South Street Health Services Family Health and Psychiatry NPS PLLC
David Julien, DNP, FNP-C
Sheryl Campbell-Julien, DNP, PMHNP-BC
12 South Street
Lockport, NY 14094
716-727-0099

Office Policy

I consent to treatment for the care of ____
(Patient's Name)

I certify that the insurance information provided is correct.

I authorize David Julien, DNP, FNP-C to apply for benefits on my behalf for covered services. I authorize direct payments to David Julien, DNP, FNP-C.

I consent to the exchange of information between David Julien, DNP, FNP-C, and my other treatment providers. I consent to the exchange of information for the purposes of processing claims and obtaining payment. I permit a copy of this authorization to be used in place of the original.

Co-payments, fees for services beyond covered benefits, and self-pay fees are required at the time of service. Payment options include Visa, MasterCard, Discover, personal checks, and cash. Alternative payment arrangements must be made in advance. Unpaid fees are subject to collection proceedings. Returned checks will result in a $25.00 bank fee being charged to patient accounts.

Appointments canceled with less than 24 business hours' notice or a no-show for a scheduled appointment, will result in a charge of $100.00 for an initial evaluation and $50.00 for a follow-up visit. Dr. David Julien reserves the right to charge a $50.00 fee for any patient who arrives late for their appointment.

Your signature below indicates your consent for treatment and your acknowledgment of financial responsibility for the services provided.

Patient Signature ____________________________________ Date ______________________

Guarantor Signature __________________________________ Date _____________________

South Street Health Services Family Health and Psychiatry NPS PLLC
David Julien, DNP, FNP-C
Sheryl Campbell-Julien, DNP, PMHNP-BC
12 South Street
Lockport, NY 14094
716-727-0099

Health Record Information

Name: (circle one) Mr, Mrs, Ms ____

Age ____ Marital Status (circle one): Single, Married, Separated, Divorced, Widowed

Date of Birth ___________ Sex (circle one): M F Social-Security #____________________

Address ____

City ________________________________ State ___________ Zip Code_______________

Employer/ School ____

Cell Phone Number ____________________ Home Phone Number ____________________

Work/Other Phone Number (Please Specify) ____________ Pref. Contact: Cell, Home, Work

Preferred Pharmacy ____

Pharmacy Address, Phone Number (or location) ____________________________________

Primary Care Provider (Doctor) ____

Primary Care Address and/or Phone ____

Primary Insurance Plan ____________________________ Group #____________________

Insurance ID# and Suffix ____

Insurance Address ____________________________ Phone # ________________________

Secondary Insurance Plan_________________________ Group # _____________________

Secondary Insurance ID# and Suffix ____

Insurance Address ____________________________ Phone # ________________________

Insurance Guarantor _______________________ Relationship to Guarantor _____________

Date Completed: ____________________

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

1. We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
2. We are required to abide by the terms of this Notice currently in effect.
3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. The examples are meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. [If there are other such disclosures that you might make, list them here.] These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer from our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements of our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

These are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization.** Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials' information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Others involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgement, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain rights regarding your health record information, as follows:

1. You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restriction involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.
2. You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
3. You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.
4. All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.
5. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.
6. If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be addressed to the Privacy Officer (in the case of complaints to us) or the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

Signature ____ Date ________________________

Print Name ____

HIPAA Privacy Authorization Form

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R Parts 160 and 164)

Authorization

I, __________________________________, authorize__________________________________ (health provider) to disclose and use the protected health information described below to

_______________________________________ (individual seeking health information).

Effective Period

This authorization for release of information covers the period of healthcare from:

☐_________________________________ to _________________________________

OR

☐All past, present, and future periods

Extent of Authorization

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, treatment of alcohol or drug abuse).

OR

☐ I authorize the release of my complete health record with the exception of the following information:

- ☐Mental health records
- ☐Communicable diseases (including HIV and AIDS)
- ☐Alcohol/drug abuse treatment
- ☐Other (please specify): ____

This medical information may be used by the person I authorized to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. This authorization will be effective until _________________ (date or event), at which time this authorization expires. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the

insurer has a legal right to consent a claim. I understand that my treatment, payment, enrolment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____

Signature of patient or personal representative

____

Printed name of patient or personal representative and his or her relationship to patient

____

Date

Authorization for Release of Protected Health Information

____ has recognized you, ______________________________________, as their medical provider. This patient receiving treatment at____, has authorized the release of protected health information.

New York State regulations require us to maintain documentation of consumers' current medical status, including a physical examination within the past 6 months.

Please respond to the items below and send copies to our clinic, along with the information requested on the authorization form and any additional relevant medical information. Please keep the Authorization and a copy of this letter for your records to permit future care coordination.

- Most recent physical examination within the last 12 months:
- Date of next scheduled follow-up examination: ____________________
- Most recent lab work within the last 12 months:

  Please comment: ____________________________

  ____

Patient Signature_______________________________________Date_____________________

Patient Bill of Rights

Name ____ Date ________________

1. To receive services without regard to age, race, color, sexual orientation, gender expression, religion, marital status, sex, and national origin;
2. To be treated with consideration, respect and dignity, including privacy in treatment;
3. To be informed of the services available at South Street Services;
4. To be informed of the provisions for the off-hour emergency services;
5. To be informed of the charges for services, eligibility for third party reimbursements and, when applicable, the availability of free or reduced cost care;
6. To receive complete and current information concerning your medical diagnosis, treatment, and prognosis in terms that you can be reasonably expected to understand;
7. To receive an itemized copy of your account statement upon request;
8. To receive information from South Street Health Services' staff necessary to give informed consent (including the nature of the procedure, the reasonably foreseeable risks, and alternatives for care or treatment, if any) prior to the start of any non-emergency procedure or treatment, or both;
9. To refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of your refusal;

10. To voice grievances and recommend changes in policies and services to the South Street Health Services staff, to South Street Health Services and the NYS Department of Health without fear of reprisal;
11. To refuse treatment to participate in experimental research;
12. To express complaints about the care and services provides, to have South Street Health Services investigate such complaints, and if unsatisfied, to complain to the NYS Department of Health. Complaints may be made to (716) 727-0099
13. To the privacy and confidentiality of all information and records pertaining to your treatment;
14. To approve or refuse the release or disclosure of the contents of your medical record to any health care provider except as required by law, or third-party payment contract;
15. To review your medical record at a meeting mutually convenient to the patient and South Street Health Services;
16. Make known your wishes regarding anatomical gifts. You document your wishes in your health care proxy or on a donor card, available from South Street Health Services.