Bassett Healthcare Network
School-Based Health

Initial Enrollment

Dear Parent / Guardian:

Bassett Healthcare Network and your school district have partnered to provide health care to the students in your community through an innovative health care delivery clinic known as a School-Based Health Center (SBHC). The SBHC provides primary and preventive medical and mental health care and preventive dental services to students enrolled in the program, right in the school. Please see the enclosed folder for service details

The Bassett School-Based Health Program is going through the process of applying for status as an NCQA-qualified Patient-Centered Medical Home (PCMH), and as we go through this process we are working to expand our services and availability to ensure that we provide high quality, value-based and comprehensive medical care to all of our patients. SBHC services are available when school is in session and many days during the summer. During normal work hours when school is not in session, you may call 844-ALL-SBHC for assistance; both a medical and mental health worker will be available to assist you.

The School-Based Health Center will bill students' health insurance for all services provided, including physical examinations. We stress that no family will ever have to pay out of pocket for any service provided at the SBHC. We recommend that you become familiar with your child's health coverage, especially regarding physical exams. If you do not have health insurance or your health insurance does not cover SBHC visits, there will be no charge. If you do not have health insurance for your children, we can connect you with someone who can assist you with receiving free or low cost health insurance.

If you should receive a statement from your child's health insurance that you do not understand or if you inadvertently receive a SBHC bill from Bassett Healthcare, please contact your SBHC office or 1-844-ALL SBHC immediately.

In order for the SBHC to provide optimal care and to receive insurance funds to help sustain its operations, it is important that we have current information on your child's health and his/her current health insurance. We kindly ask that you complete the enclosed forms:

- **Student Information Form**
- **Consent to Bill Insurance**
- **Initial Health History Form**
- **Notice of Privacy Practices**
- **Immunization Consent**

Please return these forms to the SBHC office in the enclosed white envelope. Please contact a member of the SBHC team if you have any questions.

We suggest that you periodically check our website www.bassett.org/wc/sbhc.cfm for updates and new information. We will also be including information about the SBHC on your school's website.

Thank you for your help. We look forward to an exciting, healthy year.

Sincerely,

Chris Kjolhede, MD, MPH
Co-Director, School-Based Health

Kerri LeBlanc, MD
Co-Director, School-Based Health

8661 12/07;10/08;3/10;6/11;8/14;9/15;2/16;8/16 (f\forms\sbhc\.doc)

Bassett Healthcare Network
School-Based Health

INITIAL ENROLLMENT FORM

Please complete and return to the School-Based Health Center in the provided envelope.

Student Information

Student's Name: Date of Birth: / / ☐ M ☐ F ☐ Other_____

Preferred Name: Student Email:

Home Phone #: Student's Cell #: Social Security #:

Address:

City: Zip: County: Religious Preference:

Student's Mother's Maiden Name:

Primary Care Provider/Address

Pharmacy/Address:

Name of School District: Grade:

Parent/Guardian Information

Parent/Guardian Name: _____ DOB_____ ☐ Mom ☐ Dad ☐ Guardian	Parent/Guardian Name: _____ DOB_____ ☐ Mom ☐ Dad ☐ Guardian
Home #:	Home #:
Work #	Work #
Cell #:	Cell #:
Address (If different than student):	Address (If different than student):
E-Mail:	E-Mail:

Emergency Contact (other than parent/guardian)

Name: Relationship to Student:

Home #: Cell # Work #:

Address:

Health Insurance Information

Does the student have Health Insurance? ☐ Y ☐ N

If yes, please continue. If no, would you like help getting health insurance? ☐Y ☐N

PLEASE SEND A COPY OF YOUR INSURANCE CARD, BOTH FRONT AND BACK (or stop in and we'll make a copy for you)

Insurance Name: Is this Child Health Plus? ☐ Y ☐ N

Policy #: Group #: Effective Date:
If there is a two-digit # next to student's name please provide after policy #.

