Westchester Institute *for* Human Development

Behavioral Psychology Program
REGISTRATION PACKET

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

This packet includes:

WIHD PAPERWORK	ADDITIONAL INFORMATION REQUIRED
❑ Registration Form ❑ Intake Form ❑ Consent for Care and Treatment ❑ Cancellation and Missed Appointment Agreement ❑ Financial Agreements ❑ Notice of Privacy Practices ❑ Patient Bill of Rights ❑ Consent to Exchange Protected Health Information (if applicable) ❑ Authorization to Disclose and/or Exchange Protected Health Information (written records, if applicable)	❑ Copy of ALL the patient's insurance cards (front and back) ❑ Guardianship paperwork (if applicable) ❑ Previous treatment records (if applicable) ❑ Agreement indicating permission for the Agency to provide health services† ❑ Agreement authorizing Agency to receive review, and release pertinent medical information†

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

****PLEASE COMPLETE AND MAIL/FAX/EMAIL THIS REGISTRATION PACKET TO:**

Behavioral Psychology Program
Westchester Institute for Human Development
Cedarwood Hall, Room 300A
Valhalla, New York 10595
Ph. (914) 493-7070
Fax. (914) 409-9036
behaviorpsych@wihd.org

Directions to our facility are located in the packet.

If you have questions, feel free to contact us.

Westchester Institute for Human Development

Behavioral Psychology Program
Directions

By Car (GPS Address: 20 Hospital Oval West, Valhalla, NY)

From the Bronx and South:
Bronx River Parkway North to Sprain Brook Parkway North. Exit at Hawthorne/Westchester 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 onto Sunshine Cottage Road. Make second right onto Hospital Oval West.*

From the North:
Taconic Parkway South to Medical Center/Route 100 exit (just past the New York 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 onto Sunshine Cottage Road. Make second right onto Hospital Oval West.*

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 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 onto Sunshine Cottage Road. Make second right onto Hospital Oval West.*

From the East:
Cross Westchester Expressway (287) Westbound to Exit 3 (Sprain Parkway). Bear left after exiting to Northbound Sprain Parkway. 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 onto Sunshine Cottage Road. Make second right onto Hospital Oval West.*

Park in **lot 16, taking a ticket at the parking booth. The entrance to Cedarwood Hall is directly opposite the parking lot. Once you enter Cedarwood Hall, make a right down the hall and the elevators will be on the left. The Behavioral Psychology Program is on the 3rd floor.*

By Train
Westchester Institute for Human Development is served by Metro North's Harlem Line via two stations:

White Plains: For train fare and schedule information, call 1-800-METRO-INFO. Once you arrive at the White Plains stations, Westchester Institute for Human Development is about a 10-minute bus ride. There are three bus lines (Westchester Bee Line) you can take to our campus. Please call 914-813-7777 for bus routes and fares.

Hawthorne: This station has a taxi stand that can provide taxi service directly to Westchester Institute for Human Development.

By Bus
Westchester Institute for Human Development is serviced by several local bus companies, including the Westchester Bee Line (914) 813-7777.

Revised 9/2016, 8/2017, 12/2019

Westchester Institute for Human Development

Behavioral Psychology Program

Program Information

The Behavioral Psychology Program at Westchester Institute for Human Development (WIHD) is a highly specialized program providing psychological services for individuals with a developmental disability, including autism spectrum disorder, of all ages (early childhood through adulthood) as well as for children without a developmental disability who display challenging behaviors. Two of our licensed psychologists, Dr. Stephanie Bader and Dr. Kiley Bliss are also Board Certified Behavior Analysts (BCBAs) and New York State Licensed Behavior Analysts.

Our licensed psychologists develop an individualized, evidence-based treatment plan which involves a range of techniques including Applied Behavior Analysis, Pivotal Response Training, Cognitive-Behavior Therapy, parent training, behavior therapy and a variety of other evidenced-based treatment modalities. We work in collaboration with other medical specialties (e.g., psychiatry, neurology) and allied services (e.g., speech, occupational therapy, assistive technology) to ensure the best treatment outcomes.

