Program : ___ Child PHP___ Adolescent PHP___ Adolescent AIOP___ Adult PHP____ Adult IOP
Date: _____ MR# _____ For Office Use Only

BEHAVIORAL HEALTH SERVICES PATIENT REGISTRATION

Patient Name: _____Date of Birth: _____ Age: _____Sex: M F
Street Address : _____
Street City State Zip Code County
Patient's Primary Contact Phone #: _____Ok to call/leave message __Yes __No
Patient's Primary Email Address: _____

PARENT INFORMATION/EMERGENCY CONTACT
Name: _____ Relationship:_____
Address (if different):_____
Home Phone: _____Work Phone: _____ Cell Phone: _____

Name: _____ Relationship:_____
Address (if different):_____
Home Phone: _____Work Phone: _____ Cell Phone: _____

Primary Care Physician: _____ Phone: _____ Fax: _____
Address: _____
Psychiatric Prescriber: _____ Phone: _____ Fax: _____
Address: _____
Outpatient Therapist: _____ Phone: _____ Fax: _____
Address: _____
Pharmacy: _____ Phone: _____ Fax: _____
Address: _____

INSURANCE INFORMATION
Primary Insurance :_____ Policy # _____ Group# _____
Insurance Company Phone #: _____
Subscriber's Name: _____ DOB: _____
Subscriber's Employer: _____ Relationship to Patient: _____
Subscriber's Address: (if different from patient): _____
Secondary Insurance :_____ Policy # _____ Group# _____
Insurance Company Phone #: _____
Subscriber's Name: _____ DOB: _____
Subscriber's Employer: _____ Relationship to Patient: _____
Subscriber's Address: (if different from patient): _____

_____ _____ _____
Patient Signature (if 18 or older) Printed Name Date

_____ _____ _____
Parent/Guardian Signature Printed Name Date

Rev.1/4/23

Four Winds HOSPITALS **DOCUMENT SIGNATURE PAGE** **CONSENT FOR TREATMENT**	Patient Name: Date of Birth:

I am requesting voluntary admission to the Partial Hospital Program and/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 Guide, 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.

Additionally, the prescribing of over the counter medications may occur which will allow for the administration of medications that treat symptoms such as minor aches and pain, stomach upset, cold symptoms or other minor physical complaints. All other medications which are recommended for my / my child's treatment will be reviewed with me prior to the prescribing of such medication.

☐ Yes, I consent to over-the-counter medications ☐ No, I do not consent to over the counter medications

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

☒ Bills Of Rights
☒ Notice of Privacy Practices
☒ Patient Guide
☐ 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)	☐ Yes	☐ No
Patient refused handouts (check if applicable)	☐ Yes	☐ No

Staff Signature:	**Date/time:**

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
- Timely services
- Improved coordination of care
- 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.
- 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

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: _____

Patient Name: _____
DOB: _____
MR# _____

Four Winds Saratoga PHP/IOP Group Rules

- Confidentiality of all group members is important for everyone. Do not discuss what is said in group or disclose names of other participants to anyone else outside of the group.
    - Please sign in with first name or preferred name and last initial only

- Everyone should be treated with respect. Targeting a peer or staff, or repeatedly bringing up offensive content will not be tolerated. Use of "I" statements is encouraged to avoid overgeneralizing.

- Respect other people when they are speaking and raise your hand if you would like to participate in group discussion.

- Participants are expected to attend all meetings and groups on time any day you are here unless an exception has been made through the treatment planning process. All planned absences should be discussed and approved by your therapist at least 24 hours in advance. We also expect you to notify the program using the call-out line (518-584-8514) before 9:00 AM any day that you are unable to attend.
    - Absence from PHP without notifying PHP therapists will result in a phone call and potentially a call to officials for a wellness check at the home address.
    - If you miss three (3) consecutively scheduled program days or show a pattern of lateness or absence in accordance with your treatment plan, and you do not have an acceptable reason for the absence, you may be discharged from the program.