Policy Holder's Name: DOB: SSN:

Employer of Policy Holder: Relationship to Student:

Copay Amounts: **(SBHC does not collect copays)**

Medicaid #: Access #: Seq #:

Effective Date:

ENROLLMENT.SBHC

Bassett Healthcare Network
School-Based Health

Student's Legal Name: DOB:

Dental Enrollment

Please check all that apply:

☐ No SBHC dental services are requested at this time. My child receives **yearly** dental care.

☐ Yes I would like my child to receive preventative dental care at SBHC.

Date of last dental cleaning: MM _____ DD _____ YR _____ need to be 6 months apart for Insurance Purposes

Dentist Name/Address/Phone: _____

Allergies: _____

If Yes, please sign below:

I give permission for School-Based Health to evaluate my child's teeth at school and if appropriate, provide preventative dental services (cleanings, fluoride treatment, sealants). I also give permission for the School-Based Medical Staff to apply fluoride varnish to my child's teeth.

Parent/Guardian Signature: _____ **Date:** _____

If you would like to be present for the dental visit please call your SBHC or 1-844-255-7242

DENTAL INSURANCE

Dental insurance coverage varies. Most plans will allow for only one cleaning (prophylaxis**) every six months**. Please become familiar with your child's dental insurance coverage in order to avoid confusion with benefit payments.

Please copy both sides of insurance card and send with this form.

☐ We **do not** have **dental** insurance

Insurance Company: _____ Is this Child Health Plus ☐ Yes ☐ No

Phone # of Company: _____ Effective Date: _____

Insurance Co. Address: _____

_____

Subscriber ID #: _____ Group #: _____

If there is a two digit # next to student's name please provide after ID # _____

Legal Name of Policy Holder: _____ Date of Birth ____/____/_____

Social Security # of Policy Holder ___ ___ ___- ___ ___ -___ ___ ___ ___

Policy Holder's Mailing Address: _____

_____ Phone # _____

Employer of Policy Holder: _____ Policy Holder's Relationship to child: _____

Does your child have more than one Health Insurance Plan? ☐ Yes ☐ No (If yes please copy card or contact SBHC)

Medicaid ID# ☐☐ ☐☐☐☐☐☐☐ Access # _____ Seq# _____

For office use only: last SBHC cleaning date: ___/___/___ Entered into Dentrix ☐

New to SBHC Dental ☐ Care Team Entered ☐

ENROLLMENT SBHC

INITIAL ENROLLMENT FORM

Please complete and return to the School-Based Health Center in the provided envelope.

Student's **Legal** Name: _____ Date of Birth: ___/___/___ Sex: M / F / O Grade: _____

I give consent for my child to receive oral /health care services including telemedicine. I understand that every effort will be made to contact me prior to any treatment that requires parental consent according to New York State law. New York State law does not require parental consent for treatment or advice about drug abuse, alcoholism, sexually transmitted disease, reproductive health or mental health issues.

I WILL NOTIFY THE SCHOOL-BASED HEALTH CENTER IN WRITING IF I WISH TO REMOVE MY CHILD FROM THE HEALTH PROGRAM.

In order to provide optimal health care to your child, it is necessary for the School-Based Health Center staff and school nurse to regularly communicate and share medical and health related information. I hereby authorize the release of information from the School-Based Health Center to the school nurse and the school nurse to the School-Based Health Center. I understand that the information to be released is confidential and protected from re-disclosure. It will not be released except to the School-Based Health Center or school nurse without a completed authorization to do so. It may also be necessary, if your child is receiving services from a SBHC Mental Health clinician, for information to be discussed with other clinicians in the SBH mental health program as part of the case supervisory process. I understand that any shared information is confidential and protected from re-disclosure.

X _____ Date: ____/____/____
Parent/Guardian Signature

☐ I would like fluoride varnish applied if necessary. Initial _____

Please be sure to read and sign the authorization below.

