ROCHESTER RHIO

Regional Health Information Organization

New York State Department of Health

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

**PROVIDER:** Webster Psychiatry & Medicine, PLLC

| Patient Name | Date of Birth | Patient Identification 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.

| 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 clinical notes, discharge summaries, allergies, a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), treatments you have received, your diagnoses, and lists of medicines you have taken. These records may contain all of this information about 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 Provider Organization at: _____; 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.

**NAME:** _____ **DOB:**_____ **DATE:**_____

## PSYCHIATRIC & MEDICAL HISTORY

***PRESENTING PROBLEM***_____

***PSYCHIATRIC HISTORY: If "YES" is checked, please briefly explain***

Prior Psychiatric treatment ☐NO ☐ YES Diagnosis_____

_____

In patient hospitalization ☐NO ☐ YES _____

Suicide Attempt ☐NO ☐ YES _____

Therapist ☐NO ☐ YES Name:_____

Psychiatrist: ☐NO ☐ YES _____

***CURRENT PSYCHIATRIC MEDICATIONS*** Prescription ☐ NO ☐ YES

_____

_____

***CURRENT NON-PSYCHIATRIC MEDICATIONS:***_____

_____

_____

***OTC/Herbs*** ☐ NO ☐ YES _____

***PLEASE CHECK ANY OF THE FOLLOWING MEDICATIONS PREVIOUSLY TAKEN OR FAILED***:

Antidepressant: ☐ Prozac ☐ Paxil ☐ Zoloft ☐ Celexa ☐ Lexapro ☐ Effexor ☐ Wellbutrin ☐ Remeron ☐ Serzone ☐ Cymbalta ☐ TCA ☐ MAOI ☐ Other _____

Antipsychotic: ☐ Risperdal ☐ Zyprexa ☐ Seroquel ☐ Geodon ☐ Abilify☐ Haldol ☐ Prolixin ☐ Other

Mood stabilizer: ☐ Lithium ☐ Depakote ☐ Tegretol ☐ Trileptal ☐ Lamictal ☐ Topamax ☐ Gabitril ☐ Other

Hypnotic: ☐ Trazodone ☐ Benadryl ☐ Ambien ☐ Sonata ☐ Restoril ☐Halcyon ☐ Other

Stimulant: ☐ Ritalin ☐ Adderal ☐ Concerta ☐ Strattera ☐ Other

Anxiolytics: ☐ Xanax ☐ Ativan ☐ Klonopin ☐ Valium ☐ Buspar ☐ Vistaril ☐ Benadryl ☐ Other

Other: _____

***CHEMICAL DEPENDENCY HISTORY:*** Ever used any drugs and/or alcohol ☐NO ☐ YES

1=experimented 2=used previously 3=actively using

| | | | | | |
|---|---|---|---|---|---|
| __Alcohol | __Inhalants | __Mushrooms | __ Ecstasy | __ Prescription benzos | __Nicotine |
| __Marijuana | __PCP | __ Amphetamines | __ Methadone | __ Prescription Opioids | |
| __Cocaine | __LSD | __ Heroin | __ other | __ Prescription other | |

Ever stopped using? ☐ YES ☐ NO Longest time of abstinence _____Most recent relapse ☐ Yes ☐ No ____

Rehab ☐ Yes ☐ No Half way House ☐ Yes ☐ No AA/NA meetings ☐ Yes ☐ No Sponsor ☐ Yes

