Richmond Health Network

NOTICE OF PRIVACY PRACTICES

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.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:
Office Manager and they will report your concern to the Corporate Compliance Department or Call our Compliance Hotline 1-844-783-0010

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that related to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked to sign a consent form. Once you have consented to use and to disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this Section 1.
Your protected health information may be used and disclosed by your physician, our office staff and other outside our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types and uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services, This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to discuss your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used as needed to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for a medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to: quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you.
You may contact our Privacy Contact to request that these materials not be sent to you.

We may also use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made with Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

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 judgment. 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, 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 health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Disease: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to contact post marketing surveillance, as required.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, a discovery request or other lawful process.

Law Enforcement: We may also disclose your protected health information, so long as applicable legal requirements are met, for law enforcement purposes. The law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners. Funeral Directors. and Organ Donation: We may disclose protected health information to a coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities, (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conduction national security and intelligence activities, including for the provision of protected services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Users and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements if Section 164.500 et.seq.

Substance Use Disorder Treatment Information: If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment, or health care operations, we may use and disclose your Part 2 Program record for treatment, payment, and health care operations purposes as described in this notice. If we receive or maintain your Part 2 Program record through a specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us.

In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect a copy of your protected health information. This means you may inspect and obtain a copy of protected information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have the right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical records.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for specific restriction and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restrictions you wish to request with your physician. You may request a restriction by informing a Manager within PRACTICE NAME. We will appropriately document your medical record.

You have the right to request to receive confidential communications from us by alternative means or at an alternate location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternate address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your physician amend your protected health information.

This means you may request an amendment of protected health information about you in a designated record set as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have any questions about amending your medical record.

You may the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excluded disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after (Date) 2008. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact the Office Manager for further information about the complaint process.

This notice was published and becomes effective on 5/11/2015.

Richmond Health Network

Notification Policy

Name: _____ **Date:**_____

The HIPAA Privacy Rule permits health care providers to communication with patients regarding their healthcare, whether through mail, phone and email or voicemail. We may also leave a message with a family member or other person who answers the phone when the patient is not present. To reasonably safeguard patient's privacy, we take care to limit the amount of information disclosed.

Please provide the telephone number(s) and/or email where we may contact you:

Home: _____ **Cell:** _____

Work: _____ **Email:** _____

Please list names of authorized people to release medical information and records:

_____

Name Phone Relationship Yes/No

_____

Name Phone Relationship Yes/No

_____

Name Phone Relationship Yes/No

Who may we discuss your financial situation with?

_____

Name Phone Relationship Yes/No

_____

Name Phone Relationship Yes/No

Richmond Health Network

Notification Policy

As part of our commitment to improving patient care, we invite you to provide feedback about your experience after your appointment. If you agree, we will send you a text message following your visit to ask for your feedback.

Please review the following information:

Purpose: To request your feedback about your recent appointment.

Message Frequency: You will receive one message per visit.

Message Content: The message will ask you to rate your experience

Cost: Message and data rates may apply, depending on your mobile plan.

Opt-Out: You can stop receiving these messages at any time by replying STOP to any message.

Help: For assistance, please confirm the contact number with staff at that location.

Privacy: Your mobile number will only be used for appointment-related feedback and will not be shared for marketing or promotional purposes.

After reviewing this information, please let our staff know if you agree to receive feedback from text messages. Your verbal agreement will serve as your consent.

The signature below attests I have been offered a copy of the Amboy Medical Practice PC HIPAA policy

Signature (Patient/Guardian) _____ **Date**_____

Emergency Contact Name_____ **Telephone#**_____

Emergency Contact Name_____ **Telephone#**_____

Richmond Health Network

Affiliate of Richmond University Medical Center

AGREEMENT OF FINANCIAL RESPONSIBILITY
ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

PATIENT NAME (Please Print)

1. RESPONSIBILITY FOR PAYMENT:

I understand that I, personally, am financially responsible for charges not covered by the assignment.

2. RESPONSIBILITY FOR PAYMENT:

I hereby assign, transfer, and set over directly to sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said department.

3. MEDICAL BENEFITS:

I certify that the information given by me in applying for payment under Title VIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration and Health Care Financing Administration, or its intermediaries or carriers, any information needed for this, or related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to.

4. RELEASE OF INFORMATION:

I hereby authorize and direct any member physician having treated me or my dependent, to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

5. COLLECTION FEES:

I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. I understand that these additional fees will be my personal responsibility.

