Stony Brook University Hospital

General Consents, Agreements, Acknowledgments and Guide to Observation Services

Stony Brook Medicine

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I. We Speak Your Language

Stony Brook University Hospital complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Stony Brook University Hospital does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Stony Brook University Hospital:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Roseanna Ryan, Director of Patient Advocacy & Language Assistance Services at 1-631-444-2880.

If you believe that Stony Brook University Hospital has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Roseanna Ryan
Director Patient Advocacy & Language Assistance Services
101 Nicolls Road
Hospital, Level 5, Room 540
Stony Brook, NY, 11794-7522
Phone **1-631-444-2880** or Fax **1-631-444-6637**
Email **roseanna.ryan@stonybrookmedicine.edu**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance,

Roseanna Ryan, Director of Patient Advocacy & Language Assistance Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, **800-537-7697 (TDD)**

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Stony Brook University/SUNY is an affirmative action, equal opportunity educator and employer.

ATTENTION: If you speak American Sign Language, language assistance services, free of charge, are available to you. Call 1-631-444-2880.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-631-444-2880.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-631-444-2880.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-631-444-2880.

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-631-444-2880 ।

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-631-444-2880.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-631-444-2880.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-631-444-2880.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-631-444-2880.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-631-444-2880.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-631-444-2880.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-631-444-2880.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-631-444-2880.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-631-444-2880.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-631-444-2880 ۔

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-631-444-2880

II. What You Need to Know

This booklet, *Stony Brook University Hospital General Consents, Agreements, Acknowledgments and Guide to Observation Services,* serves to assist you and your representative to understand what you need to know about your general consents, and includes the language contained in the electronic or paper consent that you sign. This booklet is given to you at the time you sign the consent, agreements, and acknowledgment forms for your general care and treatment at your Stony Brook Medicine hospital or provider location.

These general consents and agreements do not include specific procedural or surgical consents, signed separately given to you by doctors or other licensed practitioners. At Stony Brook Medicine, Stony Brook University Hospital locations a general consent and agreement form is signed for each Inpatient, Observation, Emergency Department, Ambulatory Surgery (and corresponding) encounter.

For hospital ambulatory services a general consent and agreement form is signed for each person which is valid for one full year (365 days) for these kind of visits.

If you have any questions, please know that you may ask your Stony Brook care provider, or you may refer to the helpful phone numbers at the back of this booklet.

General Consents and Agreements for Inpatient, ED, Ambulatory Surgery and Pre-Surgical Testing

This general consent and agreement form is specifically for your emergency department, observation visit, inpatient stay, ambulatory surgery stay, and/or your pre-surgical testing related to this encounter, thus if you come in through the emergency room and give consent and later are admitted as an inpatient for example, this consent covers you for this encounter. Another example would be signing this consent at the time of pre-surgical testing which covers the pre-surgical testing visit as well as the consent for that surgical procedure, so long as the testing and the procedure are within 30 days of each other. This general consent has 8 sections which includes:

1) General Consent for Treatment
2) Telehealth Services
3) Disposal of Tissues and Specimens
4) Responsibility for Patient Care
5) Right to Designate a Caregiver (to choose someone you want to take care of you when you go home)
6) Photographs, videos/voice recordings
7) Acknowledgment that you have received the information guides in accordance to NYS DOH
8) Personal Valuables

If you have any further questions about your consents, you may ask at the time of your registration or anytime thereafter or see the section titled “Helpful Phone numbers” for further inquiries.

General Consent and Agreements for Hospital Ambulatory Services

This general consent and agreement form is specifically for your ambulatory services which include hospital outpatient visits. This consent shall be valid for all hospital services you receive for one year (through 365 days). This consent has 6 sections which includes:

1) General Consent for Treatment
2) Telehealth Services
3) Disposal of Tissues and Specimens
4) Responsibility for Patient Care
5) Photographs, videos/voice recordings
6) Acknowledgment that you have received the information guides in accordance to NYS DOH

If you have any further questions about your consents, you may ask at the time of your registration or anytime thereafter or see the section titled "Helpful Phone Numbers" for further inquiries.

Agreements for Physician Practices *[FOR PATIENTS RECEIVING OUTPATIENT PROVIDER VISITS]*

Similar to the General Consent, this agreement is specifically for your outpatient ***provider*** visit.

Additional Sections – General Consents and Agreements

Privacy Acknowledgment *[FOR ALL PATIENTS]*

Signing the Acknowledgment of Privacy Practices acknowledges that we have explained that your information is held in the strictest confidence and we follow all regulations regarding health care privacy in adherence to HIPAA regulations.

Release of Information, Authorization to Release Health Information to My Caregiver, Release of Information to Primary Care Practitioner & Uniform Assignment *[FOR ALL PATIENTS]*

The Assignment of Benefits provides us with permission to bill your insurance company. Your signature on the Release of Information and on the Uniform Assignment allows our facility to bill your insurance company for payment with your consent. And similarly, to permit information to be given to a caregiver if you choose one.

Financial Agreement/Guarantee of Payment *[FOR ALL PATIENTS]*

The Financial Agreement acknowledges that you are responsible for all or part of your bill. This includes hospital and separate physician billing. Please see Section V for out of network care. Some physicians may or may not be within your health plan. Included are phone numbers and web addresses for further information.

Patient Consent to the Release of Records for NYS External Appeal *[FOR HOSPITAL SERVICES ONLY]*

The patient/patient's designee and the patient's provider have the right to an external appeal of certain adverse determination made by health plans. In the event an external appeal is filed, consent to the release of your medical records is necessary.

Medicare Assignment of Benefits *[FOR MEDICARE PATIENTS ONLY]*

By signing the Medicare Assignment of Benefits, you are authorizing the hospital to submit a claim for payment to Medicare on your behalf.

Other Consents and Notices

An Important Message from Medicare About Your Rights *[FOR INPATIENT MEDICARE PATIENTS ONLY]*

Because you are a Medicare patient, this is an acknowledgment that you have received an Important Message from Medicare about your rights as an inpatient.

Medicare Lifetime Reserve Days Election Form *[FOR INPATIENT MEDICARE PATIENTS ONLY]*

Please be sure to read and understand the lifetime reserve days. If you need to use these lifetime reserve days or have any questions about them we can have a financial counselor visit you. If you have questions or would like help with this, please let us know or call (631) 444-7332.

New York Motor Vehicle No-Fault Insurance Law Assignment of Benefits Form (if applicable) *[FOR PATIENTS INVOLVED IN MOTOR VEHICLE AND PEDESTRIAN ACCIDENTS, *EXCLUDING MOTORCYCLE ACCIDENTS]*

**If the patient carries MedPay insurance, this form would be applicable for motorcycle accidents.*

This is an important form if you were involved in a motor vehicle accident related to no fault allowing Stony Brook Hospital to bill and receive reimbursement on your behalf.

PSYCKES Information and Consent/Withdrawal *[FOR MEDICAID PATIENTS ONLY]*

This consent allows your treatment team to access your health information in a Medicaid database. This Medicaid database containing your medical and behavioral health information will help our treatment team provide you with the best possible care.

Medicare Outpatient Observation Notice (MOON) *[FOR MEDICARE PATIENTS ONLY]* Observation Notice *[FOR NON-MEDICARE PATIENTS]*

Understanding your rights and status as an observation patient are covered in this booklet, including related consents.

NY Care Information Gateway *[FOR ALL PATIENTS]*

There is information in this booklet about the consent forms from NY Gateway which is a health information exchange (HIE) giving you the opportunity to give or deny consent.

Paying For Your Care at Stony Brook University Hospital – Participating and Out of Network (OON) Services *[FOR ALL PATIENTS]*

Please see this section in the booklet to understand how you will be charged for the services you will receive including charges by non-participating providers and out of network coverage.

Has Anything Changed *[FOR ALL PATIENTS]*

For your safety and to ensure appropriate billing, up to date information is important. Please see section VI. "Has Anything Changed?" to ensure that we have your current Pharmacy, Primary Care Physician, Contact and Insurance Coverage information.