Services are provided to address a wide array of behaviors including, but not limited to, challenging behavior (e.g., self-injurious behavior, aggression, tantrums), co-occurring psychiatric disorders (e.g., anxiety, depression, OCD, phobias), social skills deficits (e.g., understanding nonverbal cues, holding a conversation), and difficulties with daily living skills (e.g., dressing, toileting, feeding, sleeping).

Parents, teachers, group home and day program staff, and other caregivers have an integral role in the assessment, treatment planning, and treatment process. We also provide hands-on training for those who work directly with the individual seeking treatment to maximize the benefits of our services.

We look forward to working with you and your family!

Stephanie Bader, Ph.D., BCBA, Program Director
Kiley Bliss, Ph.D., BCBA
Nicole Turygin, Ph.D.

Revised 9/2016, 8/2017, 12/2019

Westchester Institute *for* Human Development

REGISTRATION FORM

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

Westchester Institute *for* Human Development

Behavioral Psychology Program

Intake Form

NAME _____

D.O.B. _____

WIHD # _____

For the most complete evaluation, please provide these additional items (when possible):

1. The patient's most recent educational and psychological evaluations,
2. All programs (previous and current) designed to treat target behaviors
3. The patient's typical daily schedule

Today's Date: _____ Completed by:_____

PATIENT INFORMATION			
Patient's Name:			Gender:
Date of Birth: / /	Age:	Ethnicity:	
Patient currently lives at: (please check one) ❑ Home ❑ Group Home ❑ Other:_____			
Social Security Number:	Phone: ( )		
Address:	City:	State:	ZIP Code:
Preferred means of contact: ❑ Phone ❑ Email ❑ Other:_____			
Preferred contact email/number:	Any special contact instructions:		
Mother's Name:	Email Address:		
Phone: ( )	Cell Phone: ( )		
Mother's Address:	City:	State:	ZIP Code:
Father's Name:	Email Address:		
Phone: ( )	Cell Phone: ( )		
Father's Address (if not same as above):	City:	State:	ZIP Code:
If the patient is over 18, who has legal custody? (please check one) ❑ Patient ❑ Parent ❑ Other ❑ Not Assigned Yet		Do you have legal documentation? (Please provide) ❑ Yes ❑ No	
Contact Person (if different than above):	Phone: ( )		Emergency Contact? ❑ Yes ❑ No
Address:	City:	State:	ZIP Code:
Referred by (please check one): ❑ Dr._____ ❑ Family ❑ Friend	❑School ❑ Yellow Pages	❑ Hospital ❑ Other_____	❑ Self
Has the patient been seen before at WIHD? ❑ Yes ❑ No	Does the patient receive any other mental health/psychological services? ❑ Yes (please specify:_____) ❑ No		
Patients Who Reside in a Group Home:			
Group Home Name and Agency:		Phone: ( )	
Address:	City:	State:	ZIP Code:
Contact Person's Name and Position:	Type of Placement:		
Accommodations or considerations for the patient due to behaviors:			

School-Aged Patients:			
School:		Phone: ( )	
Address:	City:	State:	ZIP Code:
Teacher's Name:	Type of School Placement and Grade:	Does the patient have a 1:1 aide? ❑Yes ❑ No	
Number of teachers and aides in the classroom:		Number of students:	

Patients Who Attend a Day Program:			
Day Program Name and Agency:		Phone: ( )	
Address:	City:	State:	ZIP Code:
Contact Person's Name and Position:	Type of Placement:		
Accommodations or considerations for the patient due to behaviors:			

All Patients: Other community agencies or contacts who provide services to the patient or family:		
Agency	Contact/Phone	Type of Service

PSYCHOSOCIAL BACKGROUND

Parents	Age	Education	Occupation	Marital Status
Father				
Mother				
Guardian				

Individuals who live with the patient:

Name, Age, Gender, Relationship	Age	Gender	Relationship

MEDICAL HISTORY

Primary Care Physician:	Phone: ( )	Agency/ Address:
Psychiatrist (if applicable):	Phone: ( )	Agency/ Address:

If the patient is over 18, are they interested in receiving psychiatry services at WIHD? ❑ Yes ❑ No ❑N/A

Mental health diagnoses (and who diagnosed):

Medical conditions and diagnoses:

Height:	Weight:

Current medical equipment used (e.g. feeding pump, wheelchair, walker):

Current medical treatments (e.g., dialysis, tube feeding, tracheotomy):

Current medications and reason for prescription (attach additional pages if necessary):

Medication	Dosage	Reason for Prescription

PROBLEM BEHAVIORS

Record each problem behavior the patient displays and describe it specifically. Include any damage resulting from the problem behavior either to the patient or others. Please rank in order of concern to yourself or other caretakers.