***RELEVANT MEDICAL HISTORY& MEDICATIONS***

***Weight*** ☐ loss ☐ gain _____ pounds in _____weeks/months trying to: ☐ Gain ☐ Lose

***Nutrition*** ☐ Binging ☐ Purging ☐ Laxative ☐ Special Diet

***Sleep*** ☐ Continuous ☐ Interrupted ☐ Difficulty falling asleep ☐ Awaken frequently

# hrs of sleep last night? _____

***GYN*** Last period date_____ Are you currently pregnant? ☐ NO ☐YES Due date?_____

Contraceptive ☐NO ☐ YES

**Please continue to back of page.**

**NAME:**_____ **DOB:**_____**DATE:**_____

**PSYCHIATRIC & MEDICAL HISTORY-continued**

***Respiratory*** □Asthma □ Chronic Obstructive Lung disease

***Gastrointestinal*** □ Irritable bowel syndrome

***Cardiovascular*** □Hypertension □ Heart disease

***Sensory*** □ Visual deficit □ Hearing deficit □Other ***Neurological*** □Seizures □Stroke □ Head trauma

***Endocrine*** □Diabetes Mellitus □ Hypothyroidism □ Hyperthyroidism □ Hyperlipidemia

***Muscle/skeletal*** □ Chronic fatigue syndrome □ Fibromyalgia □Migraines □chronic pain _____

□Trauma _____

***Disease/Illness:*** □Hepatitis □HIV □ Cancer_____

**PCP: Name**_____**Phone**_____**Fax**_____

***ALLERGIES*** □ No Known Drug Allergies □ Penicillin □ Sulfa □ Other _____

***PERSONAL/ SOCIAL HISTORY***

Childhood History: Parent/Caregiver: □ Mother □ Father □ Step □ Grandparents □ Family □ Foster □ Adopted

_____

_____

_____

***FAMILY HISTORY:*** (state age, cause of death, any mental or major medical illness)

Maternal Grandmother_____Maternal Grandfather_____

Paternal Grandmother_____Paternal Grandfather_____

Mother _____Father_____

Siblings: _____

_____

Other family with mental illness_____

**Marital status** □ Single □Widowed □Divorced □Separated □Girlfriend □Boyfriend □Married □Engaged

**Children**: □ None □ Own □ Step

Age/sex:_____

_____

**Support System** □ None □Family □Friends □Church □Sponsor □ other _____

**Living at:** □House □Apartment □Assisted Living Live with: □Alone □Significant Other □Family □Friends

**Education:** □Elementary □HS □Some College □AA □BS □ MS □Doctorate

**Learning Disabilities:** □ NO □ YES_____

**Occupation:** □Disabled □Retired □Unemployed □Employed at_____

**Finances:** □ No issues □ Behind in paying bills □ Bankruptcy □ shopping sprees

**Sexual History:** □Inactive □ Sexually active with □Male □Female □Both; □ Monogamy □ Multiple partners

**Abuse History:** □NO □YES □Sexual □ Physical □ Emotional

_____

**Legal History** □ No □ Yes

□ Incarceration □ Arrests □ Probation □ Pending Law Suits/ Legal Actions □ DUI □ CPS/APS reports

Name _____Signature _____

**WEBSTER PSYCHIATRY & MEDICINE, PLLC**
**1527 EMPIRE BLVD**
**WEBSTER, NY 14580**
**T 585-670-0507 F 585-645-0939**
**OFFICE HOURS TUESDAY- FRIDAY 8AM-5PM**

## PATIENT REGISTRATION

Name (Last, First, MI) _____ DOB_____ Sex M F

Street Address _____

City, State, Zip_____

**Please check which phone number(s)/email we are authorized to contact you at and leave messages/email, if necessary:**

☐ Cell Phone _____ ☐ Home Phone _____ ☐ Work Phone _____

☐ Email Address_____

**Please authorize how you would like to receive appointment reminders:**

☐ Text cell phone ☐ Call cell phone ☐ Email ☐ Call other phone _____

Occupation _____Employer/School Name _____

Employer/School Address _____

Emergency Contact Name _____Phone _____

Relation _____Street Address_____

City, State, Zip_____

Whom may we thank for referring you? _____

**Primary Medical Insurance** _____ Subscriber No_____

Subscriber Name (if different) _____Sex M F DOB _____

Relation to Patient _____

Address (if different) _____

Employer Name _____

**Secondary Medical insurance** _____ Subscriber No _____

Subscriber Name (if different) _____ Sex M F DOB _____

Relation to Patient _____

Address (if different) _____

Employer Name _____

PATIENT SIGNATURE_____DATE_____

**WEBSTER PSYCHIATRY & MEDICINE, PLLC**
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**T 585-670-0507 F 585-735-4641**

# FINANCIAL POLICY

Welcome to our practice, we ask that all our patients read, understand, and accept our Financial Policy.