- Smoking, vaping (e-cig, juul, puff bar), or other drug use while engaged in group programming (either virtual or in-person) will not be tolerated and is grounds for discharge from PHP/IOP.

- Do not engage in relationships of any kind (texting, phone calls, social media) with group members outside of the group. This distracts from your treatment.

Virtual Program Expectations

- Patients are required to engage in programming from a quiet, private, and confidential space, and are required to inform group facilitators of any change of location or deviation from participation from their address of record.

- All participants are expected to remain fully visible with their camera turned on throughout the duration of all groups/programming. Please leave your microphone on mute while not sharing to avoid unnecessary distractions. Individuals with their camera turned off may be removed from group.

- If you need to leave group for any reason, please alert the group facilitator that you will be stepping away and when you expect to return.

- Apart from the functioning electronic device used to participate in group, no cell phones or electronic devices should be used during group times. Gaming, texting, or use of social media is not allowed during group times.

Patient Name: _____
DOB: _____
MR# _____

In-Person Program Expectations

- Healthy Boundaries are important. As a result, please refrain from the following actions:
  - Engaging in physical contact with others
  - Giving rides to others
  - Borrowing, lending, or trading of belongings.
  - Sharing medications

- Dress Code: Clothing should fit appropriately and not be tight or revealing in nature and should not portray inappropriate images or signage (i.e. alcohol, drug logos, political messages, death and dying references, or sexually inappropriate messages.) If there are concerns regarding participant attire, the participant will be asked to change or leave the group.

- What to Bring Daily: Program folders, group materials, documentation needed to share with your provider, and any medications you will need to take during program hours. The following items will not be permitted in the facility/group rooms.
  - Cell phones (Electronics will be stored securely during group programming)
  - Large purses/backpacks
  - Items of value
  - Outside Food or Drinks (Snacks and Drinks will be provided)
  - Dangerous Items (glass, aluminum, metal, plastic bags, weapons)

All items brought into the facility will be subject to search

I acknowledge understanding of the group rules and expectations. I agree to discuss any barriers to following group expectations with my assigned therapist prior to the start of group.

I understand that failure to comply with these expectations could result in removal from group programming for the day and/or discussion regarding termination from the program.

_____ _____
Patient Signature Date

_____ _____
Staff Signature Date

Rev. 5/9/23

Four Winds HOSPITALS

FAMILY MEDICAL QUESTIONNAIRE
ONGOING MEDICAL PROBLEMS

Patient's Name:

Patient's Date of Birth:

Name of Your/Your Child's Primary Medical Provider:	**Phone Number:**
Date of Last Visit to Your/Your Child's Primary Medical Provider:	**Reason for this Visit:**

HAVE YOU/YOUR CHILD EVER HAD:			**Comments**
Chicken Pox Illness	☐ Yes	☐ No	
Chicken Pox Vaccine	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	
Allergies	☐ Yes	☐ No	
High Blood Pressure	☐ Yes	☐ No	
Heart Condition or Murmur	☐ Yes	☐ No	
Head Injury	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Seizures/Convulsions	☐ Yes	☐ No	
Tuberculosis or Positive Skin Test	☐ Yes	☐ No	
Undescended Testicles	☐ Yes	☐ No	
Last Menstrual Period/Age at 1st Period	☐ Yes	☐ No	
Eye/Ear/or Speech Problem	☐ Yes	☐ No	

List Any Surgeries or Hospitalizations You/Your Child Has Had:

CHECK AND EXPLAIN ANY OF THE FOLLOWING CURRENT OR ONGOING PROBLEMS:			
Weight Loss	☐ Yes	☐ No	
Weight Gain	☐ Yes	☐ No	
Sore Throat	☐ Yes	☐ No	
Frequent Headaches	☐ Yes	☐ No	
Skin Rashes/Eczema	☐ Yes	☐ No	
Difficulty Breathing	☐ Yes	☐ No	
Cough	☐ Yes	☐ No	
Sinus Problems	☐ Yes	☐ No	
Diarrhea	☐ Yes	☐ No	
Constipation	☐ Yes	☐ No	
Vomiting	☐ Yes	☐ No	
Problems with Urination	☐ Yes	☐ No	
Bedwetting	☐ Yes	☐ No	
Joint Problems or Pain	☐ Yes	☐ No	

OTHER:

Please continue on to the back of the form.