Problem Behavior	***Description (Topography)*** What does it look like? What happens when it occurs?	***Frequency*** How often does it occur per day/week/month?	***Duration*** How long does it last when it occurs?	***Intensity*** How damaging or destructive is it?

Estimate the severity of the problem behavior of greatest concern (please check one):

❑ Mild ❑ Moderate ❑ Severe ❑ Life-Threatening

How long has the patient been engaging in the problem behavior(s)?

❑ Within the past 6 months ❑ More than 6 months but less than 1 year ❑ More than 1 year but less than 3 years ❑ More than 3 years but less than 5 years ❑ More than 5 years but less than 10 years ❑ More than 10 years

Estimate the general trend of the problem behavior(s) during the past year: ❑ Increasing ❑ Decreasing ❑ Stable

When is/are the problem behavior(s) likely to occur? (please check all that apply)

❑ When the patient is left alone or unattended ❑ Mealtimes ❑ Certain time of day _____

❑ When demands are placed on the patient ❑ Dressing ❑ Other: _____

❑ When there are a lot of people around ❑ Bathing _____

In what setting(s) do these behaviors occur? ❑ Home ❑ School ❑ Community ❑ Other_____

Are there any occasions when the problem behavior(s) rarely or never occurs? ❑ Yes ❑ No

Describe:

Has the patient ever been sent to the hospital to treat an injury resulting from the behavior? ❑ Yes ❑ No

Describe:

Has the patient ever sent someone else to the hospital to treat an injury resulting from the behavior? ❑ Yes ❑ No

Describe:

Does the patient target particular adults/peers (if aggressive)? ❑Yes ❑ No

How do others (parents, teachers, staff) typically respond when the patient engages in the problem behavior(s)?
(If a formal program is currently being implemented, refer to it here and attach a copy)

BEHAVIOR CHECKLIST

How does the patient communicate? (please check all that apply) ❑ Verbally ❑ Sign Language ❑ Pictures ❑ Communication Device ❑ Pointing ❑ Other:_____

Please list some things that the patient likes: (for example; bubbles, music, TV shows, tickles, water, etc.)

Please indicate which of the following are areas of concern:

1) Compliance and Following Directions (for example: follows directions to come here, sit still, keep hands to self, clean up, get the red cup, turn off the light)	When is this a concern:	❑ Never ❑ Sometimes ❑ Often ❑ Always	
2) Independent Living Skills (for example: toileting, dressing, feeding self, drinking from a cup, brushing teeth, eating too fast or slow)	When is this a concern:	❑ Never ❑ Sometimes ❑ Often ❑ Always	
3) Rituals and Routines (for example: difficulties changing from one activity to another, difficulty when unexpected or expected changes occur)	When is this a concern:	❑ Never ❑ Sometimes ❑ Often ❑ Always	
4) Academic Skills (for example: matching, math, reading, telling time, identifying colors, numbers, or letters)	When is this a concern:	❑ Never ❑ Sometimes ❑ Often ❑ Always	
5) Social Skills or Social Awareness (for example: imitating others, responding to greetings, taking turns, asking and answering questions)	When is this a concern:	❑ Never ❑ Sometimes ❑ Often ❑ Always	
6) Communication (for example: making eye contact, using verbal language, pointing, sign language, or pictures to express wants and needs)	When is this a concern:	❑ Never ❑ Sometimes ❑ Often ❑ Always	
7) Play and Leisure (for example: playing with toys, able to keep self busy for a period of time, sharing, taking turns)	When is this a concern:	❑ Never ❑ Sometimes ❑ Often ❑ Always	
8) Restrictive Behavior (for example: will not eat a variety of foods, will not play with a variety of toys, will only wear certain clothing)	When is this a concern:	❑ Never ❑ Sometimes ❑ Often ❑ Always	
9) Repetitive Behavior (for example: engages in repetitive motor movements, "stims;" engages in repetitive verbal statements, scripting or perseverations)	When is this a concern:	❑ Never ❑ Sometimes ❑ Often ❑ Always	
10) Other (please describe)	When is this a concern:	❑ Never ❑ Sometimes ❑ Often ❑ Always	

