Karen Carpenter Palumbo
President & CEO

INTAKE PACKAGE INFORMATION

THE FOLLOWING INFORMATION IS REQUIRED PRIOR TO OR AT THE TIME OF ADMISSION:

- Consent for child's routine medical and dental care (must be signed by parents/guardians)
- Health services package (to be completed by parents/ guardians)
- Consent for release of information (signed by parents/guardians)
- Authorizations

ADDITIONAL INFORMATION NEEDED AT THE TIME OF PLACEMENT:

- Supply of medication and a copy of the prescription order signed by MD or escript to Omnicare of Ballston Spa
- Birth Certificate
- Social Security Number (card if possible)
- Medical Records - Immunizations
- Insurance Information – Medicaid Card
- Court Orders

Mary Beth Carman, LCSW-R
Vice President of Operations

2/21 ev revised

VANDERHEYDEN

Giving new life to youth, adults and families

Karen Carpenter Palumbo
President & CEO

CONSENT FOR CHILD'S ROUTINE MEDICAL AND DENTAL CARE

(By Parents or Guardian)

I, _____, hereby give my consent for medical and dental care to the child listed below while under the care of Vanderheyden, Inc., or any person or agency acting as the agent of Vanderheyden, Inc.

This medical care includes, but is not limited to, physical examinations, administration of medications, immunizations against communicable diseases (including Hep B, Chicken Pox), and any necessary tests and emergency room treatment which in the opinion of the physician, dentist, or psychiatrist treating the child listed are deemed necessary or advisable and/or is prescribed by such physician, dentist, or psychiatrist.

This includes the right, in the case of an emergency, to admit for hospitalization and to administer necessary treatment, including surgery whenever such treatment is deemed medically necessary.

RESIDENT NAME	**BIRTHDATE**	**RELIGION**	**SOCIAL SECURITY NUMBER "REQUIRED"**
_____	_____	_____	_____-_____-_____

Address: _____

_____

Home Phone: _____

Work Phone: _____

Parent's email: _____

PARENT/GUARDIAN SIGNATURE: _____

Relationship: _____

Witness: _____

Date: _____

I understand that this authorization may not extend past date of discharge or 1 year from date of signing: must be renewed yearly.

Ev 2/21 revised

Karen Carpenter Palumbo
President & CEO

Health Package

Introduction:

The purpose of the health service package is to enable our program to organize the health information of each individual we serve. This will help us to identify health problems and establish a plan to meet these needs. It is understood that the information requested on the forms will not always be available. However, every effort should be made so the forms are as complete as possible.

While completing the forms please feel free to call the Health Services Office if you have any questions. We will be glad to assist you in any way we can.

HEALTH HISTORY

_____
Name of Individual

_____
Date of Birth

_____
Place of Birth

_____
Signature of person completing form

FAMILY HEALTH HISTORY:

FAMILY MEMBERS: Please not any special relationships such as step-parent, foster child, adopted, etc. If deceased include date and cause of death.

Relationship	Age	Name	State of Health	Occupation School	Grade Reached/School
Mother					
Father					
Siblings:					

Family: Annual Income:

under $5,000	$5,000-$9,000	$10,000-$14,999
$15,000-$24,999	$25,000-$34,999	$35,000 or more

Individual: Racial/Ethnic Composition

White (non-Hispanic/non-Latino	Black, African American	Multi-Racial, Multi Ethnic
Hispanic, Latino	American Indian, Alaska Native	Race/Ethnicity (not listed)
Pacific Islander	Asian -non-Pacific Islander	

Religion:

Catholic	Jewish	Muslin	Prostestant	Religion Not Listed

_____
Name

_____
D.O.B.

DEVELOPMENTAL HISTORY:

I. Pregnancy History – Mother

a. What number pregnancy was this?_____
b. What number live birth?_____
c. Was mother under a doctor's care during pregnancy?_____
d. Were there any complications:

_____
_____
_____
_____

e. Did the baby arrive on time?_____
    1. If premature or over due- how long?_____
    2. Birth weight_____
f. Were there any complications with labor and delivery?_____
   Explain_____
   _____

II. Infancy – did this child have any problems – rolling over, sitting up, crawling, feeding, standing or walking etc.? Explain:_____

_____

III. Toddler – did this child have any problems with speech, behavior, toileting, etc.? Explain:_____

_____

IV. Pre-School: (3-5 yr.) Did this child attend pre-school? Any problems with bed wetting, soiling behavior, socialization, etc.

