Westchester Institute for Human Development

Dental Care Services
REGISTRATION PACKET

Welcome to the Westchester Institute for Human Development (WIHD). The attached Registration Packet must be completed prior to the patient's first appointment.

This packet includes:

WIHD PAPERWORK	ADDITIONAL INFORMATION REQUIRED
❑ Registration Form ❑ Consent for Care and Treatment ❑ Financial Statements Form ❑ Notice of Privacy Practices ❑ Patient Bill of Rights ❑ Consent to Disclose or Exchange PHI ❑ Patient Portal Consent	❑ Copy of ALL the Individual's Insurance Cards (front & back) ❑ Agreement indicating permission for the Agency to provide health services† ❑ Agreement authorizing Agency to receive review, and release pertinent medical information† ❑ Current Physical Exam within 1 year ❑ List of Medications

†*Required if an Agency Representative signs all paperwork in lieu of parent/guardian signature*

****PLEASE COMPLETE AND MAIL THIS REGISTRATION PACKET AS SOON AS POSSIBLE TO:**

Dental Department
Westchester Institute for Human Development
221 Cedarwood Hall
Valhalla, New York 10595
Phone: 914-493-8081 or 493-7232
Fax: 914-493-8184
Dental@wihd.org

If you have questions feel free to reach out to us at the contact information above.

Westchester Institute *for* Human Development

REGISTRATION FORM

Today's Date _____/_____/_____			WIHD ACCOUNT NO_____	
PATIENT INFORMATION				
Patient's Last Name First Middle			❑ New Registration ❑ Registration Update	Preferred Language
Social Security #	Race/Ethnicity *(for gov't reporting)* ❑ White ❑ Black/African Am ❑ Asian ❑ Hispanic/Latino ❑ Other		Birth Date / /	Age / Sex
Residential Agency & House (if Applicable)		Phone No. ( )		Fax (if available) ( )
Street Address (Home or Residential Agency)	City	State	ZIP Code	
Agency Contact Name (if Applicable)	Email Address		Pharmacy Name & Address	
Does he/she have a Health Care Proxy or other form of Advance Directive (MOLST, Living Will, DNR)? (If over 18 years old) ❑ Yes ❑ No If Yes, Does WIHD have a copy?(required) ❑ Yes ❑ No *If you would like more information please speak with your provider.				
Primary Care Provider	Phone No.	Dental Care Provider	Phone No.	
***If New Registration please indicate service requested:** _____				
FAMILY/GUARDIAN INFORMATION				
Parent/Guardian/Foster Parent Name (1)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )	
Street Address	City	State	ZIP Code	
Email Address	Do you have Guardianship? (If over 18 yr. old) ❑ Yes ❑ No If Yes, Does WIHD have a copy of papers (required)? **Yes / No**			
Parent/Guardian/Foster Parent Name (2)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )	
Street Address	City	State	ZIP Code	
Email Address	Do you have Guardianship? (If over 18 years old) ❑ Yes ❑ No If Yes, Does WIHD have a copy (required)? **Yes / No**			
Mother's Maiden Name (if Applicable)	Preferred Contact Instructions			
INSURANCE INFORMATION	**(PLEASE LIST ALL INSURANCES AND SUBMIT INSURANCE CARD OR COPY WITH FORM)**			
Medicaid No.	Medicare No.			
Private Insurance Co. (1)	Policy No.			
Name of Insured	Relationship to Patient			
Private Insurance Co. (2)	Policy No.			
Name of Insured	Relationship to Patient			

Westchester Institute *for* Human Development

NAME _____

D.O.B. _____

WIHD # _____

Consent for Care and Treatment

1. I hereby authorize _____ to participate in out-patient care and treatment at the Westchester Institute for Human Development, and the physicians, dentists, allied health professionals on its staff, nursing staff, and paramedical staff, assisted by the employees of the Institute, to provide such medical or dental care and to administer such routine diagnostic tests and procedures, including but not limited to, diagnostic x-rays; the administration and/or injection of pharmaceutical products and medications, including but not limited to sedatives, influenza and hepatitis vaccines and antibiotics, when indicated; and the drawing of blood, as in the judgment of the above Institute's personnel and/or attending physician(s) is deemed necessary.

   I acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from the treatment(s) or examination(s) at the Westchester Institute for Human Development.

2. I confirm that I have read and fully understand the above, and have been given the opportunity to ask questions, and that all my questions have been answered fully and to my satisfaction. I have deleted and initialed procedures for which I withhold permission.

Patient/Relative or Guardian*

_____ _____

Signature of Patient or Personal Representative | Print Name of Patient or Personal Representative

_____ _____

Date | Description of Personal Representative's Authority

Interpreter (if required)

_____ _____

Signature | Print Name

***Patient must sign unless he/she is unemancipated minor under the age of 18 or lacks the capacity to understand what is being signed.**

THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD.

