- ☐ Non-UR Employee