_____

_____

V. School Age (5-present): Did this child have problems with school, peers, clumsiness, behavior etc. Explain:_____

_____

VI. Present: Problem that brought this child into Vanderheyden for placement:

_____

_____

Completed by:_____

Date:_____

_____
Name

_____
D.O.B.

ALLERGIES:_____
_____

CURRENT MEDICAL PROBLEMS:_____
_____

ILLNESSES/INJURIES/SURGERY (without being admitted to hospital ____
_____
_____

HOSPITALIZATIONS: (include medical/surgical/psychiatric):_____
_____
_____

CHILDHOOD DISEASES: (fill in the circle)

	Age		Age
German Measles (Rubella)	_____	Rheumatic Fever	_____
Chicken Pox	_____	Hepatitis	_____
Mumps	_____	Mononucleosis	_____
Whooping Cough	_____	T. B.	_____
Scarlet Fever	_____	Meningitis	_____

Completed by_____

Date_____

IMMUNIZATION RECORD

Name: _____
Specific Dates must be included to comply with Public Health Regulations.

Vaccine	#1	#2	#3	#4	#5	#6
D.P.T. (Diphtheria-Pertussis-Tetanus)						
O.P.V. (Oral Polio Vaccine)						
MEASLES						
MUMPS						
RUBELLA (german measles)						

Complete by _____
Date _____

_____
Name

County:_____

DOB:_____

DENTAL INFORMATION:

Dentist:

Name:_____

Address:_____

Phone:_____

Please give dates for the following questions.

Has this child been seen by a dentist during the past six months? _____ Yes ____ No
Has this child had dental X-rays? _____ Yes ____ No
Has this child had Fluoride treatments? _____ Yes ____ No
Has all necessary dental work been completed? _____ Yes ____ No

_____

Do you have dental insurance coverage? (please enclose a form)

Insurance Co._____
ID Number_____

Completed by_____

Date_____

Name_____

MEDICAL INFORMATION:

Family Doctor – Pediatrician – Clinic:

Name_____

Address_____

Phone_____

Date of last appointment_____

Reason for appointment_____

_____

Specialist: Reason for appointment (Eye-Ear-Nose-Throat-Skin, etc.)

_____

_____

Do you have medical/health insurance coverage? (Please provide copy of card)

Insurance Company_____

Employer_____

Name of person carrying Insurance_____

SS # of Insurance Carrier_____

DOB of Insurance Carrier_____

ID#_____

Group#_____ Plan:_____

Is coverage a managed care policy provided by Medicaid? (Please provide copy of card)

Yes_____ No_____

MEDICAID #_____

Completed by_____

Date_____

_____
Name

_____
D.O.B.

MEDICATION HISTORY:

Please list any medication the child is currently receiving and the reason he is receiving it. A Doctor's prescription and a one week supply of medication must be presented to Vanderheyden when the child is admitted.

_____

_____

_____

_____

_____

_____

_____

Below please list the best of your recollection any medications the child has received in the past.

MEDICATION	AGE WHEN GIVEN	REASON	EFFECT OF MEDICATION

Completed by_____
Date_____

FAMILY HEALTH HISTORY – Circle any of the following that this child or his parents, grandparents, brothers, sisters, etc. have had.

	CONDITION	RELATIONSHIP TO CHILD
1.	Allergy	1.
2.	Asthma	2.
3.	Arthritis (Rheumatoid or Osteo)	3.
4.	Alcoholism	4.
5.	Cancer	5.
6.	Drug Addiction	6.
7.	Diabetes (Sugar)	7.
8.	Epilepsy (Convulsions)	8.
9.	Gout	9.
10.	High Blood Pressure	10.
11.	Heart Disease	11.
12.	Hemorrhagic Problems	12.
13.	Kidney Problems	13.
14.	Liver Problems	14.
15.	Migraine	15.
16.	Mental Illness (Psychiatric Problems)	16.
17.	Mental Retardation	17.
18.	Nervous Breakdown	18.
19.	Obesity	19.
20.	Rheumatic Fever	20.
21.	Sickle Cell Problems	21.

VANDERHEYDEN

Giving new life to youth, adults and families

Karen Carpenter Palumbo
President and CEO

Authorization for Medical

Release of Information

Vanderheyden Hall, Inc.

I, _____, hereby give permission to Vanderheyden Hall, Inc. to request medical or dental information from any of the physicians or dentists who have cared for _____, when deemed necessary by the Health Service's Staff.

The purpose or need for such disclosure is:

_____

_____

Specification of the date, event, or condition upon which this consent expires:

- ❑ 90 days from date of consent for one time release of information.
- ❑ May not extend past date of discharge or 1 year from date of signing: must be renewed yearly.

I hereby permit the use or disclosure of the above information to the Person/Organization/Program(s) identified above. I understand that:

- Only this information may be used and/or disclosed, as a result of this authorization.
- This information is confidential and cannot legally be disclosed without my permission.
- If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
- I have the right to revoke this authorization at any time. My revocation must be in writing on the form provided to me by Vanderheyden Hall. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Vanderheyden Hall, nor will it affect my eligibility for benefits.
- I have a right to inspect and copy my own protected health information to be sued and/or disclosed as stated by law and/or regulation.

