Clear Form

WMC Health | MidHudson Regional Hospital
Westchester Medical Center Health Network

OFFICIAL USE

-Verbal Consent-

Patient's Name: _____

Date of Birth: _____

MRN: _____

FIN: _____

Name of Patient or Legal Representative: _____

Relationship: _____

Caregiver Form:

☐ ***Assign Caregiver Person*** ☐ ***Decline Assigning Caregiver***

Name	*Relationship*	*Address*	*Phone*

HIE:

Other Names Used (e.g. Maiden Name): _____

- ☐ ***I give consent***
- ☐ ***I deny consent except in a Medical Emergency***
- ☐ ***I deny Consent***

Reason for Verbal Consent:

_____

_____ _____

Hospital Staff Person's Name ***Date / Time***

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ACCESS TO PROTECTED HEALTH INFORMATION AUTHORIZATION

Name of Patient:_____

☐ I hereby assign the person below as the Caregiver:

Name	Relationship	Address	Phone

☐ I hereby decline assigning any Caregiver:

"CAREGIVER" shall mean any individual duly identified as a caregiver by a patient under this article who provides after-care assistance to a patient living in his or her residence. An identified caregiver shall include, but is not limited to, a relative, partner, friend or neighbor who has a significant relationship with the patient.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE: By signing below, I acknowledge receipt of the Notice of Privacy Practices, which outlines how health information about me may be used or disclosed.

Patient Name (Print) _____ Date/Time: _____

Patient Signature **Verbal Consent Obtained** Date/Time: _____

_____ _____

Hospital Staff Person's Name *Date / Time*

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Westchester Medical Center Health Network

CN0008

GENERAL CONSENT FOR TREATMENT

AUTHORIZATION FOR MEDICAL TREATMENT: I hereby authorize the physicians, house staff, nursing, paramedic and allied health professional staff, assisted by the employees of Westchester Medical Center (WMC), to provide medical treatment to me or the above named patient. I agree to diagnostic tests and procedures, including X-rays and the administration/injection of pharmaceutical products and medication, in addition to the drawing of blood as well as access to my medication history data. I understand and authorize the administration of pharmaceutical agents and medications by anyone of several techniques including peripheral intravenous access (inserted into a vein in an arm or leg) and peripheral insertion of a venous catheter that then enters the central circulation (PICC line). I acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from treatment or examination at WMC. If I have any questions or concerns regarding my care, including ethical issues, I can ask my physicians or nurses for more information.

RELEASE OF MEDICAL INFORMATION: I hereby authorize and direct WMC and my attending physician to release such medical information from my medical records as is necessary to complete forms for continued care, payment by insurance carriers, health care plans and third party payors and employers of self-funded plans.

ASSIGNMENT OF BENEFITS, GUARANTEE OF PAYMENT AND FINANCIAL ASSISTANCE PROGRAM: I hereby assign to WMC any and all rights, title, and interest that I have in any insurance proceeds or benefits payable to me or on my behalf for services rendered to me by WMC, whether such services are considered in-or out-of-network with respect to any third party payor. I therefore hereby authorize and direct my insurance carrier and/or health care plan to make payment of any and all such amounts directly to WMC, rather than to myself or any other insured. I acknowledge that as a member of a health care plan, I may be responsible to notify my primary care physician or obtain pre-certification for services. I understand that I am financially responsible to WMC for all charges, including those not paid by insurers or health care plans for services not authorized as specified in my benefit package, incurred by me or in my behalf. I understand I will receive a separate bill from my attending physician, emergency department physician, radiologist, anesthesiologist and other consultants. (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.) As part of WMC's commitment to serving the community it recognizes that it is sometimes necessary to provide care to the uninsured or underinsured patients who cannot afford to pay for care according to established hospital guidelines. WMC has a Financial Assistance Program for patients who financially qualify. Please ask for more details.