We ONLY accept the following methods of payment: CASH, MASTER CARD or VISA.

We will bill your medical insurances for any office services provided; if your insurance plan determines that the service is not covered, you will be responsible for its full charge. If your insurance fails to pay the submitted claim within 30 days, you will be responsible for the amount charged. You are also responsible for checking with your insurance plan for any prior authorization required. If your insurance denies the claim for lack of prior authorization, you will be responsible for the full charge of the service. If we do not accept your health insurance or if you do not have insurance, you will be responsible for the full charge of the service before your visit.

Required co-pays, deductibles, coinsurance or any other outstanding balance is due **at the time of service**. We will contact your insurance company prior to your appointment to determine whether your deductible or out of pocket maximum has been met, and if not, will collect payment from you at the time of your appointment. Failure to pay a copay, deductible, coinsurance or any other outstanding balance may result in cancellation of your scheduled visit and be considered a missed appointment. There will be a $15 fee added to your account for any outstanding balance or copay not paid at the time of your appointment. If you arrive late for a scheduled appointment, we reserve the right to reschedule your appointment and charge you for a missed appointment.

Your appointment time is reserved especially for you and it is your responsibility to notify us if you are unable to keep your scheduled appointment. If you fail to notify us of cancellation 48 hours prior to a scheduled appointment, or if you do not show for a scheduled appointment, we will charge your account the full amount of the visit, ranging from $100-$175. This fee is due prior to your next scheduled appointment. This fee may be waived one time per calendar year if you cancel due to an emergency. If there is a second emergency cancellation in a calendar year, you will be charged for the second cancellation. In order to be compliant with our 48 hour policy, you must cancel your appointment by 5:00 p.m. two business days prior to the scheduled appointment. For your convenience, we have a 24 hour answering machine; messages are time stamped and cancellation messages will need to be compliant with our policy.

If you are charged for three No Shows and/or Late Cancellations in one year, you will be subject to dismissal from the practice.

Mailed checks returned for insufficient funds will have an added fee of $25 in addition to the original amount owed.

**I have read and agree to the terms of the Financial Policy described above.**

I have been given a copy of the Office Medication Policy, and agree to the terms of the policy.

Signature Name Date

We are dedicated to providing you with the best care and service possible. Thank you for accepting responsibility for prompt payment.

## PRIVACY POLICY

I have been given the opportunity to read and review the privacy policy of the office.

Signature Name Date

Revised 5/1/19

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# OFFICE MEDICATIONS POLICY

Revised 2/19/2021

# PATIENT COPY

- We require office visits a minimum of every three months; we will prescribe a maximum three month supply of medications. If it is no longer indicated clinically that the patient needs to see us as specialists, we will refer the patient back to their Primary Care Physician to continue prescribing their medications.

- For controlled substances, we require patient contact at least every four weeks. As mandated by New York State, prescriptions will be filled electronically during your appointment and the New York State Prescription Monitoring Program will be checked prior to prescribing. We do not prescribe controlled substances to patients with a prior history of substance abuse or dependence.

- Prescriptions are refilled at scheduled appointments, adhering to the above guidelines. It is the responsibility of the patient to ensure they have an appointment scheduled prior to running out of a medication. We do not accept refill requests from pharmacies on your behalf. If you need a prescription refill and do not have a scheduled appointment, please contact our office and we will schedule a medication check appointment as soon as possible or you may have your pharmacy dispense an emergency supply.

- We do not process medication refill request after hours, on weekends or holidays; your pharmacist can provide you with some of your medications until we are contacted during normal business hours.

- It is the patient's responsibility to follow the above policies to ensure no interruptions to their treatment. We work collaboratively with all our patients to ensure optimum medical care.