Date _____

_____
Signature of Individual

_____
Signature of Witness

_____
Signature of parent/guardian/authorized representative

Karen Carpenter Palumbo
President and CEO

REQUEST FOR CONSENT TO EVALUATE

In an effort to provide appropriate educational services it will be necessary to evaluate your child. Permission to test your child is being requested. A multidisciplinary team will evaluate your child's abilities and recommend an appropriate education program based on evaluation results. This consent in no way causes you to waive or relinquish any rights for your child. To revoke this consent at any time, you must submit in writing your desire to do so.

Please check the box below and sign.

☐ YES, I hereby grant consent for my child _____
(Students Name)

to be evaluated for the purpose of determining appropriate educational services.

_____ _____
Signature of Parent/Guardian Date

I understand that this authorization may not extend past date of discharge or 1 year from date of signing: must be renewed yearly.

2/21 revised ev

VANDERHEYDEN

Giving new life to youth, adults and families

Karen Carpenter Palumbo
President and CEO

VANDERHEYDEN HALL, INC.
Authorizations

In the course of providing the best possible care and services for your child while at Vanderheyden Hall and operating the wide and varied programs that we do, many situations arise where parental consent is advisable or necessary. Please check the box next to each of the following paragraphs and sign your name at the end.

Re: _____ _____
Name of Child Date of Birth

I agree to continue with the medications currently prescribed upon admission to Vanderheyden . ☐ **YES** ☐ **NO**

I agree to allow Vanderheyden to administer OTC (over the counter) medications as per the approved OTC list given to me. ☐ **YES** ☐ **NO**

I have been given the information sheet for Parents/Guardians on the use of physical restraints and hereby give permission for staff to utilize a physical restraint on my child if it is clinically justified. ☐ **YES** ☐ **NO**

I hereby grant permission for use of any photograph or videography of my child to appear in website, public relations brochures, pamphlets, videotapes, booklets, and exhibits compiled and used by Vanderheyden Hall. The identity of my child will not be disclosed but he/she may be identified as a resident of Vanderheyden. ☐ **YES** ☐ **NO**

I hereby give permission for my child to participate in any police agency investigation of assault, sexual abuse, or other crime committed against my child or other persons or property. I understand that such information concerning any such investigation will be made available to me by Vanderheyden. ☐ **YES** ☐ **NO**

I hereby give permission for staff to transport my child to outside appointments, recreational activities and school events, and home visitation as needed. ☐**YES** ☐**NO**

I hereby give permission for my child to participate in recreational programs including activities in the community:

☐ Swimming ☐ Troy Boys/Girls Club ☐ YMCA ☐ **YES** ☐ **NO**

_____ _____ _____
Date Print Full Name Parent/Guardian

Witness: _____

I understand that this authorization may not extend past date of discharge or 1 year from date of signing: must be renewed yearly.

2/21 ev revised

VANDERHEYDEN

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President and CEO

Authorization for Release of Information

This authorization must be completed by the individual or his/her personal representative to use/disclose/obtain protected health information (for other than treatment, payment, or health care operations purposes), in accordance with State and Federal laws and regulations. A separate authorization is required to use or disclose confidential HIV related information.

I, _____, authorize Vanderheyden, Inc. to

- ❑ Obtain information from:
- ❑ Disclose information to:

Name: _____

Information to be obtained/disclosed:

	Treatment Goals/Treatment Plan		Discharge summary/Discharge Plan		Complete medical records
	Safety plans/behavior management plans		Description of progress and prognosis		Medical history and physical, consultation reports
	Psychiatric Evaluation		Assessment and Screening		Individualized Education Plan
	Medication Management		Educational/psychological testing		Laboratory tests
	Psychosocial Assessment				Other:

The purpose of obtaining or disclosing the information:

	To provide ongoing communication with referring agency		To convey treatment recommendations and progress		To complete an evaluation (alcohol/drug, psychiatric, psychological, etc.)
	To contact in case of emergency		To maintain continuity in care		Other:
	To provide ongoing treatment aftercare		For treatment planning purposes		Other:

Specification of the date, event, or condition upon which this consent expires:

- ❑ 90 days from date of consent for one time release of information.
- ❑ May not extend past date of discharge or 1 year from date of signing: must be renewed yearly

I hereby permit the use or disclosure of the above information to the Person/Organization/Program(s) identified above. I understand that:

- Only this information may be used/obtained/disclosed as a result of this authorization.
- This information is confidential and cannot legally be disclosed without my permission.
- If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be redisclosed and would no longer be protected.
- I have the right to revoke this authorization at any time. My revocation must be in writing on the form provided to me by Vanderheyden. I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Vanderheyden, nor will it affect my eligibility for benefits.
- I have a right to inspect and copy my own protected health information to be used and/or disclosed as stated by law and/or regulation.
- I have the right to receive a copy of this Release of Information.