III. General Consents, Agreements and Acknowledgments

Stony Brook Medicine
Stony Brook, NY 11794

General Consent and Agreements for Inpatient, Observation, ED, Ambulatory Surgery and Pre-Surgical Testing

By signing this document:

General Consent and Agreements for Inpatient, Observation, ED, Ambulatory Surgery and Pre-Surgical Testing

1. **General Consent for Treatment:** I consent for Stony Brook University Hospital (Stony Brook University Hospital including all locations) to perform routine diagnostic and treatment procedures including x-rays, blood tests and IVs (intravenous fluids) and medications. I understand that this General Consent and Agreement is for this encounter, Inpatient Admission, Surgical Procedure, Ambulatory Surgery and the corresponding Pre-Operative Testing visit, or Emergency Department visit and/or Observation stay. I further understand that other Inpatient Encounters, Surgical Procedures/Ambulatory Surgery Procedures and the corresponding Pre-Operative Testing visits, Emergency Department visits, and/or Observation stays, will need another General Consent and Agreement form to be signed.

2. **Telehealth Services:** I understand that I may elect to get Telehealth Services.

   Telehealth includes both telemedicine and remote patient monitoring. Telemedicine is the use of two-way, real time interactive audio video communication between patient and physician or other licensed clinical providers which include assessment, diagnosis and treatment.

   Images and conversations from the Telehealth video conferences may be recorded and may become part of the electronic medical record.

   My doctor will document Telehealth notes in my medical chart in the same manner as in a face to face session.

   I may withhold or withdraw my consent to Telehealth services at any time, and it will not affect my future care.

3. **Disposal of Tissues and Specimens:** I understand that all tissues and specimens removed from me during my care and treatment become the property of Stony Brook University Hospital. I also authorize Stony Brook University Hospital to dispose of such tissues and specimens as appropriate when required.

4. **Responsibility for Patient Care:** I understand that my attending physician is responsible for my care and that he/she may assign other physicians, practitioners, and hospital staff members as deemed appropriate, to provide care to me. I also understand that since Stony Brook University Hospital is a teaching facility, medical, nursing, social work and other students may observe or assist in my care, under the direction of my physician and other staff members.

5. **Right to Designate a Caregiver:** You will be asked during your nursing assessment if you would like to name a "Caregiver" who can help you with tasks at home after you leave the hospital. This could be a family member, friend, neighbor or anyone else who is significant in your life. Your Caregiver does not have to be your health care agent or next of kin. Your Caregiver will be included in any necessary teaching regarding your discharge plan and any other instructions and demonstrations by hospital staff related to things that you may need after you leave the hospital. This could include medications, dressing changes and follow-up appointments. If you agree, we will share your medical information with your Caregiver so they can better help you.

6. **Photographs / Video / Voice Recordings:** I understand that photographs, video and / or voice recordings may be taken of me and used for medical purposes such as documenting or planning my care as well as for teaching or for publication in a scientific journal. Prior to any publication or disclosure of the photographs, video and / or voice recordings, other than as part of a Telehealth video conference, we will obtain your written authorization, unless the images / recordings do not identify you or have been changed so that they no longer identify you. I understand that the photographs, videos and / or voice recordings taken to document my care are part of my medical record and those taken for other purposes are not part of my medical record.

7. **Information Guides:** I acknowledge that, in accordance with the New York State Department of Health guidelines, I have received:

   As an inpatient:
   - Department of Health booklet titled: *Your Rights As a Hospital Patient In New York State*
   - Booklet titled: *What You Need To Know as a Patient*
   - Patient Information Guide: *A Guide to Patient and Visitor Services*

   As an outpatient:
   - Booklet titled: *What You Need To Know as a Patient*

8. **Personal Valuables:** I acknowledge that Stony Brook University Hospital is not responsible for any personal property that I bring to the hospital. I understand that I should not bring any valuables (jewelry, furs, expensive clothing, or other items) with me to the hospital and that I should send valuables home with a family member or friend. However, if I am unable to do this, I understand that I can have my small valuables collected by staff and brought to the cashier's office and locked in a safe.

Privacy Acknowledgement

Privacy Acknowledgement: I acknowledge that I have been provided a copy of the Stony Brook Organized Health Care Arrangement-Joint Notice of Privacy Practices and have been advised of how health information about me may be used and disclosed by the facilities listed at the beginning of the privacy notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request additional information explaining special privacy protection that applies in other areas such as HIV-related information, mental health and genetic counseling. I have received the Joint Notice of Privacy Practices as of this date, or at a previous visit, not earlier than April 14, 2003.

Release of Information: I consent to the release of all or part of my health record, including my social security number to insurance carriers, government agencies, and other third party payors as needed in order for Stony Brook University Hospital to obtain reimbursement for my care. I also understand that my social security number may be provided to the New York State Department of Health in accordance with incidence reporting and other New York State hospital regulatory requirements and to manufacturers of medical devices and the Federal Food and Drug Administration for medical device tracking purposes. I consent to the use and disclosure of my protected health information as necessary to treat my condition, obtain payment for treatment and conduct health care operations.

I understand the above information is protected by Federal Regulation 42CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I need not consent to the Release of Information in order to obtain treatment services, I choose to do so willingly and voluntarily for the purposes provided above. This consent shall expire twelve (12) months or upon the date, event, or condition listed below.

I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance upon it.

Authorization to Release Health Information to My Caregiver

I consent to the release of health information regarding my care and treatment to the Caregiver identified during my Nursing Assessment to assist me in my home when I leave the hospital. To the extent necessary for the Caregiver to assist me, this may include information relating to alcohol and drug abuse treatment, mental health treatment and HIV-related information.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 12 months from the date signed.

Release of Information to Primary Care Practitioner & Uniform Assignment

Release of Information to Primary Care Practitioner: I authorize Stony Brook University Hospital and its Emergency Department staff to disclose the health care related information for this Emergency Department encounter to my Primary Care Practitioner (PCP) for the purpose of continuity of my health care. I understand that this will include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection.

Uniform Assignment: I transfer, assign and set over to Stony Brook University Hospital / University Faculty Practice Corporations, sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my hospitalization and medical care to cover the costs and treatment rendered to myself or my dependent.

Financial Agreement / Guarantee of Payment: I, the undersigned patient or responsible party, agree to be fully responsible for payment to Stony Brook University Hospital / University Faculty Practice Corporations for the care and treatment of the patient whose name appears on this form.

I understand that this includes cost-sharing payments to the provider (including any co-payments and deductibles) for care and treatment as required by the patient's health insurance contract and benefits.

I understand that the patient is responsible for ensuring that authorizations and approvals are obtained as required by their insurance company. If prior approval is not obtained when required or authorization has been denied, I am fully responsible for all charges that the insurance company does not pay, as may be specified under the provisions of my insurance contract and the extent permitted by law.

I understand that I am responsible to provide accurate information to the provider regarding: contact, demographic, health insurance and other pertinent information required for hospital / professional billing and that I must promptly notify the provider of any changes in this information. I agree to provide any other information reasonably requested by the provider in order to bill for the care and treatment provided.

Hospital Billing / Financial Services:	Stony Brook University Hospital: 631-444-4151
	Stony Brook Southampton Hospital: 631-723-2160
	Stony Brook Eastern Long Island Hospital: 631-477-5555
Additional Contact Numbers:	Stony Brook CPMP (Physician & Hospitalist) Services: 631-444-4800
	Stony Brook Southampton Emergency Room Physician Billing: 1-855-691-9890
	Stony Brook Southampton Hospitalist Billing: 631-726-3172

You may contact your Physician or Hospitalist Practice with questions regarding your physician / hospitalist bill.

Patient Consent to the Release of Records for NYS External Appeal

The patient, the patient's designee and the patient's provider have a right to an external appeal of certain adverse determination made by health plans. In the event an external appeal is filed, consent to the release of medical records signed and dated by the patient is necessary. An external appeal agent, assigned by the New York State Department of Financial Services, will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I authorize my health plan and providers to release relevant medical or treatment records related to the external appeal including any HIV-related information, mental health treatment information or alcohol/substance abuse treatment information to the external appeals agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else.

This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence or to bring an action against my health plan.

_____

Patient's Health Plan ID#

X _____ _____ _____

Signature of Patient (or representative) Time Date

MEDICARE ASSIGNMENT OF BENEFITS FOR MEDICARE PATIENTS

Medicare Assignment of Benefits: 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 about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for this or any related Medicare Claim. I request that payment of authorized benefits be made on my behalf directly to the physician or organization providing medical care. I assign, transfer and set over all benefits payable for physician services to the physician or organization to submit a claim to Medicare for payment.