***Authorization to release information*:** I hereby authorize and direct The Mary Imogene Bassett Hospital, A.O. Fox Hospital, O'Connor Hospital, Cobleskill Regional Hospital, Little Falls Hospital, A.O. Fox Tri-Town Campus and Bassett Medical Group to release to government agencies, insurance carriers, managed care companies or others who are financially liable for my hospitalization and medical care and their authorized agents all information needed to substantiate payment for this hospitalization and medical care and to permit representatives thereof to examine and request copies of records to this care and treatment. This authorization includes information such as psychological or psychiatric impairments, drug use and/or alcoholism, information indicating HIV-related test, HIV infection, HIV related illness, AIDS or any information which would indicate potential exposure to HIV and any information related to or regarding genetic testing. I further authorize the Mary Imogene Bassett Hospital, A.O. Fox Hospital, O'Connor Hospital, Cobleskill Regional Hospital, Little Falls Hospital, A.O. Fox Tri-Town Campus and Bassett Medical Group to release billing information to any provider involved in my care.

***Assignment of Insurance Benefits*:** I hereby assign and transfer to The Mary Imogene Bassett Hospital, A.O. Fox Hospital, O'Connor Hospital, Cobleskill Regional Hospital, Little Falls Hospital, A.O. Fox Tri-Town Campus, and Bassett Medical Group sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care to cover costs of the care and treatment rendered to myself or my dependent.

X _____ _____ _____
Signature of Parent/Guardian Date Time

ENROLLMENT SBHC

MR # DOB

NAME

* 3 4 9 7 *

BASSETT HEALTHCARE NETWORK
SCHOOL-BASED HEALTH CENTER

INITIAL HEALTH/DENTAL HISTORY

H-3497 12/02;3/04;3/06;4/08;10/08;9/15;10/16;5/18 (d:\forms\hosp\.ofm)

DATE

SBHC: _____

Child's Name: _____ Date of Birth: _____

Existing Medical Diagnoses (if applicable): _____

Do you have any additional health concerns about your child (dental, emotional, physical)? ☐ Yes ☐ No If Yes, please explain: _____

_____

Does your child have any allergies (food, medication, environmental, latex, pine nuts)?

Allergy: _____ **Reaction:** _____

_____

_____

Current medications (include vitamins, fluoride, supplements)

1. _____
2. _____
3. _____
4. _____

Please list any specialist your child sees (Physician Specialist, Counselor or Speech, Physical or Occupational Therapist)

_____

_____

_____

Name /address of primary care provider: _____

Date of last physical examination: _____ By whom: _____

List hospitalizations, serious illnesses, accidents, broken bones, surgeries, etc.

Date	Child's Age	Details

_____

_____

_____

Social History: Do you have any concerns (behavioral, emotional, or otherwise) about this child? If yes please elaborate.

_____

_____

_____

Where does your child go after school? _____

What does your child do in his/her spare time (hobbies/sports)? _____

How many hours a day does your child watch TV/computer? _____

Indicate any financial, interpersonal, or family problems you are worried about: _____

_____

Any history of sexual/physical/emotional abuse? (Please describe) _____

_____

How is he/she doing in school? _____

Does he/she have good friends? _____

HEALTH MAINTENANCE SBHC

CONTINUED ON BACK

Who else lives at your child's home?

	Name	Age	Healthy?
Mother			
Father			
Siblings			
Others			

Relationship	Name	Living? Y/N	No Known Problems	Alcohol Abuse	Arthritis	Asthma	Autism	Autoimmune Disorder	Clotting Ddisorder	Cancer	COPD	Depression	Diabetes	Drug abuse	Heart disease	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Stroke	Inflamatory Bowel Disease	Psoriasis	Thyroid Disease	Multiple Sclerosis	Other
Mother																									
Father																									
Sibling (1)																									
Sibling (2)																									
Sibling (3)																									
Sibling (4)																									
Mat. Gma																									
Mat. Gpa																									
Pat. Gma																									
Pat. Gpa																									
Cousin																									
Aunt																									
Uncle																									
Other																									

Mat. Gma = Maternal Grandmother
Mat. Gpa = Maternal Grandfather
Pat. Gma = Paternal Grandmother
Pat. Gpa = Paternal Grandfather

BASSETT HEALTHCARE NETWORK
SCHOOL-BASED HEALTH

PATIENT SELF REPORTING SURVEY

Dear Parent/Guardian
Asking about ethnicity, race and language is part of our organization's efforts to ensure quality care. Also, it is part of new healthcare initiatives. This information will be confidential and it will never be used to deny you care.