_____ _____ _____

Date Signature of Individual Parent/Guardian/authorized representative

_____

Signature of Witness

Notice of Privacy Practices

Vanderheyden Hall, Inc.

THIS NOTICE DESCRIBES HOW HEALTH AND MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Our Commitment to You: We at Vanderheyden Hall, Inc. understand that the information we collect about you and your health is personal. Keeping your health information confidential and secure is one of our most important responsibilities.

We keep a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. We are committed to protecting your health information and to following all state and federal laws regarding the protection of your health information.

This notice tells you how we may use or release your health information. It also tells you about your rights and requirements concerning the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to health information about you
- Follow the terms of the notice that is currently in effect
- If you have any questions about this notice, please contact the Assistant Executive Director at (518) 283-3458, ext. 11.

2. Who will follow this notice: This notice describes the practices of Vanderheyden Hall and that of:

- Any student or member of a volunteer group we allow to help you while you are in our care

3. Your Health Information Rights:

You have the following rights regarding health information we have about you:

RIGHT to Inspect and Obtain Copies: You have the right to inspect and obtain a copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records. It does not include information that is needed for civil, criminal, or administrative actions or proceedings. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

- To inspect or obtain a copy health information that may be used to make decisions about you, you must submit your request in writing to the Associate Executive Director
- We may deny your request to inspect and obtain a copy in very limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed. Medical/Clinical Team will review your request and the denial. The person(s) conducting the review will not include the person who denied your request. We will comply with the outcome of the review.

RIGHT to Amend: If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend that information. You have the right to request an amendment for as long as the information is kept by or for us.

- To request an amendment, your request must be made in writing and submitted to Associate Executive Director. In addition, you must provide a reason that supports your request.

RIGHT to an Accounting of Disclosures: You have the right to request a list of information releases that we have made of your health information. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

RIGHT to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for the purpose of treatment, payment, or health care operations. You also have the right to request that we restrict or limit health information about you that we may use or disclose to someone who is involved in your care or the payment for your care, such as a family member. Please be aware that we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

RIGHT to Request Confidential Communications: You have the right to request that we communicate with you about your health matters in a certain way or at a certain location. For example, you can ask that we only contact you at a certain phone number or by mail.

RIGHT to a Paper Copy of this Notice: You have a right to a paper copy of this notice. You

- May ask us to give you a copy of this notice at any time. Even if you have agreed to receive
- This notice electronically, you are still entitled to a paper copy of this notice.
- You may obtain a copy of this notice at our website, www.vanderheyden.org

TEAR OFF **TEAR OFF**

Under the Federal HIPAA Privacy Rule, we are required to give you our Notice of Privacy Practices and make a good faith effort, before providing services, to get your:

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices for Vanderheyden Hall, Inc.

_____ _____

Name of Individual Served Signature (Individual, parent or personal representative and relationship)

Date: _____

This document may be mailed or faxed to Vanderheyden Hall, Inc. Fax number is 518-283-7156

Use or Disclose of Your Health Information:
For Treatment: Caregivers, such as nurses, doctors, therapists and social workers, may use your health information to determine your plan of care. Individuals and programs within Vanderheyden Hall may share health information about you to coordinate the services you may need, such as clinical examinations, therapy, nutritional services, medications, hospitalization, or transfers or referrals for follow-up care. We may use health information about you to provide you with treatment or services.
For Payment: Vanderheyden may release information about you to your health insurance carrier or agency responsible for paying for your care, i.e. DSS to obtain payment for our services. For example, we may need to give your health plan information about a clinical exam or medications that you received so your health plan will pay us for treatment or services we provided. We may also share your information, when appropriate, with other government programs such as Medicaid to determine if you are eligible for, or to coordinate, your benefits, entitlements, and payments. We may need to disclose a limited amount of information about you to explore your financial situation for possible sources of payment for your care, but we will only do so as permitted under law. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
For Operations: Vanderheyden may use and release information about you to ensure that the services and benefits provided to you is appropriate and are high quality. For example, we may use your information to evaluate our treatment and service programs or to evaluate the services of other providers that use government funds to provide health care services to you. We may combine health information about many individuals to research health trends, or determine what services and programs should be offered, or whether new treatments or services are useful. We may share your health information with our business partners who perform functions on our behalf.
To Keep You Informed: Unless you provide us with alternative instructions, we may contact you about reminders for treatment, medical care, or health check-ups. We may also contact you to tell you about health-related benefits or services that may be of interest to you or to give you information about your health care choices.
Business Associates: We provide some services through contracts with business associates, such as accountants, consultants, and attorneys. When such services are contracted, we may disclose health information about you to our business associates so that they can perform the tasks that we have assigned to them. To protect your health information, we require the business associates to appropriately safeguard health information.
To Other Government Agencies Providing Benefits or Services: We may release your health information to other government agencies that are providing you with benefits or services when the information is necessary for you to receive those benefits or services.
As Required by Law: We will disclose health information about you when required to do so by federal, state, or local law.
To Avert a Serious Threat to Health or Safety: We may release your health information if it is necessary to prevent a serious threat to your health or safety or to the health and safety of the public or another person.
For Public Health Activities: We may disclose health information about you to public health agencies, subject to the provision of applicable state and federal law, such as prevention or to control disease, injury or disability; child abuse or neglect; reactions to medications or problems with products to the Food and
Drug Administration (FDA).
For Law Enforcement: We may release health information to a law enforcement official:

- in response to a court order, subpoena, warrant, summons, or other similar process
- to identify or locate a suspect, fugitive, material witness, or missing person about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- about criminal conduct at the agency
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

Medical Examiners and Others: We may release health information to a coroner or medical examiner to carry out their lawful duties. If you are an organ donor, we may release your health information to
an organization that help with organ, eye, or tissue donation or transplantation.
Government Functions: We may release your health information to an authorized federal official or other authorized persons for purposes of national security, for providing protection to the President, or to conduct special investigations, as authorized by law.

Contact Information

For Privacy Violations	**For Additional Copies or More Privacy Information**
Jenny Wiegert, Vice President of Quality Insurance	Mary Beth Carman, Vice President of Operations
Vanderheyden, Inc.	Vanderheyden Hall, Inc.
PO Box 219, Route 355	PO Box 219, Route 355
Wynantskill, NY 12198	Wynantskill, NY 12198
518-283-6500 ext. 267	518-283-6500, ext. 272

Inability to Obtain Acknowledgement: If the individual served or their parent or personal representative refuses to sign this form or it is otherwise not possible to obtain an acknowledgement of receipt of the Notice of Privacy Practices, please identify the good faith efforts made to obtain the acknowledgment and the reasons why the acknowledgement was not obtained:

- ❑ Individual/representative refused to sign Acknowledgement
- ❑ Individual/representative unable to sign Acknowledgement
- ❑ Other (explain): _____

Name of Individual/representative: _____
Signature of person who
attempted to obtain acknowledgement: _____Date: _____

OMNICARE, INC. AND AFFILIATED ENTITIES **NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Provided in compliance with 45C.F.R. § 164.520

Omnicare, Inc. and its affiliated entities (collectively "Omnicare") use health information about you for treatment, to obtain payment for treatment, to evaluate the quality of care you receive, and for other administrative and operational purposes. Your health information is contained in a medical record that is the physical property and responsibility of Omnicare.

Your Health Information Rights:

You have the following rights with respect to health information about you.

Right to Copy of Notice of Privacy Practices. You have the right to a paper copy of our Notice of Privacy Practices at any time. To obtain a copy of our current Notice of Privacy Practices, please contact your local Omnicare location or Omnicare's Chief Privacy Officer at the address or phone listed below.

Right to Inspect and Copy. You have the right to inspect and/or obtain a copy of the health information about you that we maintain in certain groups of records that are used to make decisions about your care. Your request must be in writing. If you request a copy of your health information, we will charge you a fee to cover the costs of copying and mailing the information. In certain very limited circumstances, we may deny your request to inspect and copy your health information. If you are denied access to your health information, we will explain our reasons in writing. You have the right to request that another person at Omnicare review the decision . We will comply with the outcome of the review. For information about this right, see 45C.F.R. § 164.524.

Right to Amend. If you feel that health information about you that we maintain in certain groups of records is inaccurate or incomplete, you have the right to request that we amend the information. You have the right to request an amendment as long as we maintain the information. Depending on the nature of your request, we may ask that you submit it in writing and include a reason supporting the request. In certain circumstances, we may deny your request to amend your health information. If your request for an amendment is denied, we will explain our reasons in writing. You have the right to submit a statement explaining why you disagree with our decision to deny your amendment request. We will share your statement when we disclose health information about you that we maintain in certain groups of records. For more information about this right, see 45 C.F.R. § 164.526.

Right to an Accounting of Disclosures. You have the right to request an accounting or detailed listing of certain disclosures of your health information. The time period covered by the accounting is limited. Your request must be in writing. If you request an accounting more often than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting. For more information about this right, see 45 C.F.R. § 164.528.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information about you that we use or disclose. Your request must be in writing. Please be aware that we are not required to agree to your request for restrictions. If we agree to your request for a restriction, we will comply with it unless the information is needed for emergency treatment. For more information about this right, see 45 C.F.R. § 164.522.