I have read this entire document and I understand it. I have been given the chance to ask questions and understand that I may ask additional questions at any time.

I also understand I may refuse to sign this form and that my health care treatment will not be affected or interrupted and payment will not be affected. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I may request a copy of this form after signing.

X _____ _____ _____ _____

Signature of Patient (or representative) | Relationship (if other than patient) | Time | Date

_____ _____

Print Name of Witness | Title or Relationship to Patient

X _____ _____ _____

Signature of Witness | Time | Date

Stony Brook Medicine
Stony Brook, NY 11794

General Consent and Agreements for Hospital Ambulatory Services

By signing this document:

1. **General Consent for Treatment:** I consent for Stony Brook University Hospital (Stony Brook University Hospital including all locations) to perform routine diagnostic and treatment procedures including x-rays, blood tests, IVs (intravenous fluids) and medications. I understand that for Outpatient Visits, Ambulatory Visits, Testing Services and Physician Visits this general consent and agreement will be effective for one year from the date of my signature unless withdrawn. I further understand any Inpatient Admissions, Ambulatory Surgery Procedures, Emergency Department Visits and Observation Stays will require a new additional general consent and agreement to be completed and signed.

2. **Telehealth Services:** I understand that I may elect to get Telehealth Services.

   Telehealth includes both telemedicine and remote patient monitoring. Telemedicine is the use of two-way, real time interactive audio video communication between patient and physician or other licensed clinical providers which include assessment, diagnosis and treatment.

   Images and conversations from the Telehealth video conferences may be recorded and may become part of the electronic medical record.

   My doctor will document Telehealth notes in my medical chart in the same manner as in a face to face session.

   I may withhold or withdraw my consent to Telehealth services at any time, and it will not affect my future care.

3. **Disposal of Tissues and Specimens:** I understand that all tissues and specimens removed from me during my care and treatment become the property of Stony Brook University Hospital. I also authorize Stony Brook University Hospital to dispose of such tissues and specimens as appropriate when required.

4. **Responsibility for Patient Care:** I understand that my attending physician is responsible for my care and that he/she may assign other physicians, practitioners and hospital staff members as deemed appropriate to provide care to me. I also understand that since Stony Brook University Hospital is a teaching facility, medical, nursing, social work and other students may observe or assist in my care under the direction of my physician and other staff members.

5. **Photographs/Video/Voice Recordings:** I understand that photographs, video and/or voice recordings may be taken of me and used for medical purpose such as documenting or planning my care as well as for teaching or for publication in a scientific journal. Prior to any publication or disclosure of the photographs, video and/or voice recordings, other than as part of a Telehealth video conference, we will obtain your written authorization, unless the images/recordings do not identify you or have been changed so that they no longer identify you. I understand that the photographs, videos and/or voice recordings taken to document my care are part of my medical record and those taken for other purposes are not part of my medical records.

6. **Information Guides:** I acknowledge that, in accordance with the New York State Department of Health guidelines, I have received the booklet titled *What You Need To Know as a Patient.*

Privacy Acknowledgment

Privacy Acknowledgment: I acknowledge that I have been provided a copy of the Stony Brook Organized Health Care Arrangement-Joint Notice of Privacy Practices and have been advised of how health information about me may be used and disclosed by the facilities listed at the beginning of the privacy notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request additional information explaining special privacy protection that applies in other areas such as HIV related information, mental health and genetic counseling. I have received the Joint Notice of Privacy Practices as of this date, or at a previous visit, not earlier than April 14, 2003.

Release of Information: I consent to the release of all or part of my health record, including my social security number to insurance carriers, government agencies, and other third-party payors as needed in order for Stony Brook University Hospital to obtain reimbursement for my care. I also understand that my social security number may be provided to the New York State Department of Health in accordance with incidence reporting and other New York State hospital regulatory requirements and to manufacturers of medical devices and the Federal Food and Drug Administration for medical device tracking purposes. I consent to the use and disclosure of my protected health information as necessary to treat my condition, obtain payment for treatment and conduct health care operations.

I understand the above information is protected by Federal Regulation 42CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I need not consent to the Release of Information in order to obtain treatment services, I choose to do so willingly and voluntarily for the purposes provided above. This consent shall expire twelve (12) months or upon the date, event, or condition listed below.

I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance upon it.

Release of Information to Primary Care Practitioner & Uniform Assignment

Release of Information to Primary Care Practitioner: I authorize Stony Brook University Hospital and its Emergency Department staff to disclose the health care related information for this Emergency Department encounter to my Primary Care Practitioner (PCP) for the purpose of continuity of my health care. I understand that this will include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection.

Uniform Assignment: I transfer, assign and set over to Stony Brook University Hospital / University Faculty Practice Corporations, sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my hospitalization and medical care to cover the costs and treatment rendered to myself or my dependent.

Financial Agreement / Guarantee of Payment: I, the undersigned patient or responsible party, agree to be fully responsible for payment to Stony Brook University Hospital / University Faculty Practice Corporations for the care and treatment of the patient whose name appears on this form.

I understand that this includes cost-sharing payments to the provider (including any co-payments and deductibles) for care and treatment as required by the patient's health insurance contract and benefits.

I understand that the patient is responsible for ensuring that authorizations and approvals are obtained as required by their insurance company. If prior approval is not obtained when required or authorization has been denied, I am fully responsible for all charges that the insurance company does not pay, as may be specified under the provisions of my insurance contract and the extent permitted by law.

I understand that I am responsible to provide accurate information to the provider regarding: contact, demographic, health insurance and other pertinent information required for hospital / professional billing and that I must promptly notify the provider of any changes in this information. I agree to provide any other information reasonably requested by the provider in order to bill for the care and treatment provided.

Hospital Billing / Financial Services:	Stony Brook University Hospital: 631-444-4151 Stony Brook Southampton Hospital: 631-723-2160 Stony Brook Eastern Long Island Hospital: 631-477-5555
Additional Contact Numbers:	Stony Brook CPMP (Physician & Hospitalist) Services: 631-444-4800 Stony Brook Southampton Emergency Room Physician Billing: 1-855-691-9890 Stony Brook Southampton Hospitalist Billing: 631-726-3172

You may contact your Physician or Hospitalist Practice with questions regarding your physician / hospitalist bill.

MEDICARE ASSIGNMENT OF BENEFITS FOR MEDICARE PATIENTS

Medicare Assignment of Benefits: 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 about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for this or any related Medicare Claim. I request that payment of authorized benefits be made on my behalf directly to the physician or organization providing medical care. I assign, transfer and set over all benefits payable for physician services to the physician or organization to submit a claim to Medicare for payment.

Patient Consent to the Release of Records for NYS External Appeal

The patient, the patient's designee and the patient's provider have a right to an external appeal of certain adverse determination made by health plans. In the event an external appeal is filed, consent to the release of medical records signed and dated by the patient is necessary. An external appeal agent, assigned by the New York State Department of Financial Services, will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I authorize my health plan and providers to release relevant medical or treatment records related to the external appeal including any HIV-related information, mental health treatment information or alcohol / substance abuse treatment information to the external appeals agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else.

This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence or to bring an action against my health plan.

Patient's Health Plan ID#

X
Signature of Patient (or representative) | Time | Date

I have read this entire document and I understand it.
I have been given the chance to ask questions and understand that I may ask additional questions at any time.

I also understand I may refuse to sign this form and that my health care treatment will not be affected or interrupted and payment will not be affected. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I may request a copy of this form after signing.

X
Signature of Patient (or representative) | Relationship (if other than patient) | Time | Date

Print Name of Witness | Title or Relationship to Patient

X
Signature of Witness | Time | Date

AGREEMENTS FOR PHYSICIAN PRACTICES

Financial Agreement / Guarantee of Payment: I, the undersigned patient or responsible party, agree to be fully responsible for payment to Stony Brook University Hospital / University Faculty Practice Corporations for the care and treatment of the patient whose name appears on this form.

I understand that this includes cost sharing payments to the provider (including any co-payments and deductibles) for care and treatment as required by the patient's health insurance contract and benefits. I understand that the patient is responsible for ensuring that authorizations and approvals are obtained as required by their insurance company. If prior approval is not obtained when required or authorization has been denied, I am fully responsible for all charges that the insurance company does not pay, as may be specified under the provisions of my contract and the extent permitted by law.

