

PATIENT INFORMATION

Date: _____ MRN: _____ (Office Use Only)
Patient's Name: _____ Date of Birth: _____ Age: _____
Sex: ___ Male ___ Female Patient/Contact Email Address _____
Street Address _____ Apt# _____
City: _____ State _____ Zip Code: _____ County: _____
Patient's Home Phone Number: () _____ Okay to call: ___ Yes ___ No

PARENT INFORMATION / PERSONS TO BE CONTACTED IN CASE OF EMERGENCY:

Mother's or Father's Name: _____ Relationship: _____
Address (if different): _____
Home Phone:() _____ Work Phone:() _____ Cell Phone: () _____
Other Parent's or Contact's Name : _____ Relationship: _____
Address (if different): _____
Home Phone:() _____ Work Phone:() _____ Cell Phone: () _____
Primary Care Physician: _____ Phone Number: () _____
Physician Address: _____
Outpatient Therapist: _____ Phone Number: () _____
Therapist Address: _____

INSURANCE INFORMATION

Primary Insurance – Name of Company: _____
Policy #: _____ Group #: _____ Insurance Company Phone #: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
Subscriber's Employer: _____ Relationship to Patient: _____
Subscriber's Address(if different than patient): _____

Secondary Insurance – Name of Company: _____
Policy #: _____ Group #: _____ Insurance Company Phone #: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
Subscriber's Employer: _____ Relationship to Patient: _____
Subscriber's Address(if different than patient): _____

_____/_____
Patient, if 18 or older *Signature* / *Printed Name* Date Witness Date
_____/_____
Parent (or Guardian) *Signature* / *Printed Name* Date Witness Date



DOCUMENT SIGNATURE PAGE

Patient Name:

Date of Birth:

CONSENT FOR TREATMENT

I am requesting voluntary admission to the Partial Hospital Program or Intensive Outpatient. I understand that as a voluntary patient, I can choose to discontinue the program at any time for any reason. However, program staff strongly encourages patients to discuss their intention to leave the program prior to making the final decision. I have received a Patient Handbook, which includes patient rights and responsibilities, as well as the programs grievance procedure. I understand that I may go to any clinical staff member if I have questions or concerns about any of my rights or responsibilities. The risks and benefits of the Program have been fully explained to me and I am choosing to participate in the program, being fully aware of these risks and benefits.

I have received a copy of the following documents (check all documents given to the patient):

- Four Winds Saratoga Patient Bills Of Rights
- Notice of Privacy Practices
- Patient Handbook
- An Important Message from Medicare

Patient Signature:	Date:
Parent or Legal Guardian:	Date:

I hereby consent to the taking of my photograph for identification purposes only. I understand that, upon discharge, my photograph will be kept by Four Winds Saratoga and filed in my medical record.

Patient Signature:	Date:
Parent or Legal Guardian:	Date:

I have discussed the above with the patient and his/her family (when available) and he/she has indicated an understanding of the rights guaranteed to him/her while a patient at Four Winds Saratoga.

Patient refuses to discuss above (check if applicable)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient refused handouts (check if applicable)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Staff Signature:	Date/time:
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**AUTHORIZATION FOR
RELEASE OF INFORMATION**

Patient Name _____

Date of Birth _____

**FOUR WINDS SARATOGA
30 CRESCENT AVENUE
SARATOGA SPRINGS, NEW YORK 12866
PHONE: (518) 584-3600 FAX: (518) 580-1514**

I authorize Four Winds Saratoga to obtain from or release to any Person/Program within the Organization/Facility/Program(s) listed below

Person/Agency: _____

Address: _____

City, State, Zip: _____

Covering the period of healthcare: last 1 yr or last 2 yrs
or
From date _____ **to date** _____

Phone: _____ Fax: _____

- | | |
|-------------------------------------|---|
| Obtain | Release |
| <input type="checkbox"/> | <input type="checkbox"/> Diagnosis Only |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> Dates of Admission and Discharge |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> Integrated Assessments/Suicide Risk and Substance Abuse Assessments |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> Clinical Discharge Summary |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> Verbal/Written Communication for Discharge |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> Medical: H&P, Labs, EKG, Immunizations, etc. |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> Progress Notes |