Please describe your concerns in these areas as well as any other concerns you have regarding the patient's learning or behavior:

Please describe specific skills you would like the patient to be taught:

Please describe your immediate and long term goals for the patient while participating in treatment:

Please provide any other information that may be relevant to treatment:

Westchester Institute *for* Human Development

NAME _____

D.O.B. _____

WIHD # _____

Behavioral Psychology Program

Consent for Care and Treatment

1. I hereby authorize _____ to participate in outpatient care and treatment at the Westchester Institute for Human Development, and the professionals, assisted by the employees of the Institute, to provide such care.
2. I acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from the treatment(s) or examination(s) at the Westchester Institute for Human Development.
3. I confirm that I have read and fully understand the above, have been given the opportunity to ask questions, and that all my questions have been answered fully and to my satisfaction.

In addition, as part of my participation in services at the Behavioral Psychology Program, I understand and agree to the following:

1. Clinicians can generally be reached between the hours of 9am and 5pm, business days. Neither clinicians nor the Behavioral Psychology Program staff are available to assist in crisis situations occurring outside of the clinic appointment. I understand that if I have a behavioral emergency outside of my scheduled appointment time, I should seek 911 services.
2. Sessions are clinic-based and clinicians are unable to provide therapy sessions via telephone or outside the clinic. Additional information regarding session policies is provided within the Cancellation and Missed Appointment Agreement.
3. In the course of treating aggressive, self-injurious, or other potentially dangerous behaviors, clinicians may intervene to promote the safety of all present. This may include physical contact, or limiting the patient's access to public areas (e.g. by ensuring that the patient engaging in a tantrum remains in a private area where others are not at risk). In order to ensure the safety of the patient and others present, patients who have been engaging in potentially dangerous behaviors in session will be expected to be calm prior to departing the clinic.
4. As this is a training clinic, sessions may be conducted by student clinicians who are supervised by licensed psychologists. Periodically other trainees may also request to observe sessions, which I have the right to decline. Sessions may also be recorded for supervision (of the student clinician) or data collection purposes. Only Behavioral Psychology Program clinicians and trainees will have access to video records, which will be erased immediately following their use (and are not included in the patient's medical records). Recordings will also not be used for any publicity purposes without the explicit consent and signature of the patient/guardian.

_____ _____

Signature of Patient/Guardian* Date

_____ _____

Printed Name Relationship to Patient (if applicable)

***Patient must sign unless he/she is an unemancipated minor or has a legal guardian appointed to him/her.**

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

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

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical 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, lawenforcement, and other government requests
- Respond to lawsuits and legal actions

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

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. See Page 4 for instructions. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. See page 4 for instructions. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. • An electronic copy is also located at www.wihd.org
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the contact information located on page 4. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.
- You have the right to opt-out from any and all fundraising communications from WIHD. If you wish to opt-out you can send an email to DevelopmentTeam@wihd.org or call 914-493-1344.

Our Uses and Disclosures

How do we typically use or share your health information?

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

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Contact Information

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

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

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

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- We will follow information sharing rules as allowed by applicable statutes related to information sharing in the context of potential child abuse and neglect.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

January 2020

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

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

Acknowledgement

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

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

Westchester Institute for Human Development

NAME _____

D.O.B. _____

Cancellation and Missed Appointment Agreement

WIHD # _____

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

Financial Agreements

NAME _____

D.O.B. _____

WIHD # _____

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

   SIGNATURE: _____ DATE: _____
   Patient/Guardian

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.

   SIGNATURE: _____ DATE: _____
   Patient/Guardian

   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.