I understand that I am responsible to provide accurate information to the provider regarding: contact, demographic, health insurance and other pertinent information required for hospital / professional billing and that I must promptly notify the provider of any changes in this information. I agree to provide any other information reasonably requested by the provider in order to bill for the care and treatment provided.

I understand that if I have any questions about my bills I may call:

- 631-444-4151 for Patient Accounts / Hospital Billing
- 631-444-4800 for Physician Services

Release of Information: I consent to the release of all or part of my health record, including my social security number to insurance carriers, government agencies, and other third party payors as needed in order for Stony Brook University Hospital/University Faculty Practice Corporations to obtain reimbursement for my care. I also understand that my social security number may be provided to the New York Department of Health in accordance with incidence reporting and other New York State hospital regulatory requirements and to manufacturers of medical devices and the Federal Food and Drug Administration for medical device tracking purposes. I consent to the use and disclosure of my protected health information as necessary to treat my condition, obtain payment for treatment and conduct health care operations.

Release of Information to Primary Care Provider & Uniform Assignment

Release of Information to Primary Care Provider: I authorize Stony Brook University Hospital, its Emergency Department, and University Faculty Practice Corporations staff to disclose the health care related information for this Emergency Department encounter to my Primary Care Practitioner (PCP) for the purpose of continuity of my health care. I understand that this will include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection.

Uniform Assignment: I transfer, assign and set over to Stony Brook University Hospital/University Faculty Practice Corporations, sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my hospitalization and medical care to cover the costs and treatment rendered to myself or my dependent.

The following section ONLY pertains to Medicare patients. Patients signing this form who have Medicare Benefits understand that this information is included for their signature.

MEDICARE

Medicare Assignment of Benefits: 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 about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers, any information needed for this or any related Medicare Claim. I request that payment of authorized benefits be made on my behalf directly to physician or organization providing medical care. I assign, transfer and set over all benefits payable for physician services to the physician or organization to submit a claim to Medicare for payment to me.

Privacy Acknowledgement

Privacy Acknowledgement: I acknowledge that I have been provided a copy of the Stony Brook Organized Health Care Arrangement-Joint Notice of Privacy Practices and have been advised of how health information about me may be used and disclosed by the facilities listed at the beginning of the privacy notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request additional information explaining special privacy protection that applies in other areas such as HIV related information, mental health and genetic counseling. I have received the Joint Notice of Privacy Practices as of this date, or at a previous visit, not earlier than April 14, 2003.

I have read this entire document and I understand it. I have been given the chance to ask questions and understand that I may ask additional questions at any time.

I also understand I may refuse to sign this form and that my health care and payment will not be affected. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I may request a copy of this form after signing.

X _____ _____ _____ _____

Signature of Patient (or representative) | Relationship (if other than Patient) | Time | Date

_____ _____

Print Name of Witness | Title or Relationship to Patient

X _____ _____ _____

Signature of Witness | Time | Date

- ☐ Stony Brook Anaesthesiology, UFPC
- ☐ Stony Brook Children's Service, UFPC
- ☐ Stony Brook Dermatology Associates, UFPC
- ☐ Stony Brook Emergency Physicians, UFPC
- ☐ Stony Brook Family and Preventive Medicine Group, UFPC
- ☐ Stony Brook Internists, UFPC
- ☐ Neurology Associates of Stony Brook, UFPC
- ☐ New York Spine & Brain Surgery, UFPC
- ☐ University Associates in Obstetrics & Gynecology, UFPC
- ☐ Stony Brook Ophthalmology, UFPC
- ☐ Stony Brook Orthopaedic Associates, UFPC
- ☐ Stony Brook Pathologists, UFPC
- ☐ Stony Brook Psychiatric Associates, UFPC
- ☐ Stony Brook Radiation Oncology, UFPC
- ☐ Stony Brook Radiology, UFPC
- ☐ Stony Brook Surgical Associates, UFPC
- ☐ Stony Brook Urology, UFPC

Stony Brook Medicine
Stony Brook, NY 11794

Important Message from Medicare

Stony Brook University Hospital
Nicolls Road,
Stony Brook, NY 11794
631-689-8333

Patient Name: _____ Patient Number: _____

Your Rights as a Hospital Inpatient:

- You can receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- You can be involved in any decisions about your hospital stay.
- You can report any concerns you have about the quality of care you receive to your QIO at: **Livanta – Telephone (English and Spanish): 1-866-815-5440, TTY (English and Spanish): 1-866-868-2289.** The QIO is the independent reviewer authorized by Medicare to review the decision to discharge you.
- You can work with the hospital to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.
- You can speak with your doctor or other hospital staff if you have concerns about being discharged.

Your Rights to Appeal Your Hospital Discharge:

- You have the right to an immediate, independent medical review (appeal) of the decision to discharge you from the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the reviewer will each receive a copy of a detailed explanation about why your covered hospital stay should not continue. You will receive this detailed notice only after you request an appeal.
- If the QIO finds that you are not ready to be discharged from the hospital, Medicare will continue to cover your hospital services.
- If the QIO agrees services should no longer be covered after the discharge date, neither Medicare nor your Medicare health plan will pay for your hospital stay after noon of the day after the QIO notifies you of its decision. If you stop services no later than that time, you will avoid financial liability.
- If you do not appeal, you may have to pay for any services you receive after your discharge date.

See page 2 of this notice for more information.

How to Ask For an Appeal of your Hospital Discharge

- You must make your request to the QIO listed above.
- Your request for an appeal should be made as soon as possible, but no later than your planned discharge date and before you leave the hospital.
- The QIO will notify you of its decision as soon as possible, generally no later than 1 day after it receives all necessary information.
- Call the QIO: **Livanta – Telephone (English and Spanish): 1-866-815-5440, TTY (English and Spanish): 1-866-868-2289** to appeal, or if you have questions.

If You Miss The Deadline to Request An Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on Page 1.
- If you belong to a Medicare health plan: Call your plan at: _____

_____

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048. CMS does not discriminate in its programs and activities. To request this publication in an alternate format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Additional Information (Optional):

To speak to someone at Stony Brook University Hospital about this notice, please call our Care Management Department at 631-444-2552.

Hospital Name	Provider ID Number
Stony Brook University Hospital	330393
Stony Brook University Hospital Psychiatry	33S393

Please sign below to indicate you received and understood this notice.

I have been notified of my rights as a hospital inpatient and that I may appeal my discharge by contacting my QIO.

_____ _____

Signature of Patient or Representative Date / Time

Form CMS 10065-IM (Exp. 12/31/2022) OMB approval 0938-1019

Stony Brook Medicine
Stony Brook, NY 11794

Medicare Lifetime Reserve Days Election Form

Medicare Lifetime Reserve Days: After original Medicare coverage of up to 90 days (Hospital Full days and Hospital Partial Days) in a hospital per benefit period, Medicare offers an additional 60 days (Lifetime Reserve Days) of coverage. These 60 Lifetime Reserve Days can be used only once during a patient lifetime and do not have to be applied toward the same hospital stay.

Each Medicare beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services to draw upon after he/she has used 90 days of inpatient hospital service during their spell of illness. Medicare will make payment to the hospital for these additional days after the 90 days of benefits have been exhausted unless the individual elects not to have such payment made (and thus save his/her reserve days for a later time). There is a coinsurance payment during this period for which the patient is responsible, except if this is covered under supplementary medical coverage.

Yes I elect to use my Lifetime Reserve Days ☐ **No** I elect not to use my Lifetime Reserve Days ☐

Note to Patients: Within 5 days of the exhaustion of Part A benefits you have the option to NOT use your Lifetime Reserve days.

I have the right to retract this agreement up to 90 days after discharge by contacting Patient Accounts at (631) 444-4151 or Financial Services at (631) 444-7332.