Please review the definitions and select your appropriate response.

1. ETHNICITY:

☐ **Hispanic or Latino.** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."

- ☐ Andalusian
- ☐ Argentinean
- ☐ Asturian
- ☐ Belearic Islander
- ☐ Bolivian
- ☐ Canal Zone
- ☐ Canarian
- ☐ Castillian
- ☐ Catalonian
- ☐ Central American
- ☐ Central American Indian
- ☐ Chicano
- ☐ Chilean
- ☐ Colombian
- ☐ Costa Rican
- ☐ Criollo
- ☐ Cuban
- ☐ Dominican
- ☐ Ecuadorian
- ☐ Gallego
- ☐ Guatemalan
- ☐ Honduran
- ☐ La Raza
- ☐ Latin American
- ☐ Mexican
- ☐ Mexican American
- ☐ Mexican American Indian
- ☐ Mexicano
- ☐ Nicaraguan
- ☐ Panamanian
- ☐ Paraguayan
- ☐ Peruvian
- ☐ Puerto Rican
- ☐ Salvadoran
- ☐ Spaniard
- ☐ Spanish Basque
- ☐ South American
- ☐ South American Indian
- ☐ Uruguayan
- ☐ Valencian
- ☐ Venezuelan

☐ **Non-Hispanic or Non-Latino.**

Turn Page Over

2. RACE:

☐ **American Indian or Alaska Native.** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

☐ **Asian.** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including.

- ☐ Asian Indian
- ☐ Bangladeshi
- ☐ Bhutanese
- ☐ Burmese
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Indonesian
- ☐ Iwo Jiman
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Madagascar
- ☐ Malaysian
- ☐ Maldivian
- ☐ Nepalese
- ☐ Okinawan
- ☐ Pakistani
- ☐ Singaporean
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Thai
- ☐ Vietnamese

☐ **Black or African American.** A person having origins in any of the black racial groups of Africa.

☐ **Native Hawaiian or Other Pacific Islander.** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

- ☐ Carolinian
- ☐ Chamorro
- ☐ Chuukese
- ☐ Fijian
- ☐ Guamanian
- ☐ Guamanian or Chamorro
- ☐ Kiribati
- ☐ Kosraean
- ☐ Mariana Islander
- ☐ Marshallese
- ☐ Melanesian
- ☐ Micronesian
- ☐ Native Hawaiian
- ☐ New Hebrides
- ☐ Palauan
- ☐ Papua New Guinean
- ☐ Pohnpeian
- ☐ Polynesian
- ☐ Saipanese
- ☐ Samoan
- ☐ Solomon Islander
- ☐ Tahitian
- ☐ Tokelauan
- ☐ Tongan
- ☐ Yapese
- ☐ Other Pacific Islander

☐ **White.** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

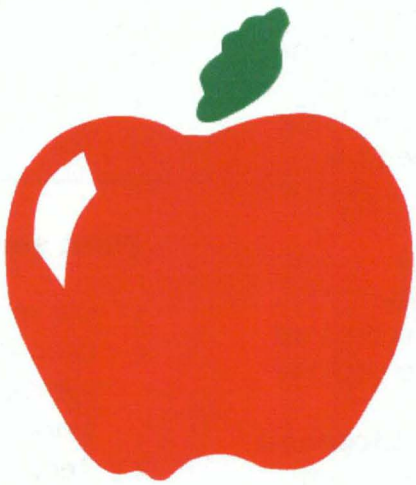
☐ **Other**

3. PATIENT LANGUAGE:

Please indicate your preferred language (i.e. English):_____

Thank you

Bassett Healthcare Network
School-Based Health



Enrollment Form

What is a Bassett Healthcare Network School-Based Health Center (SBHC)?

