



# Westchester Institute for Human Development

## **Assistive Technology REGISTRATION PACKET (Insurance & Private Pay)**

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

The following information is required to be completed:

<b>WIHD PAPERWORK</b>	<b>ADDITIONAL INFORMATION REQUIRED</b>
<ul style="list-style-type: none"><li><input type="checkbox"/> Registration Form</li><li><input type="checkbox"/> ATP Initial Intake Form</li><li><input type="checkbox"/> Consent for Care and Treatment</li><li><input type="checkbox"/> Cancellation and Missed Appointment Agreement</li><li><input type="checkbox"/> Financial Statements Form</li><li><input type="checkbox"/> Notice of Privacy Practices</li><li><input type="checkbox"/> Patient Bill of Rights</li><li><input type="checkbox"/> Consent to Disclose or Exchange PHI</li></ul>	<ul style="list-style-type: none"><li><input type="checkbox"/> Copy of ALL the Individual's Insurance Cards (front &amp; back)</li></ul>

**\*\*PLEASE COMPLETE AND MAIL/FAX/EMAIL THIS REGISTRATION PACKET AS SOON AS POSSIBLE TO:**

**AT Program  
Westchester Institute for Human Development  
Cedarwood Hall – Room 422  
20 Plaza West (GPS)  
Valhalla, New York 10595  
Ph: 914-493-1317  
Fax: 914-493-3964  
[atp@wihd.org](mailto:atp@wihd.org)**

**If you have questions feel free to contact us.**



**REGISTRATION FORM**

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_ WIHD ACCOUNT NO. \_\_\_\_\_

**PATIENT INFORMATION**

Patient's Last Name	First	Middle	<input type="checkbox"/> New Registration <input type="checkbox"/> Registration Update	Preferred Language
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Social Security #	Race/Ethnicity (for gov't reporting) <input type="checkbox"/> White <input type="checkbox"/> Black/African Am <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other	Birth Date / /	Age	Sex
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Residential Agency & House (if Applicable)	Phone No. ( )	Fax (if available) ( )
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Street Address (Home or Residential Agency)	City	State	ZIP Code
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Agency Contact Name (if Applicable)	Email Address	Pharmacy Name & Address
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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.
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\*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. ( )
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Street Address	City	State	ZIP Code
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Email Address	Do you have Guardianship? (If over 18 yr. old) <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Does WIHD have a copy of papers (required)? <b>Yes / No</b>
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Parent/Guardian/Foster Parent Name (2)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )
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Street Address	City	State	ZIP Code
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Email Address	Do you have Guardianship? (If over 18 years old) <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Does WIHD have a copy (required)? <b>Yes / No</b>
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Mother's Maiden Name (if Applicable)	Preferred Contact Instructions
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**INSURANCE INFORMATION** (PLEASE LIST ALL INSURANCES AND SUBMIT INSURANCE CARD OR COPY WITH FORM)

Medicaid No.	Medicare No.
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Private Insurance Co. (1)	Policy No.
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Name of Insured	Relationship to Patient
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Private Insurance Co. (2)	Policy No.
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Name of Insured	Relationship to Patient
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**ASSISTIVE TECHNOLOGY EVALUATION TEAM**

**INITIAL INTAKE FORM**

***Please complete and return to:***

Assistive Technology Program  
Westchester Institute for Human Development  
20 Plaza West - 422 Cedarwood Hall  
Valhalla, NY 10595-1689  
Email: [atp@wihd.org](mailto:atp@wihd.org)  
Tel# 914-493-1317  
Fax# 914-493-3964

Date: \_\_\_\_\_

1) Name of Applicant: \_\_\_\_\_ DOB \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Is applicant in school?  Yes  No

If yes, school & grade: \_\_\_\_\_

Is applicant employed?  Yes  No If yes, employer: \_\_\_\_\_

2) Parent/Guardian/Spouse (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

3) Primary Contact (for appointments etc.): \_\_\_\_\_

4) Physician: \_\_\_\_\_

Address: \_\_\_\_\_

5) Reason for Referral: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6) Medical Diagnosis and/or Functional Concerns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7) Please identify any health concerns that are pertinent to the evaluation.