X _____ _____ _____ _____
Signature of Patient (or representative) | Relationship (if other than patient) | Time | Date

_____ _____
Print Name of Witness | Title or Relationship to Patient

X _____ _____ _____
Signature of Witness | Time | Date

Stony Brook Medicine
Stony Brook, NY 11794

New York Motor Vehicle No-Fault Insurance Law Assignment of Benefits Form

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM

I, _____, ("Assignor") hereby assign to _____ ("Assignee")
(Print patient's name) *(Print hospital or healthcare provider name)*

all rights, privileges, and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, notwithstanding any prior written agreement to the contrary.
(Print accident date)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

X _____ _____ _____ _____
Signature of Patient (or representative) | Relationship (if other than patient) | Time | Date

_____ _____
Print Name of Witness | Title or Relationship to Patient

X _____ _____ _____
Signature of Witness | Time | Date

Stony Brook University Hospital	Neurology Associates of Stony Brook, UFPC	Stony Brook Psychiatric Associates, UFPC
Stony Brook Anaesthesiology, UFPC	New York Spine & Brain Surgery, UFPC	Stony Brook Radiology, UFPC
Stony Brook Children's Service, UFPC	Stony Brook Radiation Oncology, UFPC	Stony Brook Surgical Associates, UFPC
Stony Brook Dermatology Associates, UFPC	Stony Brook Ophthalmology, UFPC	Stony Brook Urology, UFPC
Stony Brook Emergency Physicians, UFPC	Stony Brook Orthopaedics Associates, UFPC	University Associates in Obstetrics and Gynecology, UFPC
Stony Brook Family and Preventive Medicine Group, UFPC	Stony Brook Pathologists, UFPC	
Stony Brook Internists, UFPC		

_____ X _____ _____
(Print name of Provider) (Signature of Provider) (Date of Signature)

(Address):_____ _____
(Time of Signature)

_____

AD2N537 (8/19)

Stony Brook Medicine
Stony Brook, NY 11794

Consent Form

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health | PSYCKES

STONY BROOK UNIVERSITY HOSPITAL

Provider/Facility Name

About PSYCKES

The New York State (NYS) Office of Mental Health maintains the Psychiatric Services and Clinical Enhancement System (PSYCKES). This online database stores some of your medical history and other information about your health. It can help your health providers deliver the right care when you need it.

The information in PSYCKES comes from your medical records, the NYS Medicaid database and other sources. Go to **www.psyckes.org,** and click on **About PSYCKES**, to learn more about the program and where your data comes from.

This data includes:

- Your name, date of birth, address and other information that identifies you;
- Your health services paid for by Medicaid;
- Your health care history, such as illnesses or injuries treated, test results and medicines;
- Other information you or your health providers enter into the system, such as a health Safety Plan.

What You Need to Do

Your information is confidential, meaning others need permission to see it. Complete this form now or at any time if you want to give or deny your providers access to your records. What you choose will not affect your right to medical care or health insurance coverage.

Please read the back of this page carefully before checking one of the boxes below. Choose:

- "I GIVE CONSENT" if you want this provider, and their staff involved in your care, to see your PSYCKES information.
- "I DON'T GIVE CONSENT" if you don't want them to see it.

If you don't give consent, there are some times when this provider may be able to see your health information in PSYCKES – or get it from another provider – when state and federal laws and regulations allow it.[1] For example, if Medicaid is concerned about the quality of your health care, your provider may get access to PSYCKES to help them determine if you are getting the right care at the right time.

Your Choice. *Please check 1 box only.*

◯ **I GIVE CONSENT** for the provider, and their staff involved in my care, to access my health information in connection with my health care services.

◯ **I DON'T GIVE CONSENT** for this provider to access my health information, but I understand they may be able to see it when state and federal laws and regulations allow it.

Print Name of Patient

Patient's Date of Birth

Patient's Medicaid ID Number

X

Signature of Patient or Patient's Legal Representative

Time

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative Patient (if applicable)

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

Stony Brook Medicine
Stony Brook, NY 11794

Information and Consent

1. **How providers can use your health information.** They can use it only to:
   - Provide medical treatment, care coordination, and related services.
   - Evaluate and improve the quality of medical care.
   - Notify your treatment providers in an emergency (e.g., you go to an emergency room).

2. **What information they can access.** If you give consent, *Stony Brook University Hospital* can see ALL your health information in PSYCKES. This can include information from your health records, such as illnesses or injuries (for example, diabetes or a broken bone), test results (X-rays, blood tests, or screenings), assessment results, and medications. It may include care plans, safety plans, and psychiatric advanced directives you and your treatment provider develop. This information also may relate to sensitive health conditions, including but not limited to:
   - Mental health conditions
   - Alcohol or drug use
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Sexually transmitted diseases

3. **Where the information comes from.** Any of your health services paid for by Medicaid will be part of your record. So are services you received from a state-operated psychiatric center. Some, but not all information from your medical records is stored in PSYCKES, as is data you and your doctor enter. Your online record includes your health information from other NYS databases, and new databases may be added. For the current list of data sources and more information about PSYCKES, go to: www.psyckes.org and see "About PSYCKES," or ask your provider to print the list for you.

4. **Who can access your information, with your consent.** *Stony Brook University Hospital's* doctors and other staff involved in your care, as well as health care providers who are covering or on call for *Stony Brook University Hospital* Staff members who perform the duties listed in #1 above also can access your information.

5. **Improper access or use of your information.** There are penalties for improper access to or use of your PSYCKES health information. If you ever suspect that someone has seen or accessed your information – and they shouldn't have – call:
   - *HIPAA Privacy Office at 631-444-5796*, or
   - the NYS Office of Mental Health Customer Relations at **800-597-8481.**

6. **Sharing of your information.** *Stony Brook University Hospital* may share your health information with others only when state or federal law and regulations allow it. This is true for health information in electronic or paper form. Some state and federal laws also provide special protections and additional requirements for disclosing sensitive health information, such as HIV/AIDS, and drug and alcohol treatment.[1]

7. **Effective Period.** This Consent Form is in effect for 3 years after the last date you received services from *Stony Brook University Hospital* or until the day you withdraw your consent, whichever comes first.

8. **Withdrawing your consent.** You can withdraw your consent at any time by signing and submitting a Withdrawal of Consent Form to *Stony Brook University Hospital*. You also can change your consent choices by signing a new Consent Form at any time. You can get these forms at **www.psyckes.org** or from your provider by calling *Pre Registration Call Center at 631-444-1870*. Please note, providers who get your health information through *Stony Brook University Hospital* while this Consent Form is in effect may copy or include your information in their medical records. If you withdraw your consent, they don't have to return the information or remove it from their records.

9. **Copy of form.** You can receive a copy of this Consent Form after you sign it.

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

Stony Brook Medicine
Stony Brook, NY 11794

Consent Withdrawal Form

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health | PSYCKES

STONY BROOK UNIVERSITY HOSPITAL

Provider/Facility Name

What you need to know

You previously signed a Consent Form, giving this health care provider permission to access your Medicaid and other health information available in the Psychiatric Services and Clinical Enhancement System (PSYCKES) online database.

You must complete and sign this Consent Withdrawal Form if you no longer want this provider, and their staff who provide your care, to see your information. When you complete, sign and return this form to them:

1. This health care provider won't be able to access your health information through PSYCKES. The exceptions are:
   - In an emergency, or
   - When state and federal confidentiality laws and regulations allow it. For example, if Medicaid is concerned about the quality of your health care, your provider may get access to PSYCKES to help them determine if you are getting the right care at the right time.[1]
2. Your provider may be able to access your medical information in other ways. For example, the same laws and regulations may allow them to get information needed to treat you from another provider.
3. This Withdrawal of Consent will not affect the health information shared while your Consent was in effect.
4. Your access to medical care and health insurance coverage won't change because you withdrew consent. Your health care providers will still submit claims to your insurer for the services you receive.
5. You can complete a new PSYCKES Consent Form at any time. Forms are available from your provider and, once completed and signed, should be returned to them.
6. You'll get a copy of this form when you sign and submit it.

What you need to do

Provide the information requested below and give this form to your provider.

Print Name of Patient

Patient's Date of Birth

Patient's Medicaid ID Number

X

Signature of Patient or Patient's Legal Representative

Time

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative Patient (if applicable)

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

Stony Brook Medicine
Stony Brook, NY 11794

Consent for Participation in NYSIIS for Individuals 19 Years of Age or Older

The New York State Immunization Information System (NYSIIS) is a confidential, computerized system that contains immunization records and allows authorized users access to a person's shot record. Strict federal and state laws protect the privacy of your personal information in the system. The benefits of participating in NYSIIS include:

- Your health care provider can use NYSIIS to be sure that you receive the needed immunizations, and proper medical treatment is received when needed.
- There will be a permanent and easily accessible record of your immunizations.

Participation in NYSIIS for people 19 years of age and older is voluntary, so your consent is needed. If you want to participate, please carefully read the consent below and sign in the space provided. For additional information about this consent, please call (518) 473-2839.