Westchester Institute for Human Development

Financial Agreements

NAME _____

D.O.B. _____

WIHD # _____

1. **Release of Information:**
   I hereby authorize and direct the Westchester Institute for Human Development to release to governmental agencies, insurance carriers, or others who are, or may be, financially responsible for my hospitalization and medical care, all information needed to substantiate payment for such hospitalization and medical care, and to permit representatives thereof to examine and make copies of all records relating to my care and treatment.

   DATE: _____ SIGNATURE: _____
   Patient or Responsible Person

2. **Assignment of Benefits and Guarantee of Payment:**
   I hereby authorize and direct my insurance carrier to make payment directly to the Westchester Institute for Human Development, and hereby assign to said institute, all rights, title and interests I have in insurance proceeds or benefits payable to me or in my behalf for services rendered to me by said institute. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE ABOVE-NAMED INSTITUTE FOR ALL CHARGES, INCLUDING THOSE NOT PAID BY INSURERS OR THIRD PARTIES, INCURRED BY ME OR IN MY BEHALF. However, if treatment has been given in accordance with New York State's No-Fault law, it is understood that my liability is limited to charges authorized under such law and applicable New York State No-Fault Fee schedules. I hereby authorize and direct the above-named institute and my attending physician to release such medical information from my medical records as is necessary to complete forms for payment by insurance carriers and other payers.

   DATE: _____ SIGNATURE: _____
   Patient or Responsible Person

   IF PERSON OTHER THAN PATIENT SIGNS, INDICATE RELATIONSHIP TO PATIENT AND REASON FOR LACK OF PATIENT SIGNATURE: _____

3. **Medicare Insurance:**
   I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information regarding my treatment, to release to the Social Security Administration and/or the Centers for Medicare & Medicaid Services or its intermediaries or carriers, any information needed for this related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare in my behalf.

   DATE: _____ SIGNATURE: _____
   Patient or Responsible Person

4. **I HAVE READ THIS AGREEMENT, AND I FULLY UNDERSTAND ITS NATURE AND SIGNIFICANCE. I HAVE RETAINED A COPY OF THIS AGREEMENT.**

   DATE: _____ SIGNATURE: _____
   Patient or Responsible Person (parent if minor)

educate . innovate . advocate
Westchester Institute for Human Development
Cedarwood Hall, Valhalla, NY 10595
914.493.8202 . www.wihd.org

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical informationabout you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we'veshared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, lawenforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and4*** *for more information on these uses and disclosures*

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. See Page 4 for instructions • 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. See page 4 for instructions. • 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 (accounting) 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 (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
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. • An electronic copy is also located at www.wihd.org
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	• You can complain if you feel we have violated your rights by contacting us using the contact information located on page 4. • You can 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/.** • We will not retaliate against you 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 *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
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. • You have the right to opt-out from any and all fundraising communications from WIHD. If you wish to opt-out you can send an email to DevelopmentTeam@wihd.org or call 914-493-1344.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

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.*
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.*
Bill for your 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.*

continued on next page

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 about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • 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: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For 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.

Contact Information

- *For Any Requests please contact Medical Records by the following methods:*
  - *WIHD Medical Records*
    Cedarwood Hall Second Floor
    Valhalla, New York 10595
    914-493-8651
    MedicalRecords@wihd.org

- *For Specific Questions related to this notice please contact the Regulatory Compliance & Quality Improvement Officer:*
  - *Compliance Office*
    Cedarwood Hall, Room 308
    Valhalla, New York 10595
    914-493-8367
    Compliance@wihd.org

There are special circumstances which would require your specific authorization before sharing. We will never share substance abuse treatment records or HIV related information without your written permission. Please contact Medical Records or the Regulatory Compliance & Quality Improvement Officer for further information.

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. Let us know in writing if you change your mind.

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.

August 2015

Liya Caiazzo, PT, MPT, MBA ● Regulatory Compliance & Quality Improvement Officer ●
Compliance@wihd.org ● 914-493-8367

Westchester Institute *for* Human Development	NAME _____
NOTICE OF PRIVACY PRACTICES	D.O.B. _____
	WIHD # _____

Acknowledgement

By signing below, I acknowledge that I have been provided a copy of this *Notice of Privacy Practices* and have therefore been advised of how health information about me may be used and disclosed by the Institute and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information.

Signature of Patient or Personal Representative	Print Name of Patient or Personal Representative
Date	Description of Personal Representative's Authority

Patients' Bill of Rights for Diagnostic & Treatment Centers (Clinics)

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

(1) Receive services(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or sponsor;

(2) Be treated with consideration, respect and dignity including privacy in treatment;

(3) Be informed of the services available at the center;

(4) Be informed of the provisions for off-hour emergency coverage;

(5) Be informed of the charges for services, eligibility for third-party reimbursements 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's Office of Primary Health Systems Management;

(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 health-care 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. For additional information link to: http://www.health.ny.gov/publications/1449/section_1.htm#access

(16) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors; and

(17) Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the center.

NEW YORK STATE | Department of Health

Public Health Law(PHL)2803 (1)(g)Patient's Rights, 10NYCRR, 405.7,405.7(a)(1),405.7(c)

Westchester Institute *for* Human Development

NAME _____

D.O.B. _____

WIHD # _____

Patient Bill of Rights Acknowledgement

I acknowledge that I was provided a copy of the Patient Bill of Rights and that I have read, or have had the opportunity to read, this Notice and I understand the Notice.