# Westchester Institute for Human Development

- hearing loss     seizures     vision problems     recurring health problems  
 medications     other: \_\_\_\_\_

Explanation of checked items: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 8) Current AT equipment being utilized in home, school and/or work environment. (communication device, switches, expanded keyboards, software, walkers, wheelchairs etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 9) Does the individual have any activity interests and preferences (e.g., games) or sensory preferences (colors, lights, sounds): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- 10) List specific concerns or questions you want addressed in this evaluation: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- 11) Is there any other information that you feel we should know: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Please fill out APPLICABLE PORTIONS ONLY of the remaining pages. Thank you.***



**FUNCTIONAL OVERVIEW**

1) Has the individual ever received speech/language therapy? \_\_\_\_\_  
How does the individual generally make himself/herself understood (e.g., speech, gestures, graphic cues, object cues, vocalizing)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) Does the individual presently receive speech/language therapy? \_\_\_\_\_  
Please describe the time period, frequency of service, and major goals in therapy:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SLP's name & phone: \_\_\_\_\_

3) How do you communicate with the individual?

Verbal alone: \_\_\_\_\_

Verbal with visual cues: \_\_\_\_\_

4) What kinds of information does the individual communicate spontaneously?

\_\_\_\_\_  
\_\_\_\_\_

5) Please identify specific means of communicating:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> facial expressions | <input type="checkbox"/> gestures/informal signs      | <input type="checkbox"/> behavior       |
| <input type="checkbox"/> sign language      | <input type="checkbox"/> sounds                       | <input type="checkbox"/> alphabet board |
| <input type="checkbox"/> words              | <input type="checkbox"/> non-electronic communication |   |

6) How does the individual gain your attention when you are not paying attention to him/her?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7) How does the individual ask questions for directions, information and personal needs?

\_\_\_\_\_  
\_\_\_\_\_



8) How does the individual communicate choices or indicate preferences?

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9) Does this client have a recognizable way to indicate yes/no? \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

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10) Please describe major educational setting(s) and major emphasis in program.

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11) Cognitive Level: \_\_\_\_\_

Reading Level: \_\_\_\_\_

Writing Skills:         no ability     legible handwriting     keyboarding skills

Motor Abilities:         ambulatory     functional hand use     functional head use

volitional controlled movement of body part (explain):

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12) Does this individual presently receive OT? \_\_\_\_\_

Please describe the time period, frequency of service, and major goals in therapy:

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OT's name & phone: \_\_\_\_\_

13) Does the individual presently receive PT? \_\_\_\_\_

Please describe the time period, frequency of services, and major goals in therapy:

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PT's name & phone: \_\_\_\_\_

***\*Please forward any pertinent PT, OT and/or Speech Reports along with any current  
IFSP/IEP or vocational reports.***



Westchester Institute  
for Human Development

NAME \_\_\_\_\_

D.O.B. \_\_\_\_\_

WIHD # \_\_\_\_\_

**Consent for Care and Treatment**  
*ASSISTIVE TECHNOLOGY PROGRAM*

1. I hereby authorize \_\_\_\_\_ to participate in an Assistive Technology Evaluation and/or Training at the Assistive Technology Program at WIHD.
2. I acknowledge that no guarantees or assurances are made to me concerning the implementation of recommendations resulting from this evaluation by third parties.
3. 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.

**Patient/Relative/Guardian or Personal Representative**

\_\_\_\_\_  
Signature of Parent/Guardian/Personal Representative

\_\_\_\_\_  
Print Name of Parent/Guardian/ Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority

**Interpreter (if required)**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name



NAME \_\_\_\_\_

D.O.B. \_\_\_\_\_

WIHD # \_\_\_\_\_

**Cancellation and Missed Appointment Agreement**

We, at Westchester Institute for Human Development (WIHD), understand that sometimes you need to cancel or reschedule your appointment. If you are unable to keep your appointment, please notify us as soon as possible. Missed or late appointments disrupt schedules that can impact you and other patients.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call or email to you is made/attempted 1 business day prior to your scheduled appointment. However, it is your responsibility to arrive for your appointment on time.