I give my consent for _____ (name of doctor or organization) to release my immunization(s) and identifying information to the New York State Immunization Information System (NYSIIS). I understand the purpose of NYSIIS 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 NYSIIS may be released to the following: myself, my health insurance plan, 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 enroll in NYSIIS. This consent may be withdrawn at any time by using the form provided. Information about immunizations received by NYSIIS with my consent will remain in NYSIIS if I later choose to withdraw my consent. However, future immunizations will not be recorded in NYSIIS.

Print Name	Date of Birth
X Signature	Date

IS2C672 (9/21)

Stony Brook Medicine
Stony Brook, NY 11794

Withdrawl of Consent for Participation in NYSIIS for Individuals 19 Years of Age or Older

I withdraw my consent for inclusion of my immunization information and identifying information in the New York State Immunization Information System (NYSIIS). I understand that records of immunizations received by NYSIIS with my consent will remain in NYSIIS; however, information about any future immunizations I receive will not be recorded in NYSIIS.

Name _____ Date of Birth _____

Address _____

_____

_____

X _____
Signature

Send this completed form to: New York State Immunization Information System
New York State Department of Health
Corning Tower, Room 678
Albany, NY 12237

IIIa. Observation Services

Understanding Your Rights and Status as an Inpatient or Observation Patient

When your medical needs bring you to Stony Brook University Hospital, one of the last things on your mind is probably,

"Are they going to bill me as an inpatient or an outpatient?" Yet it's important to know your status because it affects how much you pay out-of-pocket for hospital services. And if you have Medicare or Medicaid, the guidelines differ from those for patients with commercial insurance or health plan coverage.

The information here is designed to help you with the following:

- Navigate through the different terminology you will encounter while under "Observation."
- Explain your rights.
- Answer questions about who to call and what to ask.

For All Patients *Not* Covered by Medicare

Am I considered an inpatient or an outpatient?

You're an **inpatient** on the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.

You're an **outpatient** if you're getting Emergency Department (ED) services, observation services, outpatient surgery, lab tests or x-rays, and the doctor hasn't written a formal order to "admit" you to the hospital as an inpatient. In these cases, you're an outpatient even if you spend the night at the hospital.

Note: Observation services are hospital outpatient services given to help the doctor decide if you need to be admitted as an inpatient or instead can be discharged. Observation services may be given in the ED or another area of the hospital.

What kinds of conditions usually require Observation services?

Observation services are usually ordered for conditions that can be treated in 48 hours or less, or when the cause for your symptoms has not yet been decided. Some examples are nausea, vomiting, weakness, stomach pain, headache, kidney stones, fever, some breathing problems and some types of chest pain.

Within the first 48 hours of your stay, the doctor will decide whether you require an inpatient stay, or may be discharged home for care in another setting. If your condition requires acute inpatient care, the doctor will write out a formal order to change your outpatient observation stay to a full inpatient admission.

If you're in the hospital more than a few hours, ask your doctor or the hospital staff if you're an inpatient or an outpatient.

Since insurance and health plans usually pay different amounts for covered services that are provided as "inpatient" or as "outpatient," your out-of-pocket costs may be different depending on your status. How do you find out?

For reliable information, call your insurance company or health plan administrator. The phone number of your health insurance company or health plan administrator should be on the back of your insurance ID card.

Some helpful questions to ask your health insurance or health plan administrator:

For Inpatients

- What is my deductible (if any)? Have I met some or all of it yet?
- What is my co-payment for this admission?
- Will doctors' bills be covered? How much will I have to pay out of pocket?
- Will all prescriptions that I am given at the hospital be covered by my plan? What is my out-of-pocket share?
- Will all of my tests be covered? How much is my out-of-pocket share?

For Outpatients (If you're on Observation status, say so.)

- What is my deductible (if any)? Have I met some or all of it yet?
- What is my co-payment for these services?
- Will doctors' bills be covered? How much will I have to pay out of pocket?
- Will all prescriptions that I am given at the hospital be covered by my plan?
- What is my out-of-pocket share?
- Will all of my tests be covered? How much is my out-of- pocket share?

For Medicare Patients

Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!

Did you know that even if you stay in a hospital overnight, you might still be considered an "outpatient?" Your hospital status (whether the hospital considers you an "inpatient" or "outpatient") affects how much you pay for hospital services (like X-rays, drugs, and lab tests) and may also affect whether Medicare will cover care you get in a skilled nursing facility (SNF) following your hospital stay.

- You're an **inpatient** starting when you're formally admitted to a hospital with a doctor's order. The day **before** you're discharged is your last inpatient day.
- You're an **outpatient** if you're getting emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, and the doctor **hasn't** written an order to admit you to a hospital as an inpatient. In these cases, you're an outpatient even if you spend the night at the hospital.

Note: Observation services are hospital outpatient services given to help the doctor decide if the patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the emergency department or another area of the hospital.

The decision for inpatient hospital admission is a complex medical decision based on your doctor's judgment and your need for medically necessary hospital care. An inpatient admission is generally appropriate when you're expected to need 2 or more midnights of medically necessary hospital care, but your doctor must order such admission and the hospital must formally admit you in order for you to become an inpatient.

Read on to understand the differences in Original Medicare coverage for hospital inpatients and outpatients, and how these rules apply to some common situations. If you have a Medicare Advantage Plan (like an HMO or PPO), your costs and coverage may be different. Check with your plan.

What do I pay as an inpatient?

- Medicare Part A (Hospital Insurance) covers inpatient hospital services. Generally, this means you pay a one-time deductible for all of your hospital services for the first 60 days you're in a hospital.
- Medicare Part B (Medical Insurance) covers most of your doctor services when you're an inpatient. You pay 20% of the Medicare-approved amount for doctor services after paying the Part B deductible.

What do I pay as an outpatient?

- Part B covers outpatient hospital services. Generally, this means you pay a copayment for each individual outpatient hospital service. This amount may vary by service.

  Note: The copayment for a single outpatient hospital service can't be more than the inpatient hospital deductible. However, your total copayment for all outpatient services may be more than the inpatient hospital deductible.

- Part B also covers most of your doctor services when you're a hospital outpatient. You pay 20% of the Medicare-approved amount after you pay the Part B deductible.

- Generally, prescription and over-the-counter drugs you get in an outpatient setting (like an emergency department), sometimes called "self-administered drugs," aren't covered by Part B. Also, for safety reasons, many hospitals have policies that don't allow patients to bring prescription or other drugs from home. If you have Medicare prescription drug coverage (Part D), these drugs may be covered under certain circumstances. You'll likely need to pay out-of-pocket for these drugs and submit a claim to your drug plan for a refund.

  Call your drug plan for more information.

For more detailed information on how Medicare covers hospital services, including premiums, deductibles, and copayments, visit **Medicare.gov/publications** to view the "Medicare & You" handbook.
You can also call **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**.

Here are some common hospital situations and a description of how Medicare will pay. Remember, you pay deductibles, coinsurance, and copayments.

Situation	Inpatient or outpatient	Part A pays	Part B pays
You're in the emergency department (ED) (also known as the emergency room or "ER") and then you're formally admitted to the hospital with a doctor's order.	Outpatient until you're formally admitted as an inpatient based on your doctor's order. Inpatient following such admission.	Your inpatient hospital stay	Your doctor services
You visit the ED and are sent to the intensive care unit (ICU) for close monitoring. Your doctor expects you to be sent home the next morning unless your condition worsens. Your condition resolves and you're sent home the next day.	Outpatient	Nothing	Your doctor services
You come to the ED with chest pain and the hospital keeps you for 2 nights. One night is spent in observation and the doctor writes an order for inpatient admission on the second day.	Outpatient until you're formally admitted as an inpatient based on your doctor's order. Inpatient following such admission.	Your inpatient hospital stay	Doctor services and hospital outpatient services (for example, ED visit, observation services, lab tests, or EKGs)
You go to a hospital for outpatient surgery, but they keep you overnight for high blood pressure. Your doctor doesn't write an order to admit you as an inpatient. You go home the next day.	Outpatient	Nothing	Doctor services and hospital outpatient services (for example, surgery, lab tests, or intravenous medicines)
Your doctor writes an order for you to be admitted as an inpatient, and the hospital later tells you it's changing your hospital status to outpatient. Your doctor must agree, and the hospital must tell you in writing – while you're still a hospital patient before you're discharged – that your hospital status changed.	Outpatient	Nothing	Doctor services and hospital outpatient services

REMEMBER: *Even if you stay overnight in a regular hospital bed, you might be an outpatient. Ask the doctor or hospital.*

How would my hospital status affect the way Medicare covers my care in a skilled nursing facility (SNF)?