- | | |
|-------------------------------------|---|
| Obtain | Release |
| <input type="checkbox"/> | <input type="checkbox"/> School Discharge Summary/Educational Materials/Verbal Academic Reports |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> Medication Information only |
| <input type="checkbox"/> | <input type="checkbox"/> Billing Issues & Payment Arrangements |
| <input type="checkbox"/> | <input type="checkbox"/> Applications |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> Psychological Testing |
| <input type="checkbox"/> | <input type="checkbox"/> Other(Specify): _____ |

Whole Record (a fee of \$0.75/page may be applied)

This information will be used for the following purpose(s):

- Evaluation and Continuing Treatment Coordinating Care
 Educational Placement/Other Educational Concerns/Billing School District for Education
 Insurance Eligibility/Benefits/Claims Resolution
 Legal Other (specify): _____

I understand that I have the right to revoke this authorization at any time, by submitting a revocation in writing to the Health Information Management. The revocation will not apply to information that has already been released in response to this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire in one year from the date of the signature below and may be used until such time for either a one time release or periodic release of information.

If the disclosure is for educational purposes, I understand that the recipient may be my child's home school district and any school within the home school district. Disclosure to any other school or educational entity requires a separate authorization.

I understand that authorizing the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have a right to receive a copy of this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient, and the information may not be protected by the federal privacy rules or by New York State law.

Signature of Patient or Legal Guardian	Date
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If Signed by Legal Guardian, Relationship to Patient	Signature of Witness (over the age of 18)
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TO CANCEL PERMISSION OR REFUSE DISCLOSURE OF RECORDS FILL OUT THE INFORMATION BELOW

- | | |
|--|---|
| <input type="checkbox"/> I hereby cancel my permission to release information to the above named person or entity. | <input type="checkbox"/> I hereby refuse to authorize the release of information to the above named person or entity. |
|--|---|

Signature of Patient or Legal Guardian	Date
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**TELEMEDICINE APPOINTMENT
INFORMED CONSENT FORM**

Patient Name

DOB

MRN

Telepsychiatry uses two-way communication through audio and video equipment to provide mental health services to you at a distance. Telepsychiatry allows you and staff at different locations to interact and provide care without the need to travel long distance.

Expected Benefits

Telepsychiatry can be a benefit to you, when on-site services are not available because of the distance, location, time of day, or availability of resources. Some benefits to Telepsychiatry are:

- Improved access to care
- Improved coordination of care
- Timely services
- Improved treatment of care

Potential Risks

There are possible risks with the use of telepsychiatry. These risks could include:

- Delays in treatment due to equipment failure
- Poor picture and delays in the video
- Potential data transmission problems that happen in very rare instances, but could lead to a breach of your information
- A lack of information that might be available in a face to face visit but not in a Telepsychiatry session may result in errors in medical judgment

You have the right to:

If you choose to participate in Telepsychiatry services, you are given additional Client Rights including being informed of:

- What trained staff will be available to you and providing you services at the distant site and who can help in an emergency.
- How the Telepsychiatry equipment works and the purpose of videoconferencing technology.
- Who is in the room at each location during the Telepsychiatry session
- Your opportunity to decide about who will be in the room with you during telepsychiatry sessions, as well as the right to ask non-medical personnel to leave the room at any time if not needed for safety concerns.

Failure of Transmission

In the event your session is dropped as a result of transmission or equipment failure someone from the office will contact you. We would need to be sure that any alternative contact methods are encrypted and secure. This may mean a follow up in-person appointment or an additional telepsychiatry session to complete the appointment.

I understand this service is not the same as a direct provider visit, because I will not be in the same room as the provider performing the service. Parts of my treatment which involve physical tests/examinations such as taking my vital signs and blood pressure will not be completed. I understand that my telepsychiatry provider will be my local provider I would normally see in the office setting. Also,



**TELEMEDICINE APPOINTMENT
INFORMED CONSENT FORM**

Patient Name _____

DOB _____

MRN _____

- I have the right to refuse or withdraw my consent to telepsychiatry sessions at any time, without affecting my right to future care or treatment.
- I understand this is temporary due to the recent COVID19 state and federal restrictions put in place.
- If my provider decides my health care can no longer be managed through telepsychiatry, services may be discontinued. Other options for my care will be discussed with me.
- Telepsychiatry sessions shall not be recorded without my consent.
- Written medical information and telepsychiatry sessions are kept confidential the same as in-person medical records.
- I agree to allow individuals other than my provider and remote provider to be present during my telepsychiatry service to operate the video equipment, if necessary. Also, if additional persons are needed for safety concerns, then my permission may not be needed.