Right to Revoke Authorization. You have the right to revoke your authorization to use or disclose health information, except to the extent that action has been taken in reliance upon your authorization. Your request must be in writing.

Right to Request Alternative Method of Contact. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Your request must be in writing. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may request that we use an alternative address for billing purposes. For more information about this right, see 45 C.F.R. § 164.522(b).

Complaints

If you believe your privacy rights have been violated, you may complain to Omnicare and to the Department of Health and Human Services. You may make a complaint to us by contacting Omnicare's Chief Privacy Officer at the address or phone listed below. You will not be retaliated against for filing a complaint.

Omnicare's Obligations

Omnicare is required to:

- maintain the privacy of protected health information;
- provide you with this Notice of our legal duties and privacy practices with respect to your health information;
- abide by the terms of the Notice of Privacy Practices currently in effect;
- notify you if we are unable to agree to a requested restriction on how your health information is used or disclosed;
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations;
- obtain your written authorization to use or disclose your health information for reasons other than those identified in this Notice and permitted by law; and
- comply with your state's laws if they provide you with greater rights over your health information or provide for more restrictions on the use or disclosure of your health information.

Omnicare reserves the right to change the terms of this Notice, our privacy practices, and to make the new provisions effective for all protected health information we maintain. You may contact your local Omnicare location or Omnicare's Chief Privacy Officer at the address or phone listed below to obtain a revised Notice of Privacy Practices.

Uses or Disclosures of Your Health Information

Treatment. We may use and disclose health information about you to provide you with pharmaceutical care or other medical treatment or services. To this end, we may communicate with other health care providers regarding your treatment and coordinate and manage your health care with others. For example, information related to your treatment may be obtained by a health care provider, such as a pharmacist, nurse, respiratory therapist, or other person providing health services to you, and will be recorded in your medical record. This information is necessary for health care providers to determine what treatment you should receive. Health care providers also may record actions taken by them in the course of your treatment and note how you responded to the actions

---------- **tear off** ----------

Under the Federal HIPAA Privacy Rule, we are required to give you our Notice of Privacy Practices and make a good faith effort, before providing services, to get your:

Acknowledgement of Receipt of Notice of Privacy Practices

_____ _____

Name of Patient (*print*) **Facility of Organization**

By signing this form, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices for Omnicare, Inc. and its affiliated entities.

_____ _____

Signature (*patient, parent, or legal representative*) Date

_____

Name and Relationship to Patient (*if signed by someone other than patient*)

PLEASE FAX This document to your Omnicare products or service provider Immediately

For Omnicare Use Only ❑ Entered into computer. ❑ Processed for filing.

Uses or Disclosures of Your Health Information (cont..)

Payment. We may use and disclose health information about you to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as Medicare, an insurance company, or a health plan. The information on the bill may include information that identifies you, your diagnosis, and treatment or supplies used in the course of your treatment. In some instances, we may disclose health information about you to an insurance plan before you receive certain health care products or services, to determine whether the insurance plan will pay for the particular product or service.

Health Care Operations. We may use and disclose health information about you for administrative and operational purposes. Members of the risk management or quality improvement teams may use health information about you to assess the care and outcomes in your case and others like it. The results will be used internally to continually improve the quality of care for all patients. For example, we may combine medical information about many patients to evaluate the need for new products, services, or treatments. We may disclose information to health care professionals, students, and other personnel for review and training purposes. We also may combine health information we have with other sources to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy and to allow others to use the information to study health care without learning the identity of the specific patients.

We may also use and disclose medical information to:

- evaluate the performance of our staff and your satisfaction with our services;
- learn how to improve our facilities and services;
- determine how to continually improve the quality and effectiveness of the health care we provide; and
- conduct training programs or review competence of health care professionals.

Organized Health Care Arrangement. An organized health care arrangement is a clinically integrated care setting in which individuals typically receive health care from more than one health care provider. We may participate in organized health care arrangements with long-term care facilities, hospice, or other health care facilities in connection with the services we furnish to patients in such settings. Health information may be shared between the participants in the organized health care arrangement for the health care operations of the arrangement.

Individuals Involved in Your Care or Payment for Your Care. We may release health information about you to a family member or friend who is involved in your medical care. We also may give information about you to someone who helps pay for your care. If you do not specifically inform us of individuals who are to be excluded from involvement in your care or payment for your care, we will assume that we have your permission to release health information about you to family and friends as provided above. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort (such as the Red Cross) so that your family can be notified about your condition, status, and location

Business Associates. We provide some services through contracts with business associates, such as accountants, consultants, and attorneys. When such services are contracted, we may disclose health information about you to our business associates so that they can perform the tasks that we have assigned to them. To protect your health information, we require the business associate to appropriately safeguard health information about you.