Medicare will only cover care you get in a SNF if you first have a "qualifying inpatient hospital stay."

- A qualifying inpatient hospital stay means you've been a **hospital inpatient (you were formally admitted to the hospital after your doctor writes an inpatient admission order)** for at least 3 days in a row (counting the day you were admitted as an inpatient, but not counting the day of your discharge).
- If you don't have a 3-day inpatient hospital stay and you need care after your discharge from a hospital, ask if you can get care in other settings (like home health care) or if any other programs (like Medicaid or Veterans' benefits) can cover your SNF care. **Always ask your doctor or hospital staff if Medicare will cover your SNF stay.**

How would hospital observation services affect my SNF coverage?

Your doctor may order "observation services" to help decide whether you need to be admitted to a hospital as an inpatient or can be discharged. During the time you're getting observation services in a hospital, you're considered an outpatient. **This means you can't count this time towards the 3-day inpatient hospital stay needed for Medicare to cover your SNF stay.**

For more information about how Medicare covers care in a SNF, visit Medicare.gov/publications to view the booklet "Medicare Coverage of Skilled Nursing Facility Care."

Here are some common hospital situations that may affect your SNF coverage:

Situation	Is my SNF stay covered?
You came to the ED and were formally admitted to the hospital with a doctor's order as an inpatient for 3 days. You were discharged on the 4th day.	Yes. You met the 3-day inpatient hospital stay requirement for a covered SNF stay.
You came to the ED and spent one day getting observation services. Then, you were formally admitted to the hospital as an inpatient for 2 more days.	No. Even though you spent 3 days in the hospital, you were considered an outpatient while getting ED and observation services. These days don't count toward the 3-day inpatient hospital stay requirement.

REMEMBER: *Any days you spend in a hospital as an outpatient (before you're formally admitted as an inpatient based on the doctor's order) aren't counted as inpatient days. An inpatient stay begins on the day you're formally admitted to a hospital with a doctor's order. That's your first inpatient day. The day of discharge doesn't count as an inpatient day.*

What are my rights?

No matter what type of Medicare coverage you have, you have certain guaranteed rights. As a person with Medicare, you have the right to all of these:

- Have your questions about Medicare answered.
- Learn about all of your treatment choices and participate in treatment decisions.
- Get a decision about healthcare payment or services, or prescription drug coverage.
- Get a review of (appeal) certain decisions about health care payment, coverage of services, or prescription drug coverage.
- File complaints (sometimes called "grievances"), including complaints about the quality of your care.

For more information about your rights, the different levels of appeals, and Medicare notices, visit Medicare.gov/appeals to view the booklet "Medicare Rights & Protections." You can also call **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**.

Where can I get more help?

- If you need help understanding your hospital status, speak to your doctor or someone from the hospital's utilization or discharge planning department.
- For more information on Part A and Part B coverage, read your "Medicare & You" handbook, or call **1-800-MEDICARE** (**1-800-633-4227**). TTY users should call **1-877-486-2048**.
- For more information about coverage of self-administered drugs, view the publication "How Medicare Covers Self-administered Drugs Given in Hospital Outpatient Settings" by visiting Medicare.gov/publications, or call 1-800-MEDICARE for a free copy.
- To ask questions or report complaints about the quality of care of a Medicare-covered service, call your Quality Improvement Organization (QIO). Visit **Medicare.gov/contacts**, or call **1-800-MEDICARE** to get the phone number.
- To ask questions or report complaints about the quality of care or the quality of life in a nursing home, call your State Survey Agency. Visit Medicare.gov/contacts, or call **1-800-MEDICARE** to get the phone number.

For Medicare and Medicare Advantage Insurance plans, report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed below:

Livanta
Phone – English and Spanish 1-866-815-5440, TTY English and Spanish 1-866-868-2289

Stony Brook Medicine
Stony Brook, NY 11794

Medicare Outpatient Observation Notice (MOON)

Patient Name: _____ Patient ID: _____ Date: _____

You're a hospital outpatient receiving observation services. You are not an inpatient because:

Based on a physician's examination and the diagnostic tests thus far, you are being observed for _____ and based on this you are likely to be discharged from this hospital within
enter diagnosis here
2 days or sooner. Medicare rules permit hospital admission only for patients whose care is expected to take longer than 2 days in the hospital setting. You will remain in outpatient status unless some change in your condition or plan of care appears to require a longer hospital stay as an inpatient.

Being an outpatient may affect what you pay in a hospital:

- When you're a hospital outpatient, your observation stay is covered under Medicare Part B.
- For Part B services, you generally pay:
    - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
    - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.

Observation services may affect coverage and payment of your care after you leave the hospital:

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged.
- If you have Medicaid, a Medicare Advantage plan or other health plan, Medicaid or the plan may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan.

NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, Part A will generally cover medically necessary inpatient services if the hospital admits you as an inpatient based on a doctor's order. In most cases, you'll pay a one-time deductible for all of your inpatient hospital services for the first 60 days you're in a hospital.

If you have any questions about your observation services, ask the hospital staff member giving you this notice or the doctor providing your hospital care. You can also ask to speak with someone from the hospital's utilization or discharge planning department.

You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Form CMS 10611-MOON Expiration 12/31/2022 OMB approval 0938-1308

AD2C567 (2/20)

Your costs for medications:

Generally, prescription and over-the-counter drugs, including "self-administered drugs," you get in a hospital outpatient setting (like an emergency department) aren't covered by Part B. "Self-administered drugs" are drugs you'd normally take on your own. For safety reasons, many hospitals don't allow you to take medications brought from home. If you have a Medicare prescription drug plan (Part D), your plan may help you pay for these drugs. You'll likely need to pay out-of-pocket for these drugs and submit a claim to your drug plan for a refund. Contact your drug plan for more information.

If you're enrolled in a Medicare Advantage plan (like an HMO or PPO) or other Medicare health plan (Part C), your costs and coverage may be different. Check with your plan to find out about coverage for outpatient observation services.

If you're a Qualified Medicare Beneficiary through your state Medicaid program, you can't be billed for Part A or Part B deductibles, coinsurance, and copayments.

Additional Information (Optional):

Verbal explanation by: _____ _____ _____
Patient Access Representative | Time | Date

Please sign below to show you received and understand this notice.

X _____ _____ _____
Signature of Patient or Representative | Time | Date

CMS does not discriminate in its programs and activities. To request this publication in alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Form CMS 10611-MOON Expiration 12/31/2022 OMB approval 0938-1308

Stony Brook Medicine
Stony Brook, NY 11794

Observation Notice

This notice is provided to inform you that you are receiving observation services.

You have not been admitted to the hospital.

Observation status may affect your Medicare, Medicaid, or Private insurance coverage for the current hospital services, including medication and other pharmaceutical supplies, as well as coverage for any care provided upon discharge to a skilled nursing facility or home and community based care.

Please contact your insurance plan for specific information about how observation services may impact your insurance coverage.

I acknowledge that I understand the above.

X _____ _____ _____ _____

Signature of Patient (or Representative) | Relationship (if other than Patient) | Time | Date

_____ _____

Print Name of Witness | Title or Relationship to Patient

X _____ _____ _____

Signature of Witness | Time | Date

IV. Healthix HIE

What is Healthix?

Healthix, the largest public health information exchange in New York State, enables the electronic sharing of health information between providers – including hospitals, long-term care facilities, home care agencies, and community physicians – in New York City, Long Island, and surrounding areas.

Most health care providers store information about your health in paper records or in computer systems that are only accessible to them. If you see more than one doctor, your records are likely stored in many different places, making it hard to pull them all together for a complete picture of your health.

Healthix supports technology that allows your doctors, nurses, and other health care providers involved in your care, share their medical records using a secure computer network. This technology will help your health care providers – like your doctor – make information about your health available to other providers you choose, so better care can be provided to you.

How Do I Participate?

Your health care provider may ask you for "consent" – or permission – to access your personal health data through Healthix.

You have the right to decide who can access your health information through Healthix by giving your consent. If your doctor or other health care provider participates in Healthix, they will give you a consent form so you can decide whether they are allowed to see your information to help give you better care.