**PLEASE REVIEW THE FOLLOWING POLICY**

1. We ask that you please cancel your appointment with at least 24 hours' notice. This will enable us to accommodate other patients who are requesting similar time slots.
2. If you are more than 15 minutes late it is possible we may not be able to accommodate you. If you will be late please call in advance to make sure you can still be seen for the remainder of your appointment.
3. All late cancellations and no shows will be documented in your medical record.
4. Three or more late cancellations or no shows in a 3 month time frame may result in terminating services.
5. If there is a one-month lapse in treatment for services requiring ongoing consecutive sessions, without discussing with the clinician in advance, treatment may be terminated.
6. Please be aware that if your case is closed you may be placed on a waiting list and the same clinician or time slot cannot be guaranteed.
7. We will make every attempt to contact you after late cancellations and no shows. These attempts to contact you will be documented in your medical record.
8. If your services are terminated due to missed appointments we will attempt to assist you by recommending alternative providers.

I have read and understand WIHD's Cancellation and Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify WIHD appropriately if I have difficulty fulfilling my scheduled appointments.

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient (if applicable)





Westchester Institute  
for Human Development

NAME \_\_\_\_\_

D.O.B. \_\_\_\_\_

WIHD # \_\_\_\_\_

**Financial Agreements**

**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)



## Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about 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've shared 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, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ See pages 3 and 4 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](http://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/](http://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](mailto: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](http://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](mailto: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](mailto: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

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- 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](http://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*

 <p>Westchester Institute for Human Development</p>	NAME _____ D.O.B. _____
<b>NOTICE OF PRIVACY PRACTICES</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](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.



**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. \_\_\_\_\_

**Patient Bill of Rights Acknowledgement**

WIHD # \_\_\_\_\_

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



NAME \_\_\_\_\_
ADDRESS \_\_\_\_\_
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_
D.O.B. \_\_\_\_\_ WIHD# \_\_\_\_\_

AUTHORIZATION TO DISCLOSE and/or EXCHANGE PROTECTED HEALTH INFORMATION

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

# **DIRECTIONS TO WESTCHESTER INSTITUTE FOR HUMAN DEVELOPMENT (WIHD)**

**ASSISTIVE TECHNOLOGY DEPARTMENT – 914-493-1317  
4<sup>TH</sup> FLOOR, ROOM 422**

## **GPS**

20 Hospital Oval West  
Valhalla, NY

## **FROM THE BRONX AND SOUTH:**

Bronx River Parkway North to Sprain Brook Parkway North. Exit at Medical Center exit. Turn left onto Hospital Road. Continue straight at stop sign, following road past parking structure on your left to the end of the road. At stop sign, turn left and then make first right, following blue signs for Cedarwood Hall/WIHD. Take ticket at gate; follow road in front of Cedarwood Hall, then turn left into parking area.