_____

Patient Name (Please Print) Date

_____

Authorized Representative (Please print if applicable) Relationship to Patient

X_____

Patient's or Authorized Representative's Signature

Westchester Institute for Human Development

AUTHORIZATION TO DISCLOSE and/or EXCHANGE PROTECTED HEALTH INFORMATION

NAME _____

ADDRESS _____

CITY _____ **STATE**_____ **ZIP** _____

D.O.B. _____ **WIHD#** _____

I authorize Westchester Institute for Human Development to **disclose and/or exchange** the above-named individual's health information as follows. (Check the appropriate boxes):

☐ Entire Record ☐ Other (Please describe)_____

Include (by initialing – if applicable): ____ HIV-Related Information and test results ____ Alcohol/Drug Treatment

The information above may be disclosed to the following:

Name or Organization:_____ **Phone:**_____ **Fax:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Email (if applicable):_____

I authorize Westchester Institute for Human Development to (please check all that apply below):

☐ **Discuss my health information with the above named Individual or Organization**
☐ **Disclose medical records to the above named Individual or Organization**

This information for which I'm authorizing disclosure will be used for the following purposes.

☐ My personal records ☐ Sharing with other healthcare providers as needed
☐ Sharing with school personnel including teachers and related service providers
☐ Other (please describe): _____

TO BE READ AND SIGNED BY PATIENT:

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. This will only be included if I place my initials in the appropriate box above.
2. 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.
3. I understand that I have a right to revoke this authorization at any time by providing written notice to the practice, except to the extent that the program or person who is to make the disclosure has already acted in reliance on it..
4. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
5. I understand that authorizing the use or disclosure of the information identified above is voluntary. I understand that I have the right to refuse to sign this form and that I need not sign this form to ensure healthcare treatment, payment for my healthcare, or continuation of my healthcare benefits.
6. I understand that WIHD has the right to charge a reasonable fee to recover the costs of copying, mailing, and supplies used to fulfill my request.
7. I understand that I have the right to inspect or copy information to be used or disclosed as described in this form and in accordance with Institute policies and procedures. I have the right to receive a copy of this form after I have signed it.
8. I acknowledge that I have had the opportunity to review this authorization and understand the intent and use. My questions about the form have been answered to my satisfaction.

Signature of Patient or Personal Representative	**Print Name of Patient or Personal Representative**
Description of Personal Representative's Authority	**Date**

Westchester Institute for Human Development

WIHD PATIENT PORTAL REQUEST FORM

WESTCHESTER INSTITUTE FOR HUMAN DEVELOPMENT (WIHD) offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians through a Patient Portal.

To have access to the WIHD Patient Portal, please print all information clearly:

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

Who is requesting Portal Access? (Select all that apply):

☐ **Patient: Email Address** _____

☐ **Guardian or Representative: Email Address** _____

☐ **Agency: Email Address (preferably generic Agency email)** _____

AGENCY INFORMATION (if applicable)

Name/Organization:_____ Phone Number: _____

Address: _____

Agency Contact Person: _____ Agency Contact Email: _____

- *This Agency/Organization can request patient portal access for the agency staff providing care for the patient mentioned above*
- *Please note that the agency has the responsibility to let WIHD know when the personnel who has access to the patient portal has changed or not employed by the agency. You can let WIHD know about changes in staff who has access to the patient portal by sending an email to pportal@wihd.org*

By signing and dating this form, I am authorizing WESTCHESTER INSTITUTE FOR HUMAN DEVELOPMENT (WIHD) to create a patient portal Logon ID and password for the patient listed above. By signing this form, I also understand that records accessed by the proxy/caregiver/agency could be re-disclosed without my knowledge. I further understand that information in the patient portal may include treatment and testing regarding drug/alcohol abuse, mental health, HIV status, sexually transmitted disease and diagnosis, genetic testing and reproductive medicine.

Signature: _____ **Date**: _____

Print Name of Patient of Personal Representative: _____

Description of Personal Representative's Authority: _____

* If an agency representative signs this form, please include an agreement indicating permission for the agency to provide health services and authorizing the agency to receive, review, and release medical information
* You may at any time revoke the proxy access by contacting WIHD at 914-493-8148 and filling out the proxy revocation form. Your designated proxy will have access to your patient portal records until that time.
* Legal Guardians are required to advise WIHD immediately if there is a change in authority

- We need you to make sure we have the correct email address and you MUST inform us if it ever changes.
- If you forget your password please use the "forgot password" option on the portal.
- Patient Portal website is https://emr.wihd.org/PatientPortal/CurePatientHome.aspx?wihd
- **Please bring this form to your next appointment, fax this form to (914) 493-8755, or send it by e-mail to pportal@wihd.org**

For WIHD Use ONLY

☐ Consent to Disclose PHI or Agreement indicating permission for Agency to provide health services on file

Dev 3/2019, Rev 4/2019