DEVELOPMENTAL HISTORY (Only for patients under age 18)

	YES	NO
1. Were there problems in pregnancy, labor, or delivery?	☐	☐
If yes, what happened?		
2. Did the mother use ☐ cigarettes, ☐ drugs or ☐ alcohol during pregnancy?	☐	☐
3. Did your child experiences any problems during the first year?	☐	☐
If yes, please describe.		
4. Do you believe your child's development was normal?	☐	☐
If no, why?		

5. At what age did your child first walk? At what age did your child first use words correctly?

MEDICATIONS/ALLERGIES

6. What medication(s) are You/Your Child currently taking?

7. Are You/Your Child allergic to anything? Yes ☐ No ☐

If yes, what?

MEDICAL HISTORY

8. Do you believe You/Your Child is healthy? Yes ☐ No ☐

If no, why?

9. Are You/Your Child's immunizations (shots) up-to-date? Yes ☐ No ☐
Do You/Your Child attend school in NYS? Yes ☐ No ☐ N/A ☐

10. Have you/your child ever been hospitalized overnight or longer? Yes ☐ No ☐

If yes, when and for what reason?

11. Your/Your Child's dentist is:	12. Date of last dental check-up:

TB RISK FACTOR SCREENING

1) Any history of foreign of birth or travel greater than a three month stay in a country with higher risk of TB than the USA?	☐ Yes	☐ No	If so, which country or countries:
2) Any history of close contact with a person diagnosed with active TB?	☐ Yes	☐ No	Relationship: When:
3) Any current symptoms of TB (i.e., cough greater than two weeks, unexplained weight loss, night sweats or bloody sputum).	☐ Yes	☐ No	If yes, give details:

Signature:	Relationship to Patient:		Date:
Physician/NPP/FNP Signature:	Title:	Date:	Time:

FOR CLINIC USE ONLY

Date:_____

Time:_____ AM/PM

Reviewed by:_____

Financial Agreement and Guarantee

Please Print Date_____

Patient Name_____ Medical Record No._____

Parent's Name _____Parent's Name _____

Other Responsible Party (state relationship)_____

ASSIGNMENT OF BENEFITS

I hereby assign to Four Winds Hospitals all my right, title and interest, including benefit of payment to which I am or may be entitled from _____ insurance company under policy 1 #_____ for Insured Name_____ and from _____ insurance company under policy 2 #_____ for Insured Name_____ 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 Hospitals.

FINANCIAL AGREEMENT AND GUARANTEE

(I)We (jointly and severally) agree to pay and guarantee payment to Four Winds Hospitals the full and entire amount of any and all bills not paid in full by our health insurance plan(s), private or governmental, or combination of plans due to any reason including, without limitation, exhaustion of benefits, a pre-existing condition excluded from coverage, and responsibility for co-payments. I understand that all such bills are due and payable upon presentation at the Hospital's negotiated rate with my health insurance plan(s), or if I do not have health insurance benefits, at the rate I have negotiated with the Hospital. 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 guarantor's 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. We expressly consent to the jurisdiction of New York State and federal courts and to venue in Westchester County in any action brought relating to this agreement. We agree to pay any costs and expenses incurred by Four Winds Hospitals to enforce this agreement, including 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. Four Winds Hospitals has accepted my check or cash for such amount and provided me with a receipt. Any amounts charged or paid in excess of what is owed will be refunded within 7 to 10 business days.