CONSENT TO RECEIVE TELEPHONE CALLS, TEXTS AND/OR EMAILS: I hereby consent to WMC to contact me by voice call, text message and email at the Account contact telephone number (s) and Email address (es) reflected on my account. I understand that, by giving this consent WMC may contact me about my medical care, or my account, such as appointment, the results of any tests or procedures, billing, the repayment or collection of amount due and that these calls may be using automatic dialers or pre-recorded voice messages. I further understand and agree that, if the Account contact telephone number (s) or email address (es) provided are for a cellular telephone or other services that charge me in any way for calls or messages received (for example, per minute, per message, per unit of data received or otherwise), I am solely responsible for any charges incurred under my agreement with my cellular telephone or other service provider.

ACKNOWLEDGEMENT OF RECEIPT OF IMPORTANT INFORMATION ABOUT PAYING FOR YOUR CARE:
By signing below, I acknowledge receipt of the important information about paying for your care.

TELEPSYCHIATRY: I have been given basic information regarding the use of Telepsychiatry and consent to participate in services utilizing this technology. If I am under the age of 18, such information was shared with and consent is obtained from my parent or guardian. I understand I have the right to refuse to participate in Telepsychiatry services, in which case evaluations will not be withheld, but will be conducted in-person by appropriate clinicians. I also understand that upon my refusal of such services I will be apprised of the alternatives to Telepsychiatry services, including any delays in service, need to travel, or risks associated with not having the services provided by Telepsychiatry. Furthermore, I am made aware that each Telepsychiatry session shall not be recorded without my consent.

_____ **I do not want to participate in Telepsychiatry**

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GENERAL CONSENT FOR TREATMENT

RELEASE OF LIABILITY FOR PERSONAL PROPERTY: I understand and agree that personal property (i.e. money, jewelry) should not be brought into the hospital and understand and agree that WMC shall not be liable for lost or damage to any personal property. Please initial in the space provided to the left:

Verbal Consent Obtained

IF ADMITTED AS AN INPATIENT: I have received the Patient's Bill of Rights, information on the Self Determination Act under New York State Law, a copy of the New York State Health Care Proxy, the "Important Message from Medicare", information on DNR (do not resuscitate) order, the letter from the New York State Department of Health explaining the SPARCS data collection system, maternity information (if a maternity patient) with information about how I can exercise the right explained in these materials. If I have any questions or concerns regarding my care, including ethical issues, I can ask my physicians or nurses for more information. In the event that I am hospitalized as an inpatient beyond Medicare's allotted 90 days, I authorize Westchester Medical Center to utilize my Lifetime Reserve Medicare days.

_____ **I do not authorize WMC to utilize my Lifetime Reserve Medicare days.**

DESIGNATED CAREGIVER: I authorize WMC to share my PHI with my designated caregiver (s). Please initial in the space provided to the left.

Verbal Consent Obtained

If you are signing this Consent as the patient's Authorized Representative, put an "X" in the box that shows your legal relationship to the patient:

- ☐ pediatric patient's parent, guardian, custodian, or foster parent
- ☐ patient's spouse or domestic partner or surrogate
- ☐ other legal relationship: _____
- ☐ patient's legal guardian
- ☐ patient's healthcare proxy

PATIENT OR LEGAL AUTHORIZED REPRESENTATIVE

Signed: _____
Patient

Signed: *Verbal Consent Obtained*
Legal authorized Representative

Witness: _____

Date: _____ _____

TELEPHONE CONSENT IS GRANTED BY (if required)

Signed: _____
Name of legal representative and relationship to patient.

Signed: *Verbal Consent Obtained*
Signature of caller.

Witness: _____

Date: _____ _____

Hospital Staff Person's Name: _____ Date/Time: _____

WMCHealth

Authorization for Access to Patient Information Through Health Information Exchange Organizations

Name	Date of Birth	Identification Number
Other Names Used (e.g. Maiden Name)		

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 employees, agents, or members of the medical staff of the Provider Organizations of WMCHealth * to obtain access to my medical records through the following participating health information exchange organizations: HealtheConnections and Hixny. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network called the SHIN-NY. HealtheConnections and Hixny are not-for-profit organizations that share information about people's health electronically and meet the privacy and security standards of HIPAA and New York State Law. To learn more, visit these websites:

www.healtheconnections.org
www.hixny.org
https://www.nyehealth.org/shin-ny/what-is-the-shin-ny/

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 bills. You can make that choice in a separate Consent Form that health insurers must use.