## **FROM THE NORTH:**

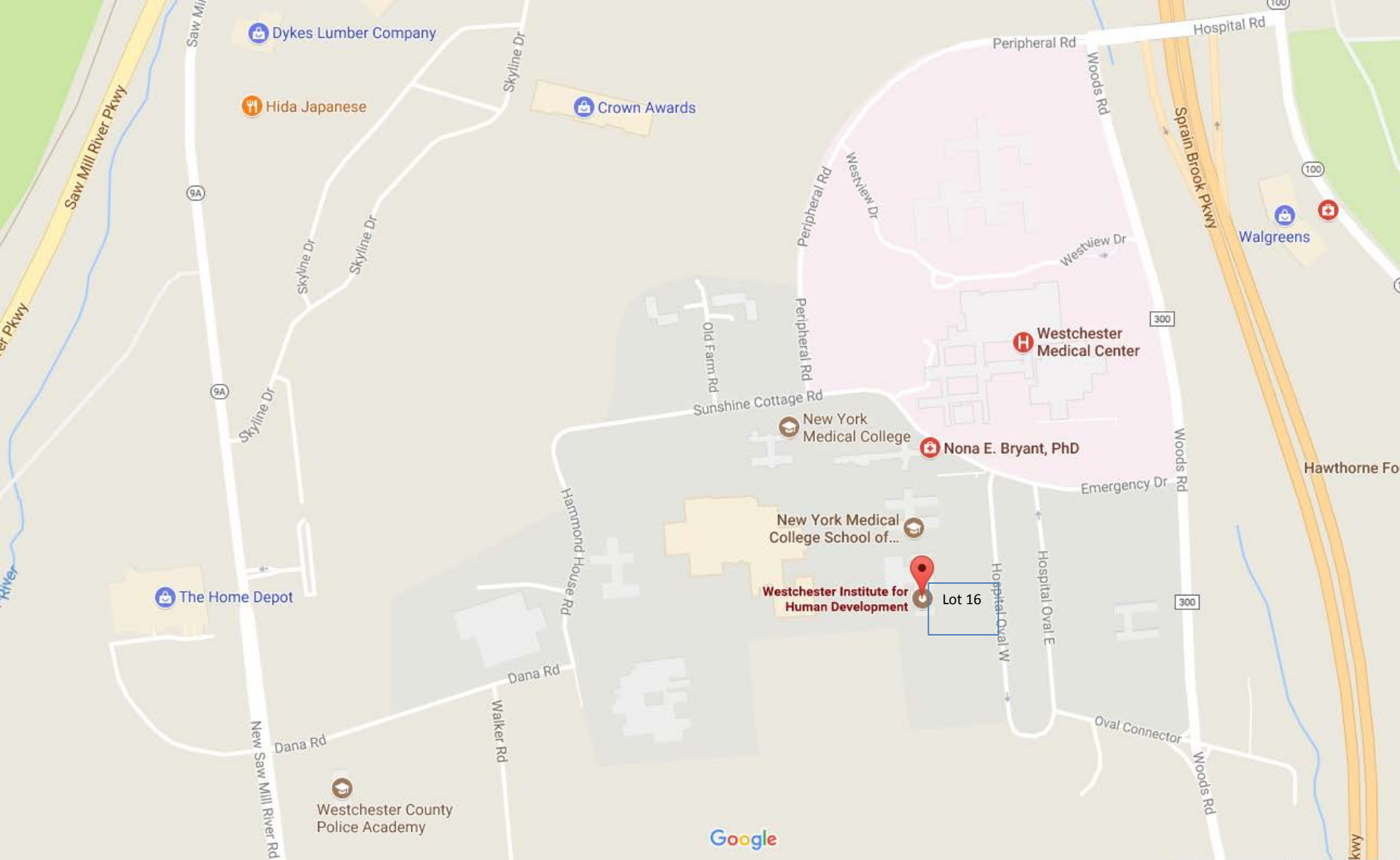
Taconic Parkway South to Medical Center/Route 100 exit (just past the New State Police Headquarters). Turn right at top of exit ramp onto Route 100 South. Turn right at light, passing over parkway. Continue straight at stop sign, following road past parking structure on your left, to the end of the road. At stop sign, turn left and then make first right, following blue signs for Cedarwood Hall/WIHD. Take ticket at gate; follow road in front of Cedarwood Hall, then turn left into parking area.

## **FROM THE WEST:**

New York State Thruway South across Tappan Zee Bridge staying to the right as you go through tolls to Exit 8A (87 South). Follow signs for Saw Mill River Parkway North. Exit at Eastview, and turn right. Follow road through business park, remaining on Route 100C (bear left) as road forks. At second light, make a left into the Westchester Medical Center campus and follow road to stop sign at end. Turn left, following road past parking structure on your left to the end of the road. At stop sign, turn left and then make first right, following blue signs for Cedarwood Hall/WIHD. Take ticket at gate; follow road in front of Cedarwood Hall, then turn left into parking area.

## **FROM THE EAST:**

Cross Westchester Expressway (287) Westbound to Exit 3 (Sprain Parkway). Bear left after exiting to Northbound Sprain. Take Sprain Parkway north to Medical Center exit. Turn left onto Hospital Road. Continue straight at stop sign, following road past parking structure on your left, to the end of the road. At stop sign, turn left and then make first right, following blue signs for Cedarwood Hall/ WIHD. Take ticket at gate; follow road in front of Cedarwood Hall, then turn left into parking area.



Dykes Lumber Company

Hida Japanese

Crown Awards

Peripheral Rd

Hospital Rd

9A

100

Walgreens

Westchester Medical Center

300

Sunshine Cottage Rd

New York Medical College

Nona E. Bryant, PhD

Emergency Dr

New York Medical College School of...

Westchester Institute for Human Development

Lot 16

300

The Home Depot

Hammond House Rd

Hospital Oval W

Hospital Oval E

Dana Rd

Oval Connector

New Saw Mill River Rd

Dana Rd

Walker Rd

Westchester County Police Academy

Google