Four Winds Financial Agreement and Guarantee (continued)

Patient Name_____ Med. Rec. No._____

RESPONSIBILITY FOR SPECIALIZED SERVICES

(I)We understand that psychiatric and basic medical care is provided by Four Winds Hospitals. However, if specialized medical services not provided at Four Winds are indicated, we agree that the cost of such medical consultation/treatment will be (my)our responsibility. Whenever possible, Four Winds will notify the family or financially responsible person that such specialized care is indicated in advance of the visit to the medical consultant.

DENIAL OF PAYMENT BY THIRD PARTY PAYOR

Four Winds Hospitals has accepted my check or cash for 7 days of hospitalization and provided me with a receipt. **My check will be held until there is a denial of payment.** Any amounts charged or paid in excess of what is owed will be refunded within 7 to 10 business days. A small number of health plans provide that beneficiaries sign an addendum to this financial obligation form at the time of a denial based on lack of medical necessity. (I)we understand that (I)we will be notified by phone or in person of the denial by Four Winds Hospitals staff at the time that the Hospital is notified. If provided by my health plan, I agree to promptly execute an addendum.

If I(we) fail to execute such addendum and (I)we elect to continue to receive services at Four Winds Hospitals, (I)we agree to promptly pay for such uncovered services.

ALL PARTIES MUST SIGN

WE HAVE READ AND UNDERSTOOD THIS AGREEMENT AND ATTEST THAT ALL INFORMATION IS TRUE, COMPLETE, AND ACCURATE.

_____
Patient (if 18 or over)

_____
Parent

_____
Parent

_____
Spouse

_____
Other Responsible Party (state relationship to patient)

INSTRUCTIONS FOR COMPLETING THE ATTACHED RELEASES

Attached are RELEASE OF INFORMATION FORMS. Please complete one page for any of the following that pertain to you / your child:

1. Your Medical Dr. (PCP)
2. Your Therapist
3. Your Medication Prescriber
4. Your Insurance Company – check both boxes marked "other" and specify "BILLING". The name of insurance company goes on top under agency

PLEASE MAKE SURE RELEASES ARE FILLED OUT WITH PROVIDERS FULL NAME – COMPLETE ADDRESS- FAX AND PHONE NUMBER.

THANK YOU

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME:

DATE OF BIRTH:

FOUR WINDS HOSPITALS

Please forward the request to the location you wish to obtain from/release to:

Westchester
800 Cross River Road
Katonah, NY 10536
Phone: (914) 763-8151
Fax: (914) 763-0950

Saratoga
30 Crescent Avenue
Saratoga Springs, NY 12866
Phone: (518) 584-3600
Inpatient Fax: (518) 580-1514
Partial Fax (518) 581-2535

I authorize Four Winds Hospitals to obtain from and/or release to:

Person/Agency/School:

Address:

City, State, Zip:

Phone: Fax:

Covers the period of healthcare: ☐Most recent hospital admission ☐Last 1 year ☐All hospital admissions

Or ☐From Date: _____ To Date: _____

Unless a period is specified, the information below will be provided from the most recent hospital location admission only

The Specific Information to be Disclosed is:

- ☐ Diagnosis Only
- ☐ Dates of admission and/or discharge
- ☐ Integrated Assessments/Psychiatric Assessment
- ☐ Discharge Summary
- ☐ Verbal/Written Communication for Discharge
- ☐ Psychological Testing
- ☐ Psychosocial Assessment
- ☐ Medical: H&P, Labs, EKG, other Medical Information
- ☐ Applications
- ☐ Progress Notes
- ☐ Educational Summary / Materials / Verbal Academic Reports
- ☐ HIV-related information, if applicable
- ☐ Entire Medical Record
- ☐ Other (specify):_____

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
- ☐ Legal / Custody / Court / Probation
- ☐ Other (specify):_____

Four Winds Hospitals is a two hospital system comprised of both Four Winds Westchester and Saratoga inpatient hospitals, partial hospitalization programs, and intensive outpatient programs. I understand authorizing this disclosure applies to both hospitals at every level of care. I understand that a separate authorization form is not needed to exchange protected health information between both hospitals at every level of care for the purposes of treatment, payment, and operations.