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 WMCHealth to access ALL of my electronic health information through the SHIN-NY to provide health care services (including emergency care).
☐ I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY for WMCHealth to access my electronic health information through the SHIN-NY.
☐ I DENY CONSENT for WMCHealth to access my electronic health information through the SHIN-NY for any purpose, even in a medical emergency (except for minor patients). Unless you check this box, New York State law allows medical providers treating you in an emergency to get access to your medical records, including records that are available through the SHIN-NY.

If I want to deny consent for all Provider Organizations and Health Plans participating in the Statewide Health Information Network for New York (SHIN-NY) that access my electronic health information through one of the following HIEs, I may do so by contacting each of the HIEs individually:

HealtheConnections	www.healtheconnections.org	315-671-2241 x 5
Hixny	www.hixny.org	518-640-0021

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 ***Verbal Consent Obtained***	Date	Date of Birth
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)	

Hospital Staff Person's Name *Date / Time*

NO SURPRISES ACT DISCLOSURE FORM

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing") ?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care - like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or hospital, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in a stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services. If your insurance ID card says "fully insured coverage," you can't give written consent and give up your protections not to be balance billed for post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, and intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

NO SURPRISES ACT DISCLOSURE FORM

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections. If your insurance ID card says "fully insured coverage," you **can't** give up your protections for these other services if they are a surprise bill. Surprise bills are when you're at an in-network hospital or ambulatory surgical facility and a participating doctor was not available, a non-participating doctor provided services without your knowledge, or unforeseen medical services were provided.

Services referred by your in-network doctor

If your insurance ID card says "fully insured coverage," surprise bills include when your in-network doctor refers you to an out-of-network provider without your consent (including lab and pathology services). These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed. You may need to sign a form (available on the Department of Financial Services' website) for the full balance billing protection to apply.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in- network deductible and out-of-pocket limit.

If you think you've been wrongfully billed and your coverage is subject to New York law ("fully insured coverage"), contact the New York State Department of Financial Services at (800) 342-3736 or surprisemedicalbills@dfs.ny.gov. Visit http://www.dfs.ny.gov for information about your rights under state law.

Contact CMS at 1-800-985-3059 for self-funded coverage or coverage bought outside New York. Visit http://www.cms.gov/nosurprises/consumers for information about your rights under federal law.

Signature: *Verbal Consent Obtained* _____ Date/Time _____

_____ _____

Hospital Staff Person's Name *Date / Time*

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Westchester Medical Center Health Network

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospital 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.

Verbal Consent Obtained

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Hospital Staff Person's Name

Date / Time

WMC Health | MidHudson Regional Hospital
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CNO004

PATIENT CONSENT TO THE RELEASE OF RECORDS FOR NYS EXTERNAL APPEAL

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The patient, the patient's designee, and the patient's provider have a right to an external appeal of certain adverse determinations made by health plans.

When an external appeal is filed, a consent to release of medical records, signed and dated by the patient, is necessary. An external appeal agent assigned by the New York State Department of Financial Services will use this consent to obtain medical information form the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at anytime, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring action against my health plan.

If the patient or the patient's designee submits this application, by signing the Patient Consent to Release of Records for New York State External Appeal, the patient attests that the information provided in this application is true and accurate to the best of his or her knowledge.

Signature of patient is required below. If the patient is a minor, the document must be signed by their parent or legal guardian. If the patient is deceased, the document must be signed by the patient's healthcare proxy or executor. If signed by a guardian, power of attorney, healthcare proxy or executor, a copy of the legal supporting document should be included.

Signature:	***Verbal Consent Obtained***
Print Name:	
Relationship to patient, if applicable:	
Patient Name:	Age:
Patient's Health Plan ID#	
Date (required):	

Hospital Staff Person's Name

Date / Time