A Bassett Healthcare Network SBHC is a health care office in the school building. It is a partnership between a school district and the Mary Imogene Bassett Hospital. A SBHC provides comprehensive health care services to students in pre-kindergarten through 12th grade at the school. The SBHC can become your child's main health care provider, and is able to take care of all primary healthcare needs, even when school is not in session. For children with a primary care provider the SBHC can work with them in your child's care.

Who is the School-Based Center Staff?

- A **Nurse Practitioner (NP)/ Physician Assistant (PA)** will be on site to diagnose and treat illnesses, prescribe medications and coordinate care. The **NP/PA** will work with a Bassett Healthcare Network **Pediatrician**.
- A Bassett Healthcare Network **Physician** will be available for consultation as needed and will be on site at the school regularly to provide direct patient services.
- A **Registered Nurse (RN)**, **Licensed Practical Nurse (LPN)** assists with healthcare.
- An **Ambulatory Office Assistant (AOA)** will provide support to the program along with assisting families.
- A **Licensed Clinical Social Worker (LCSW)** is available to provide individual and group mental health counseling. The **LCSW** is available for parent and family consultations and can provide evaluation of students as needed.
- A **Dental Hygienist (RDH)** is available to provide preventative dental services, referrals and individual and classroom oral health education.
- A **Dentist** provides dental care at limited sites.
- A **Dietician** provides nutrition counseling and coaching; travels among all sites.

How does a student receive services?

To receive services, the parent must complete the Student Information Form and the Consent to Bill Insurance Form. After that, the enrollment must be updated each year. Students who do not have a completed SBHC enrollment on file will not be able to use the SBHC. Enrollment in the SBHC is voluntary and can be completed at any time. There is no eligibility requirements except to be a student enrolled in the School.

A parent may call their child's school nurse or the SBHC staff or send a note to arrange for the child to be seen at the SBHC. Parents are welcome to accompany their children to the SBHC. If a child is too ill to attend school and the parent would like him/her to be seen by the SBHC staff, parents may call the school nurse or the SBHC to arrange for a same day appointment.

What services are provided?

- Complete Physical Examinations (may be used for NYS mandated school physicals, sports physicals, camp/college physical, working papers)
- Recommended Health Screenings
- Comprehensive Health Care Including Diagnosis and Treatment of Acute and Chronic Illness.
- Reproductive Health Care
- Health Education
- Referral Services
- HIV Testing (offered to all patients 13 years of age or older per New York State Department of Health Law)
- Preventative dental services and referrals
- First Aid
- Immunizations
- Mental health screening, consultation and referrals
- Counseling/psychotherapy services
- Child Health Plus information and enrollment assistance

How do I find insurance for my child?

New York State has a health insurance plan for kids, NY State of Health Marketplace (Affordable Care Act) www.nystateofhealth.ny.gov. The Marketplace will then direct you to Child Health Plus if the qualifying guidelines are met. You may also call your SBHC; they can direct you to a Certified Application Counselor for assistance.

Are school nurse services still available?
Yes, the school nurse will continue to provide all students with the same services they had in the past regardless of the student's enrollment in the SBHC.

Who has access to my child's medical records? All medical records are confidential, as they are part of the Bassett Healthcare Network electronic medical records system. In order to provide quality, comprehensive healthcare to the students enrolled, the SBHC staff would be happy to send a copy of your child's medical visits to her/his primary care health provider. Before any records are sent, a parent must sign the Student Information Form. My Bassett is a secure online health connection that allows you to see information from your electronic medical record. Please review the pamphlet enclosed.

If you have questions about the SBHC, feel free to call the SBHC office for further information or check our website at www.bassett.org/general/locations/school-based-health-centers/ Remember, there will never be any out-of-pocket expenses to any family for SBHC services provided on site.

Should you receive a bill for these services, please contact the SBHC office immediately. If you receive a check directly from your insurance company for services provided at the SBHC, you should deposit the check and send a personal check, made payable to MIBH, to your child's SBHC.