SIGNATURE OF PATIENT **DATE**

SIGNATURE OF PARENT OR GUARDIAN **DATE**

Healthix

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Amboy Medical PC.to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically to improve the quality of healthcare and meets the privacy and security standards of HIPAA, the requirements of the federal confidentiality laws, 42 CFR Part2, and New York State Law. To learn more visit Healthix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for Amboy Medical PC. to access ALL of my electronichealth information through Healthix to provide health care.

☐ **2. I DENY CONSENT** for Amboy Medical PC. to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through Healthix and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases
   - Medication and Dosages
   - Diagnostic Information
   - Allergies
   - Substance use history summaries
   - Clinical notes
   - Discharge summary
   - Employment Information
   - Living Situation
   - Social Supports
   - Claims Encounter Data
   - Lab Test

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Amboy Medical PC. at (718) 818-4442; or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice, death or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.

Citywide Immunization Registry
We help you call the shots!
www.nyc.gov/health/cir

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Mary T. Bassett, M.D., M.P.H., Commissioner
nyc.gov/health
NYC Health
Phone: (347) 396-2400
Fax: (347) 396-2559

Health Care Providers may document verbal voluntary consent or adapt this sample form for use.

Consent for Participation in Citywide Immunization Registry (CIR)

for individuals 19 years of age and older

The New York Citywide Immunization Registry (CIR) is a confidential, computerized system that allows authorized users access to a person's immunization records. Strict federal and state laws protect the privacy of personal information in the system. Here are some benefits of participating in the CIR:

- Your health care provider can use the CIR to ensure that you receive all needed immunizations.
- The CIR provides you with a permanent and easily accessible record of your immunizations.

Participation in the CIR is voluntary for people 19 and older, so immunizations you receive after 18 years of age will not be included unless you give consent. If you want to participate, please carefully read the statement below and sign in the space provided. For additional information about this consent, please call (347) 396-2400.

Declaration of Consent

I give my consent for _____ (name of doctor or organization) to release my immunization(s) and identifying information to the New York Citywide Immunization Registry (CIR). I understand the purpose of the CIR is to assist in my medical care and to record the immunizations that I have had or will receive in the future. My immunization information may potentially be used by the Department of Health for quality improvement purposes, epidemiologic research, and disease control purposes. Information used for quality improvement or any research purposes will have my personal identifying information removed.

The immunization information in the CIR may be released to the following: myself, my health insurance organization, the state and local health departments, the school that I am registered to attend, and authorized medical providers that deliver my medical care.

I understand that there will be no effect on my treatment, payment, or enrollment for benefits if I choose not to participate in the CIR. This consent may be withdrawn at any time by using the form provided. Information about immunizations received by the CIR with my consent will remain in the CIR if I later choose to withdraw my consent. However, future immunizations will not be recorded in the CIR.

_____	_____
Print Name	Date of Birth
_____	_____
Signature	Date

The Citywide Immunization Registry
42-09 28th Street, 5th Fl, CN 21, L.I.C, NY 11101-4132
Phone (347) 396-2400 Fax (347) 396-2559
Email: cir@health.nyc.gov

Richmond Health Network

HOW DID YOU HEAR ABOUT US?

Would you kindly take a minute to tell us how you heard about our practice?

Thank you!

_____ **Physician Referral - Name of Physician:**_____

_____ **Friend or Family Member**

_____ **Insurance Company**

_____ **Staten Island Ferry Boat Ad**

_____ **Staten Island Ferry Terminal Ad**

_____ **Staten Island Ferry Digital Board**

_____ **Staten Island Mall Ad**

_____ **Staten Island Advance**

_____ **SI Live (website)**

_____ **Staten Island PARENT Magazine Ad**

_____ **Church Bulletin**

_____ **Facebook**

_____ **Google Search**

_____ **Russian Business Magazine Ad**

_____ **Family Savings Circular**

_____ **Bus Shelter**

_____ **Wagner College**

_____ **Other** _____

Patient Name: _____ **Visit Date:** _____

Richmond Health Network

No-Show Policy Consent Form

In order to provide the best care for all our patients, we have implemented a no-show policy/ If you miss an appointment without giving us prior notice, the following fees will apply:

- **$50** for missed appointments
- **$75** for missed procedure appointments

We ask that you notify us at least **24 hours in advance** if you need to cancel or reschedule your appointment.

Please ensure that your contact information is up to date, so we can reach you easily.

By signing below, I acknowledge that I have read and understood the No-Show Policy. I agree that if I do not cancel my appointment at least 24 hours in advance, or if I do not show up for my appointment, I will be charged a fee of **$50** for missed appointment or **$75** for missed procedure appointments.

Patient Signature: _____

Date: _____