We have read the Telepsychiatry consent form to the patient/legal guardian and we witnessed the consent of telepsychiatry through the Four Winds Partial and/or Intensive Outpatient Program. The patient/family has had an opportunity to ask questions which I've answered to the best of my knowledge.

Staff1: _____ Date/Time _____

Staff2: _____ Date/Time _____

Dear Patient/Family,

Upon receipt of this form, please read through the consent above and the statement below. Sign and return to the office at your earliest convenience. Please know you have given verbal consent for your first session. After reading this form, should you change your mind please notify the staff immediately.

**Four Winds Saratoga
Partial / Intensive Outpatient Program
30 Crescent Ave Saratoga Springs NY 12866
(518) 584 - 3600**

I have read and understand the information provided above regarding telepsychiatry. I have discussed the expected benefits, potential risks, as well as possible alternatives to telepsychiatry with my provider. All of my questions have been answered to my satisfaction. I hereby authorize Four Winds Partial / Intensive Outpatient to use telepsychiatry in the course of my diagnosis and treatment.

Signature of Patient/Legal Guardian: _____ Date: _____

Print Name of Patient/Legal Guardian: _____



FINANCIAL AGREEMENT

PATIENT NAME
DATE
MEDICAL RECORD NUMBER
PATIENT ACCOUNT NUMBER

LIABILITY FOR LOSS OF VALUABLES

I hereby release the Hospital and its staff from all responsibility for any loss or damage to personal property or money not deposited with the Hospital. I further understand that valuable articles should be sent home and that money should be kept in a personal account in the business office.

RESPONSIBILITY FOR SPECIALIZED SERVICES

It is my understanding that the psychiatric and basic medical care of the above named patient is provided by Four Winds Hospital and Medical staff. However, if specialized medical services not provided at Four Winds Hospital are indicated, I agree that the cost of such medical consultation / treatment will be my responsibility.

ASSIGNMENT OF BENEFITS

I hereby assign to Four Winds Hospital all my right, title and interest, including benefit of payment to which I am or may be entitled from _____ insurance company or insurer pursuant to policy # _____ or from any governmental agency, other insurance carrier and/or their agents, or others who are financially responsible for the hospitalization and medical care and services rendered to me or my dependent at Four Winds Hospital.

FINANCIAL AGREEMENT AND GUARANTEE

We (jointly and severally) agree to pay and guarantee payment to Four Winds Hospital of the full and entire amount of any and all bills not paid by our hospitalization insurance plan, private or governmental, or combination of plans. I understand that all such bills are due and payable upon presentation at the rate of \$325 (AIOP) dollars per day. Payment may be demanded at any time from any of the undersigned and failure to demand payment of the patient shall not be a prerequisite to the guarantors immediate responsibility for payment. This agreement shall be governed by the laws of the State of New York as a contract deemed executed in New York and to be performed in New York. Any lawsuit brought to enforce this agreement shall be brought only in a state or federal court setting in New York, Albany or Saratoga Counties, and each party hereto expressly consents to the jurisdiction and venue of each such court. We agree to pay the hospital's costs and expenses in enforcing this agreement, including the hospital's reasonable attorneys' fees. This document constitutes the complete agreement of the parties. We acknowledge that we have not relied on statements, promises, or representations, oral or written, other than as contained herein.

WE HAVE READ THIS AGREEMENT AND WE FULLY UNDERSTAND ITS NATURE AND SIGNIFICANCE AND HAVE RETAINED A COPY OF THIS AGREEMENT.