   SIGNATURE: _____ DATE: _____
   Patient/Guardian

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

   SIGNATURE: _____ DATE: _____
   Patient/Guardian

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

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

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

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

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

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

(5) Be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care;

(6) Receive an itemized copy of his/her account statement, upon request;

(7) Obtain from his/her health care practitioner, or the health care practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand;

(8) Receive from his/her physician information necessary to give informed consent prior to the start of any nonemergency procedure or treatment or both. An informed consent shall include, as a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision;

(9) Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action;

(10) Refuse to participate in experimental research;

(11) Voice grievances and recommend changes in policies and services to the center's staff, the operator and the New York State Department of Health without fear of reprisal;

(12) Express complaints about the care and services provided and to have the center investigate such complaints. The center is responsible for providing the patient or his/her designee with a written response within 30 days if requested by the patient indicating the findings of the investigation. The center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the center response, the patient may complain to the New York State Department of Health's Office of Primary Health Systems Management;

(13) Privacy and confidentiality of all information and records pertaining to the patient's treatment;

(14) Approve or refuse the release or disclosure of the contents of his/her medical record to any health-care practitioner and/or health-care facility except as required by law or third-party payment contract;

(15) Access to his/her medical record per Section 18 of the Public Health Law, and Subpart 50-3. For additional information link to: http://www.health.ny.gov/publications/1449/section_1.htm#access

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

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

NEW YORK STATE | Department of Health

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

Westchester Institute *for* Human Development

NAME _____

D.O.B. _____

WIHD # _____

Patient Bill of Rights Acknowledgement

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

_____

Patient Name (Please Print) Date

_____

Authorized Representative (Please print if applicable) Relationship to Patient

X_____

Patient's or Authorized Representative's Signature

Westchester Institute for Human Development	NAME ______________________
	D.O.B. ______________________
Behavioral Psychology Program	
Consent to Exchange Protected Health Information	WIHD # ______________________

This form is to facilitate communication between providers and caregivers and is not intended to be used for the release of medical records. Requests for medical records should be made using the Authorization to Disclose and/or Exchange Protected Health Information form or by contacting *WIHD Medical Records* at medicalrecords@wihd.org or (914) 493-8651.

I authorize ______________________ (provider's name) and the Behavioral Psychology Program at WIHD to exchange protected health information about ________________________'s (patient's name) treatment with the following individuals for the purposes of collaborating and coordinating treatment efforts.

Individual/Agency	Relationship to the Patient	Contact Information	
			❑ Attend Session ❑ Phone ❑ E-mail
			❑ Attend Session ❑ Phone ❑ E-mail
			❑ Attend Session ❑ Phone ❑ E-mail
			❑ Attend Session ❑ Phone ❑ E-mail
			❑ Attend Session ❑ Phone ❑ E-mail
			❑ Attend Session ❑ Phone ❑ E-mail
			❑ Attend Session ❑ Phone ❑ E-mail
			❑ Attend Session ❑ Phone ❑ E-mail
			❑ Attend Session ❑ Phone ❑ E-mail

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time in writing (except to the extent that the information has already been released).

________________________________ ________________________________

Signature of Patient/Guardian Date

________________________________ ________________________________

Printed Name Relationship to Patient (if applicable)

Westchester Institute for Human Development

AUTHORIZATION TO DISCLOSE and/or EXCHANGE PROTECTED HEALTH INFORMATION

NAME _____

ADDRESS _____

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

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

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

☐ Entire Record ☐ Other (Please describe)_____

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

The information above may be disclosed to the following:

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

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

Email (if applicable):_____

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

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

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

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

TO BE READ AND SIGNED BY PATIENT:

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. This will only be included if I place my initials in the appropriate box above.
2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.
3. I understand that I have a right to revoke this authorization at any time by providing written notice to the practice, except to the extent that the program or person who is to make the disclosure has already acted in reliance on it..
4. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
5. I understand that authorizing the use or disclosure of the information identified above is voluntary. I understand that I have the right to refuse to sign this form and that I need not sign this form to ensure healthcare treatment, payment for my healthcare, or continuation of my healthcare benefits.
6. I understand that WIHD has the right to charge a reasonable fee to recover the costs of copying, mailing, and supplies used to fulfill my request.
7. I understand that I have the right to inspect or copy information to be used or disclosed as described in this form and in accordance with Institute policies and procedures. I have the right to receive a copy of this form after I have signed it.
8. I acknowledge that I have had the opportunity to review this authorization and understand the intent and use. My questions about the form have been answered to my satisfaction.

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