Appointment Reminders. We may use health information about you to provide appointment or prescription reminders.

Alternative Treatments. We may use health information about you to provide you with information about alternative treatments or other health-related benefits and services that may be of interest to you.

Future Communications. We may communicate with you via newsletters, mailings, or other means regarding treatment options, health-related information, disease-management programs, wellness programs, or other community-based initiatives or activities in which we are participating.

Required by Law. We may use and disclose health information about you as required by federal, state, or local law. For example, we may disclose health information for the following purposes:

- for judicial or administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect, or domestic violence; and
- to assist law enforcement officials in their law enforcement duties.

***Public Health*:** We may use or disclose health information about you for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Research. We may use or disclose health information about you for research purposes under certain circumstances. For example, we may disclose health information about you to a research organization if an institutional review board or privacy board has reviewed and approved the research proposal, after establishing protocols to ensure the privacy of your health information.

Health and Safety. We may use or disclose health information about you to avert a serious threat to your health or safety or any other person pursuant to applicable law.

Medical Examiners and Others. We may use or disclose health information about you to medical examiners, coroners, or funeral directors to allow them to perform their lawful duties. If you are an organ or tissue donor, we may use or disclose health information about you to organizations that help with organ, eye, and tissue donation and transplantation.

Food and Drug Administration (FDA). We may use or disclose health information for purposes of notifying the FDA of adverse events with respect to food, supplements, product, and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacements.

Information Not Personally Identifiable. We may use or disclose health information about you in ways that do not personally identify you or reveal who you are.

Government Functions. We may use or disclose health information about you for specialized government functions, such as protection of public officials, national security and intelligence activities, or reporting to various branches of the armed services.

Workers Compensation. We may use or disclose health information about you to comply with laws and regulations related to workers compensation.

Correctional Institutions. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may use or disclosure health information about you. Such information will be disclosed to the correctional institution or law enforcement official when necessary for the institution to provide you with health care and to protect the health and safety of others.

Affiliated Covered Entity. We are part of an affiliated covered entity with other entities that are under common ownership or control. The affiliated covered entity treats itself as a single entity for purposes of using and disclosing health information about you.

Contact Information

If you have any questions, requests, or concerns about your Omnicare-related health information rights or our use and disclosure of health information, please contact: Chief Privacy Officer, Omnicare, Inc., 1600 RiverCenter II, 100 East RiverCenter Blvd., Covington, Kentucky 41011

Toll Free Phone: 1-(888) 536-1503. *Prepared for Omnicare's patients, effective April 14, 2003*

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Inability to Obtain Acknowledgement: If the patient refuses to sign this form or it is otherwise not possible to obtain an acknowledgement of receipt of the Notice of Privacy Practices, please identify the good faith efforts made to obtain the patient's acknowledgement and the reasons why the acknowledgement was not obtained:

❑ Patient/representative refused to sign. ❑ Patient/representative unable to sign Acknowledgement.

❑ Other (*explain*): _____

_____ _____

Signature (*person who attempted to obtain acknowledgement*) Date

_____

Patient Name (*print*) Organization

For Omnicare Use Only: ❑ Entered into computer. ❑ Processed for filing.

PLEASE FAX : <u>The correct side</u> of this document to your Omnicare products or service provider Immediately

VANDERHEYDEN

Giving new life to youth, adults and families

Name of Individual: _____

PHOTO AUTHORIZATION

I hereby grant permission for use of any photograph or videography of my child to appear in website, public relations brochures, pamphlets, videotapes, booklets, and exhibits complied and used by Vanderheyden. The identity of my child will not be disclosed but he/she may be identified as a resident of Vanderheyden.

☐ **Yes** _____ _____
Parent/Guardian Date

☐ **No** _____ _____
Parent/Guardian Date

Ev 2/21

VANDERHEYDEN

Giving new life to youth, adults and families

Dear Parent/Guardians:

Vanderheyden conducts thorough investigations into significant incidents and allegations of abuse, as required by the New York State Justice Center, Office for Children and Family Services, New York State Education Department, and the Office for People With Developmental Disabilities. Vanderheyden's Quality Assurance Department works closely with representatives of these agencies to ensure all significant incidents and allegations of abuse receive objective and external review.

Individuals in Vanderheyden's care may have knowledge about a situation being investigated as a witness, and Vanderheyden and/or a representative from a state agency may need to conduct an interview with him/her/them to learn that information. Personal Representatives are required to be notified within 24 hours of any significant incident or allegation of abuse in which your individual in care is directly involved. However, you may choose to consent to your individual's participation in interviews when they are identified as a witness without additional notification by signing below:

I, _____ hereby **allow** _____ to participate in interviews with Quality Assurance, Justice Center, or other state agency investigators when they are identified as a potential witness without additional notification.

