HUDSON HEADWATERS HEALTH NETWORK

CONSENT TO TREAT A MINOR CHILD

Please list all parent(s), or legal guardian(s), that are permitted to consent for medical treatment for _____, date of birth _____:

_____ *(First and last name)*	_____ *(Phone number)*	***This person is a:*** ☐ Parent listed on birth certificate ☐ Parent/Legal guardian with custody paperwork [1]
_____ *(First and last name)*	_____ *(Phone number)*	***This person is a:*** ☐ Parent listed on birth certificate ☐ Parent/Legal guardian with custody paperwork [1]
_____ *(First and last name)*	_____ *(Phone number)*	***This person is a:*** ☐ Parent listed on birth certificate ☐ Parent/Legal guardian with custody paperwork [1]

I, a parent or legal guardian listed above, do hereby authorize the Network to perform medical treatment on the above listed patient when accompanied by the following named adult person(s) over the age of 18:

Pack Forest Environmental Camp Employee *(First and last name)*	___Camp Counselor __ *(Relationship to patient)*	***The authorization is valid:*** *(please select one)* ☒ For all medical treatment, including immunizations ☐ For all medical treatment, excluding immunizations ☒ For a specific treatment or date range: ___6/1/2024 to 8/31/2024_____
_____ *(First and last name)*	_____ *(Relationship to patient)*	***The authorization is valid:*** *(please select one)* ☐ For all medical treatment, including immunizations ☐ For all medical treatment, excluding immunizations ☐ For a specific treatment or date range: _____
_____ *(First and last name)*	_____ *(Relationship to patient)*	***The authorization is valid:*** *(please select one)* ☐ For all medical treatment, including immunizations ☐ For all medical treatment, excluding immunizations ☐ For a specific treatment or date range: _____

I attest that the information listed on this form is true and complete. Furthermore, I understand that this consent form, and the information listed, is valid until revoked in writing.

_____ Signature of Parent/Legal Guardian	_____ Print Name	_____ Date
_____ Signature of Witness	_____ Print Name	_____ Date

[1] This paperwork must be provided prior to or at the time of this document's completion.

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, _____ (*Patient's name*), _____ (*date of birth*) agree to permit the providers and staff of 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

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.

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). [2]

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. [3]

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

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

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: __Hudson Headwaters Health Network _____

Address: __3767 Main Street _____

City/State/Zip: ___Warrensburg, NY 12885 _____

Phone: __518-623-2844____ Fax: __518-623-2476_____

B) To be released TO:

Name: ___Pack Forest Environmental Camp_____

Address: __ P.O. Box 777_____

City/State/Zip: __ Warrensburg, NY 12885_____

Phone: __518-623-2037___ Fax: ___518-623-4433_____

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

☒ Medical information ☐ Dental information

- -

☐ Entire record set

☒ Date range: ___6/1/2024_____ to 8/31/2024_____

☒ Other: **Urgent care encounter summary and any applicable imaging reports**

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: ____8/31/2024_____

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.

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.

Patient Name: _____ **Patient Date of Birth:** _____

FAMILY SIZE	CATEGORY 1: ☐	CATEGORY 2: ☐	CATEGORY 3: ☐	CATEGORY 4: ☐
1	$0-14,580	$14,581 -21,870	$21,871-29,160	$29,161 +
2	$0-19,720	$19,721-29,580	$29,581-39,440	$39,441 +
3	$0-24,860	$24,861-37,290	$37,291-49,720	$49,721 +
4	$0-30,000	$30,001-45,000	$45,001-60,000	$60,001 +
5	$0-35,140	$35,141-52,710	$52,711-70,280	$70,281 +
6	$0-40,280	$40,281-60,420	$60,421-80,560	$80,561 +
7	$0-45,420	$45,421-68,130	$68,131-90,840	$90,841 +
8	$0-50,560	$50,561-75,840	$75,841-101,120	$101,121 +

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