ALL PARTIES MUST SIGN AS FOLLOWS

Patient (if 18 or over)

Mother

Father

Spouse

Other legally responsible party

Date



AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name _____

Date of Birth _____

INSURANCE COMPANY/MANAGED CARE COMPANY

FOUR WINDS SARATOGA
30 CRESCENT AVENUE
SARATOGA SPRINGS, NEW YORK 12866
PHONE: (518) 584-3600
FAX: (518) 580-1514

I authorize Four Winds Saratoga to: (please check one or both)

obtain from release to:

Person/Agency:

Address:

City, State, Zip:

Phone:

Fax:

- | | |
|--|--|
| <input type="checkbox"/> Diagnosis Only | <input type="checkbox"/> Applications |
| <input type="checkbox"/> Dates of admission and/or discharge | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Admission/Psychiatric Assessments/
Substance Abuse Assessments | <input type="checkbox"/> Educational Materials/Verbal Academic Reports/School
Discharge Summary |
| <input type="checkbox"/> Clinical Discharge Summary | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> Verbal/Written Communication for
Discharge | <input checked="" type="checkbox"/> Billing Issues & Payment Arrangements |
| <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> Other (Specify): |
| <input type="checkbox"/> History & Physical, Labs, other Medical
Information | |

This information will be used for the following purpose(s):

- For purposes of billing and/or certification of care
 Other (specify): _____

I understand that I have the right to revoke this authorization at any time, by submitting a revocation in writing to the Medical Records Department. The revocation will not apply to information that has already been released in response to this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire in one year from the date of the signature below and may be used until such time for either a one time release or periodic release of information.

If the disclosure is for educational purposes, I understand that the recipient may be my child's home school district and any school within the home school district. Disclosure to any other school or educational entity requires a separate authorization.

I understand that authorizing the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have a right to receive a copy of this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient, and the information may not be protected by the federal privacy rules or by New York State law.

Signature of Patient or Legal Guardian

Date

If Signed by Legal Guardian, Relationship to Patient

Signature of Witness (over the age of 18)

I hereby cancel my permission to release information indicated on the reverse side, to the person / organization / facility / program whose name and address is:

I hereby refuse to authorize release of information indicated on the reverse side, to the person/ organization / facility / program whose name and address is:

Signature of Patient	Date Signed	Signature of Witness	Title	Date Signed
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Record of information released pursuant to this release.

Date	Specific Document Released	Staff Person Releasing



Hixny Electronic Data Access Consent Form Four Winds

In this Consent Form, you can choose whether to allow Four Winds to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Four Winds to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date.

Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.

If you check the “**I GIVE CONSENT**” box below, you are saying “Yes, Four Winds’s staff involved in my care may see and get access to all of my medical records through Hixny.”

If you check the “**I DENY CONSENT**” box below, you are saying “No, Four Winds may not be given access to my medical records through Hixny for any purpose.”

Hixny is a not-for-profit organization. It shares information about people’s health electronically and securely to improve the quality of health care services.

Please carefully read the information on both pages of this form before making your decision.

You have two choices:

- I GIVE CONSENT for Four Winds to access ALL of** my medical records through Hixny in connection with providing me any health care services, including emergency care.

- I DENY CONSENT for Four Winds to access** my medical records through Hixny for any purpose, *even in a medical emergency*. 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 Hixny.

Print Name of Patient

Date of Birth

Date

Signature of Patient or Patient’s Legal Representative

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

Details about patient information in Hixny and the consent process:

How Your Information Will Be Used

Your electronic health information will be used by Four Winds only to:

- Provide you with medical treatment and related services
- Check whether you have health insurance and what it covers
- Evaluate and improve the quality of medical care

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

What Types of Information About You Are Included

If you give consent, Four Winds may access ALL of your electronic health information available through Hixny. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to 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

***If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, such as medications and dosages, lab test results, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social support, and health insurance claims history.**

Where Health Information About You Comes From

Information about you comes from places that have provided you with medical care or health insurance (“Information Sources”). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Hixny. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

Who May Access Information About You, If You Give Consent

Only these people may access information about you: doctors and other health care providers who serve on Four Winds’s medical staff who are involved in your medical care; health care providers who are covering or on call for Four Winds’s doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

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 Four Winds at: 607-729-9166 or call Hixny at (518) 640-0021; or call the NYS Department of Health at 518-474-4987.

Re-disclosure of Information

Any electronic health information about you may be re-disclosed by Four Winds to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Hixny and persons who access this information through the Hixny must comply with these requirements.

Effective Period

This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

Withdrawing Your Consent

You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Four Winds. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 640-0021.

NOTE: Organizations that access your health information through Hixny while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

Copy of Form

You are entitled to get a copy of this Consent Form after you sign it.