You have the right to deny consent at any time. If you deny consent to your doctor or other health care provider, they will NOT be able to access your health information through Healthix – *even in an emergency*.

Your decision to grant or deny consent will not affect your ability to get medical care or health insurance coverage.

Is My Health Information Secure?

Many people are worried about privacy and security when it comes to their health. Healthix enforces robust privacy policies and has achieved HITRUST CSF certified status, which demonstrates that Healthix' systems have met key regulatory requirements and industry-defined requirements to protect the privacy of your electronic health records. Some things you should know:

- Only practices and organizations whom you choose, by signing a Healthix consent form, are allowed to access your records through Healthix.
- All participating Healthix providers must follow New York State and Federal privacy and confidentiality laws
- You can request a list of everyone in Healthix who has accessed your records
- If inappropriate access does occur, you will be informed, and steps will be taken to correct and mitigate the problem
- 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.

How do I Withdraw or Deny Consent?

If you have already given consent, you can withdraw your consent at any time by signing a *Withdrawal of Consent Form* and returning it to your health care provider or Healthix. You can get these forms on the Healthix website at www.healthix.org.

If you want to deny access for all health care providers and/or health plans participating in Healthix, you may do so by contacting us at compliance@healthix.org or call **1-877-695-4749 / Option 2**.

To learn more about Healthix, or for a complete list of participating organizations, please visit us online at: www.healthix.org or contact us at info@healthix.org.

All mail inquiries should be sent to **Healthix**, 551 North Country Road, Suite 206, St. James, NY 11780

Stony Brook Medicine
Stony Brook, NY 11794

Healthix

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

New York State Department of Health

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 members of the Stony Brook Organized Health Care Arrangement (listed on Exhibit A) (referred to as the "SBOHCA" or "Provider Organization") to obtain access to my medical records through the Statewide Health Information Network of New York (SHIN-NY) via 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 Health Information Exchange (HIE) organization, certified by the NYSDOH, 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.

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent even in a medical emergency.

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 the SBOHCA to access ALL of my electronic health information through Healthix to provide health care services (including emergency care).

☐ **2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for SBOHCA to access my electronic health information through Healthix.

☐ **3. I DENY CONSENT** for SBOHCA to access my electronic health information through Healthix for any purpose, ***even*** *in a medical emergency*.

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 X	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)
   - Medication and Dosages
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases
   - Diagnostic information
   - Allergies
   - Substance use history summaries
   - Clinical notes
   - Discharge summary
   - Employment Information
   - Living Situation
   - Social Supports
   - Claims Encounter Data
   - Lab Test
   - Trauma history summary

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 checking 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, contact the Provider Organization at: **hipaa@stonybrookmedicine.edu** or Healthix at **compliance@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, until such time as Healthix ceases operation or until 50 years after your death, whichever occurs first. 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.

EXHIBIT A
MEMBERS OF THE SBOHCA

The following entities are members of the SBOHCA

1. Stony Brook University Hospital, including:
    - Stony Brook Children's Hospital
    - Stony Brook Southampton Hospital
    - Stony Brook Eastern Long Island Hospital
2. University Faculty Practice Corporations. To review the list of all participating providers please visit the following webpage https://www.stonybrookmedicine.edu/locations
3. SB Community Medical, PC. To review the list of all participating providers please visit the following webpage https://www.stonybrookmedicine.edu/community-medical/practices
4. Meeting House Lane Medical Practice, PC

V. Paying for Your Care at Stony Brook University Hospital – Participating and Out of Network (OON) Services

When you become a non-emergency hospital patient at Stony Brook University Hospital, you are entitled to receive information about how you will be charged for the services you receive. This is particularly important if you receive care that is not in your health plan's network, or if you are not covered by a health plan.

Inpatient Hospitalization: Stony Brook is a participating provider in many health plan networks. However, some health plans use smaller networks for certain services they offer, so it is important to check whether we participate in your specific plan. *stonybrookmedicine.edu/patientcare/oon/plans*

Physician Services While You're in the Hospital: The physician services you receive while a patient in our hospital are not included in the hospital charges. Physicians who provide services at Stony Brook may be independent voluntary physicians. If your physician does not participate in your specific plan, you may want to choose a different physician who does.
stonybrookmedicine.edu/patientcare/findadoctor
stonybrookmedicine.edu/patientcare/oon/md-charges

Specialty or Other Services While You Are Hospitalized: Stony Brook has contracts with a number of physician groups such as anesthesiologists, radiologists and pathologists, so that they can provide services at our hospital. You should contact these groups directly to find out which health plans they accept. *stonybrookmedicine.edu/patientcare/oon/contract-charges*

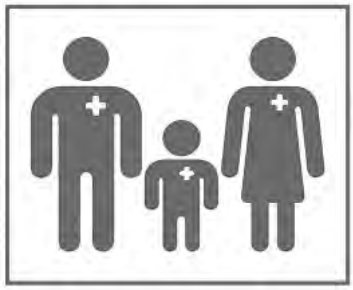
Understanding your Hospital Charges: We created a sample list of charges for our most common hospital procedures. Please keep in mind that these charges are just examples. There are different factors that affect what a patient actually pays depending on specific contracts that a health plan, insurer or other third-party payer (like Medicare) may have with us. Insured, in-network patients are usually only responsible for copayments, coinsurance and/or deductibles.
stonybrookmedicine.edu/patientcare/oon/charges

If You Don't Have Health Insurance: Contact our Financial Assistance Office to see if you may be able to get help paying for your hospital bills at **631-444-4331**.
stonybrookmedicine.edu/patientcare/oon/financial-assistance

You can find more information about our hospital fees at
stonybrookmedicine.edu/patientcare/oon/charges.

VI. Has Anything Changed?

New Home Address
New Phone Number
New E-Mail Address



Had or Adopted Another Child
Child Moved In or Out of Home
A Death in the Family
Change in Legal Marital Status

New Primary Care Doctor

New Pharmacy

To assist in ensuring that your patient information is in order and up to date, and that you are properly billed, please provide the following information today or as soon as possible. Thank you.

- ❑ Mailing address
- ❑ Primary and Secondary Phone #
- ❑ E-mail address
- ❑ Employer Name / Address / Phone #
- ❑ Next of Kin Name / Address / Phone #
- ❑ Emergency Contact Name / Address / Phone #
- ❑ Insurance Policy Plan Holder Name / ID Number
- ❑ Insurance Policy Plan Holder DOB / Phone #
- ❑ Insurance Policy ID Number
- ❑ Insurance Policy Mailing Address
- ❑ Insurance Policy Phone #
- ❑ Primary Care Physician
- ❑ Pharmacy

You may send updated information securely through the MyHealtheLife Stony Brook Medicine Patient Portal (Go to "Messaging, select "Inbox" and send to: Patient Access-Patient Information Update Request).

To complete or update your information in person please stop by one of our Patient Access locations listed below or call 631-444-1870.

Stony Brook Satellite Lab
Hours:
Monday 7:00a.m. – 3:30p.m.,
Tuesday – Friday
7:00a.m. – 5:30p.m.,
Saturday 7:00a.m. – 12:00p.m.
3 Technology Drive,
East Setauket, NY 11733

Patient Access Registration Office
Hours:
Monday – Friday 6:30a.m. – 6:00p.m.,
Saturday – Sunday 8:00a.m. – 4:00p.m.
Stony Brook University Hospital,
101 Nicolls Road, Stony Brook, NY 11794,
Level 5 (Main Floor)

Stony Brook Pre Op Services
Hours:
Monday – Friday
8:00a.m. – 4:00p.m.
1320 Stony Brook Road, Suite E.
Stony Brook, NY 11794

VII. Helpful Phone Numbers

Patient Advocacy 631-444-2880

Financial Assistance Program 631-444-4331

- Extended Time Payments 631-444-4140

HealthConnect 631-444-4000

HealthConnect provides a direct link to physicians and medical services at Stony Brook. Patients may call about medical services, physician services or appointment scheduling.

Patient Billing / Hospital Services 631-444-4151

Patient Access Financial Services (Including Medicaid Applications) 631-444-7583

Physician Billing 631-444-4800

Patient Access PreRegistration 631-444-1870

Switchboard 631-689-8333

Notes

Notes

Notes

Stony Brook Medicine

stonybrookmedicine.edu

Revised December 2021