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, any school within the home school district, and a school that my child attends which is funded by 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 law.

If I am authorizing the release of HIV-related information, the recipient is prohibited from re-disclosing 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. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

If Signed by Legal Guardian, Relationship to Patient	Date

Signature of Patient or Legal Guardian	Signature of Staff Person Releasing Information	
	Title	Date Released

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME:

DATE OF BIRTH:

FOUR WINDS HOSPITALS

Please forward the request to the location you wish to obtain from/release to:

Westchester
800 Cross River Road
Katonah, NY 10536
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Fax: (914) 763-0950

Saratoga
30 Crescent Avenue
Saratoga Springs, NY 12866
Phone: (518) 584-3600
Inpatient Fax: (518) 580-1514
Partial Fax (518) 581-2535

I authorize Four Winds Hospitals to obtain from and/or release to:

Person/Agency/School:

Address:

City, State, Zip:

Phone: Fax:

Covers the period of healthcare: ☐Most recent hospital admission ☐Last 1 year ☐All hospital admissions

Or ☐From Date: _____ To Date: _____

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- ☐ Psychological Testing
- ☐ Psychosocial Assessment
- ☐ Medical: H&P, Labs, EKG, other Medical Information
- ☐ Applications
- ☐ Progress Notes
- ☐ Educational Summary / Materials / Verbal Academic Reports
- ☐ HIV-related information, if applicable
- ☐ Entire Medical Record
- ☐ Other (specify):_____

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
- ☐ Legal / Custody / Court / Probation
- ☐ Other (specify):_____

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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, any school within the home school district, and a school that my child attends which is funded by 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 law.

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If Signed by Legal Guardian, Relationship to Patient	Date

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PATIENT NAME:

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Person/Agency/School:

Address:

City, State, Zip:

Phone: Fax:

Covers the period of healthcare: ☐Most recent hospital admission ☐Last 1 year ☐All hospital admissions

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- ☐ Medical: H&P, Labs, EKG, other Medical Information
- ☐ Applications
- ☐ Progress Notes
- ☐ Educational Summary / Materials / Verbal Academic Reports
- ☐ HIV-related information, if applicable
- ☐ Entire Medical Record
- ☐ Other (specify):_____

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
- ☐ Legal / Custody / Court / Probation
- ☐ Other (specify):_____

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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, any school within the home school district, and a school that my child attends which is funded by 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 law.

If I am authorizing the release of HIV-related information, the recipient is prohibited from re-disclosing 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. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

If Signed by Legal Guardian, Relationship to Patient	Date

Signature of Patient or Legal Guardian	Signature of Staff Person Releasing Information	
	Title	Date Released

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME:

DATE OF BIRTH:

FOUR WINDS HOSPITALS

Please forward the request to the location you wish to obtain from/release to:

Westchester
800 Cross River Road
Katonah, NY 10536
Phone: (914) 763-8151
Fax: (914) 763-0950

Saratoga
30 Crescent Avenue
Saratoga Springs, NY 12866
Phone: (518) 584-3600
Inpatient Fax: (518) 580-1514
Partial Fax (518) 581-2535

I authorize Four Winds Hospitals to obtain from and/or release to:

Person/Agency/School:

Address:

City, State, Zip:

Phone: Fax:

Covers the period of healthcare: ☐Most recent hospital admission ☐Last 1 year ☐All hospital admissions

Or ☐From Date: _____ To Date: _____

Unless a period is specified, the information below will be provided from the most recent hospital location admission only

The Specific Information to be Disclosed is:

- ☐ Diagnosis Only
- ☐ Dates of admission and/or discharge
- ☐ Integrated Assessments/Psychiatric Assessment
- ☐ Discharge Summary
- ☐ Verbal/Written Communication for Discharge
- ☐ Psychological Testing
- ☐ Psychosocial Assessment
- ☐ Medical: H&P, Labs, EKG, other Medical Information
- ☐ Applications
- ☐ Progress Notes
- ☐ Educational Summary / Materials / Verbal Academic Reports
- ☐ HIV-related information, if applicable
- ☐ Entire Medical Record
- ☐ Other (specify):_____

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
- ☐ Legal / Custody / Court / Probation
- ☐ Other (specify):_____

Four Winds Hospitals is a two hospital system comprised of both Four Winds Westchester and Saratoga inpatient hospitals, partial hospitalization programs, and intensive outpatient programs. I understand authorizing this disclosure applies to both hospitals at every level of care. I understand that a separate authorization form is not needed to exchange protected health information between both hospitals at every level of care for the purposes of treatment, payment, and operations.

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, any school within the home school district, and a school that my child attends which is funded by the home school district. Disclosure to any other school or educational entity requires a separate authorization.

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If Signed by Legal Guardian, Relationship to Patient	Date

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	Title	Date Released

Four Winds HOSPITALS

JONATHAN'S LAW CONTACT SHEET

For Inpatients and Outpatients: Clinical staff completes at the time of screening or admission. If the patient is the qualified person, complete Section A only. If the patient is not the qualified person, complete Section B.

SECTION A (Complete if the patient is the qualified person.)

- ☐ Patient received Jonathan's Law Information Sheet.
- ☐ Reviewed Jonathan's Law with the patient and (check one):
  - ☐ Patient verbalized an understanding of the above and had an opportunity to ask questions.
  - ☐ Patient not able to participate in above.

Patient's Signature:	Date:

Staff Signature:	Title:	Date:

SECTION B (Complete if the patient is not the qualified person.)

- ☐ Patient/qualified person received Jonathan's Law Information Sheet.
- ☐ Reviewed Jonathan's Law with the patient and qualified person and (check one):
  - ☐ Patient/qualified person verbalized an understanding of the above and had a opportunity to ask questions.
  - ☐ Patient/qualified person refused to participate in above.

The qualified person was asked if he/she wanted to be notified of incidents (complete one):

- ☐ Yes. Complete the following and remind the qualified person to provide updates to telephone numbers should the information change in the future.

Name of Qualified Person:

Address:	
Phone Number:	Phone Number:

- ☐ No. The qualified person indicates that he/she does not wish to be notified of incidents.

Qualified Person Signature:	Date:

Staff Signature:	Title:	Date:

Four Winds HOSPITALS

Signature Sheet For
ADVANCE DIRECTIVE

Do you have a previously executed Advance Directive and an appointed surrogate decision maker?

MEDICAL ADVANCE DIRECTIVE	**PSYCHIATRIC ADVANCE DIRECTIVE**
☐ YES ☐ NO	☐ YES ☐ NO
If YES: Please provide or arrange for my family to provide Four Winds with a copy. At a minimum please provide the name and contact phone number for your Health Care Proxy. *(required for regulatory purposes)* NAME:_____ PHONE# _____	

I would like to create my Advance Directive.

☐ YES *If yes, please read the booklet carefully. Also, please be advised that if you change/update an Advance Directive while you are a patient in Four Winds Hospital two witnesses must sign it. One of those witnesses must be a psychiatrist and the other witness must be unaffiliated with the hospital.*

☐ NO **The reason that I do not wish to create an Advance Directive:**

☐ Contrary to my cultural / spiritual believes

☐ Other: _____

I have received the booklet, ***"Planning for Your Mental and Physical Health Care and Treatment"*** which contains the copy of the Advance Directive instructions for completion of an advance directive as prepared by the Resource Center, Inc, a division of the NYS Office of Mental Health. I understand that, if after reading the material I choose to execute an advance directive, I will notify a member of the nursing staff.

Signature of Patient: _____ Date: _____