_____ _____

Signature Date

I, _____hereby **do not allow** _____to participate in interviews with Quality Assurance, Justice Center, or other state agency investigators when they are identified as a potential witness without an additional notification. I am electing to be notified whenever _____ as identified as a potential witness. I understand that every effort will be made to make that notification prior to the interview occurring, however an interview can be scheduled if Vanderheyden has attempted to make a notification and been unsuccessful.

_____ _____

Signature Date

dg
1/2020

Hixny Electronic Data Access Consent Form
Vanderheyden, Inc.

In this Consent Form, you can choose whether to allow Vanderheyden, Inc. to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Vanderheyden, Inc. to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, Vanderheyden, Inc.'s staff involved in my care may see and get access to all of my medical records through Hixny."

If you check the **"I DENY CONSENT"** box below, you are saying "No, Vanderheyden, Inc. may not be given access to my medical records through Hixny for any purpose."

Hixny is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services.

Please carefully read the information on both pages of this form before making your decision.
You have two choices:

- ☐ **I GIVE CONSENT for Vanderheyden, Inc. to access ALL of** my medical records through Hixny in connection with providing me any health care services, including emergency care.

- ☐ **I DENY CONSENT for Vanderheyden, Inc. to access** my medical records through Hixny for any purpose, *even in a medical emergency*. Unless you check this box, New York State law allows medical providers treating you in an emergency to get access to your medical records, including records that are available through Hixny.

_____ _____ _____

Print Name of Patient | Date of Birth | Date

_____ _____

Signature of Patient or Patient's Legal Representative | Print Name of Legal Representative (if applicable)

_____

Relationship of Legal Representative to Patient (if applicable)

Details about patient information in Hixny and the consent process:

How Your Information Will Be Used

Your electronic health information will be used by Vanderheyden, Inc. only to:

- Provide you with medical treatment and related services
- Check whether you have health insurance and what it covers
- Evaluate and improve the quality of medical care

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

What Types of Information About You Are Included

If you give consent, Vanderheyden, Inc. may access ALL of your electronic health information available through Hixny. This includes information created before and after the date of this Consent Form. 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 relate to sensitive health conditions, including but not limited to:

- Alcohol or drug use problems*
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

***If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, such as medications and dosages, lab test results, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social support, and health insurance claims history.**

Where Health Information About You Comes From

Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Hixny. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

Who May Access Information About You, If You Give Consent

Only these people may access information about you: doctors and other health care providers who serve on Vanderheyden, Inc.'s medical staff who are involved in your medical care; health care providers who are covering or on call for Vanderheyden, Inc.'s doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

Penalties for Improper Access to or Use of Your Information

There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Vanderheyden, Inc. at: 518-283-6500; or call Hixny at (518) 640-0021; or call the NYS Department of Health at 518-474-4987.

Re-disclosure of Information

Any electronic health information about you may be re-disclosed by Vanderheyden, Inc. to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Hixny and persons who access this information through the Hixny must comply with these requirements.

Effective Period

This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

Withdrawing Your Consent

You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Vanderheyden, Inc.. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 640-0021.

NOTE: Organizations that access your health information through Hixny while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

Copy of Form - You are entitled to get a copy of this Consent Form after you sign it**.**

Withdrawal of Consent
Vanderheyden, Inc.

I have previously signed a Patient Consent Form that granted Vanderheyden, Inc. access to my medical information through Healthcare Information Xchange of New York ("Hixny"). At this time, I no longer want Vanderheyden, Inc. to have access to my medical information through Hixny.

1. This Withdrawal of Consent applies to Vanderheyden, Inc. only. I understand that if I wish to withdraw my consent granting other Hixny organizations that participate in my treatment access to my medical information, I must do so by contacting these other Hixny Participants directly.

2. I understand that, by checking the box below, I am denying Vanderheyden, Inc. the right to access my medical information:
   - ☐ **I do not wish my medical information to be available to Vanderheyden, Inc.**

3. I understand that this Withdrawal of Consent will not affect or undo any exchange of my medical information that occurred while my original consent was in effect.

4. I understand that my withdrawal of consent for Vanderheyden, Inc. does not affect any consent(s) that I may have previously given to other Hixny Participant(s). These will remain in effect until I specifically withdraw them by contacting these other Hixny Participants directly.

5. I understand that it may take several days to process this Withdrawal of Consent.

6. I understand that no Hixny Participant can deny me medical care as a result of this Withdrawal of Consent. I also understand that my health insurance eligibility cannot be affected by this Withdrawal of Consent.

_____	_____
Print Name of Patient	Patient's Date of Birth
_____	_____
Signature of Patient/Patient's Representative (if patient is unable to sign)	Date
_____	_____
Print Name of Patient's Representative	Relationship of Patient's Representative