We look forward to working with you to assure that your child is receiving the best health care possible.

What does it cost to use the SBHC?
There will never be any out-of-pocket expenses for SBHC services. The SBHC program will bill the student's health insurance for services provided on site at the SBHC. If the student does not have health insurance, there will be no charge to the student's family for the health services provided. Billing services are provided through Bassett Healthcare Network.

- **It is important to note that the cost of services provided outside of the SBHC, such as laboratory tests, X-rays, specialty consultations and prescriptions are the responsibility of the parent.**

- **We recommend that you become familiar with your child's health insurance coverage.**

What is Telemedicine? Telemedicine allows your child to receive care even when the clinician is in another location. Using secure teleconferencing computers and cameras, our doctors can conduct a visit as though they were in the clinic. (Not all visits are appropriate for telemed)

What happens when my child is ill and the school is closed?

The SBHC will be open on days school is in session for onsite services. When the school is closed, but it is a normal work day, on-call services will be available to answer questions, renew prescriptions, and to provide guidance. They can be contacted by calling the SBHC toll-free number **1-844-255-7242**. The SBHC is open during the summer for a limited number of days. When the SBHC is not open, Bassett Healthcare Network is the back-up health care facility. If the school is closed and your child needs emergency treatment, call 911. If your child's need is not a medical emergency and it is a work holiday, call the Bassett Healthcare Network at 1-800-BASSETT (1-800-227-7388) or your outside healthcare provider.

For more details of SBHC services:

1-844-255-7242

www.bassett.org/general/locations/school-based-health-centers/

Where Are SBHC Centers Located

Cooperstown Central School –Elementary 607-547-5069

Cooperstown Central School – Middle/High School 607-547-1105

Delaware Academy 607-746-7454

Edmeston Central School 607-965-6930

Laurens Central School 607-432-2050 ext. 1300

Middleburgh Central School--Elementary 518-827-3793

Middleburgh Central School—High School 518-827-3706

Milford Central School 607-286-7909

Morris Central School 607-263-2619

Richfield Springs Central School 315-574-3015

Schenevus Central School 607-638-5402

Sherburne-Earlville Central School – Elementary 607-674-8417

Sherburne-Earlville Central School-Middle/High School 607-674-8416

Sidney Central School Elementary/Middle School 607-561-7795

Sidney Central School High School 607-561-7796

South Kortright Central School 607-538-1932

Stamford Central School 607-652-2065

Unadilla Valley Central School 607-847-6050

Worcester Central School 607-397-1013

Bassett Healthcare Network
School-Based Health

One Atwell Road
Cooperstown, NY 13326
1-844-255-7242 · 1-800-BASSETT
www.bassett.org

Bassett Healthcare Network

NOTICE OF PRIVACY PRACTICES

Effective Date: July 2017

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.

OUR COMMITMENT TO PRIVACY

You have entrusted Bassett Healthcare Network with the responsibility of providing health care for you and your family. We are dedicated to maintaining your trust. We know that the privacy of your medical information is important to you. That's why we take our responsibility to protect the privacy of your medical information very seriously.

This privacy notice describes how we protect your privacy as we provide coverage and services to you. It describes the medical information we collect about our patients, how we use it, and with whom we share it. This notice also explains your rights and certain obligations we have regarding the use and disclosure of your medical information.

This notice applies to services provided at any of the Bassett Healthcare Network hospitals, outpatient departments, health centers, specialty clinics, school based clinics, retail facilities, and convenient care centers. A complete list of affiliated covered entities can be found at http://www.bassett.org; if you do not have access to a computer, then you may call our Privacy Office at (607)547-7900 to request a complete list of affiliated entities. All of these entities, sites and locations may share your medical information for treatment, payment or healthcare operations, as described in this Notice and by law. We are required by law to make sure that medical information that identifies you is kept private, give you this notice of our legal duties and privacy practices concerning your medical information, and follow the terms of the notice that is currently in effect.

COMPLAINTS

If you have any questions about this Notice of Privacy Practices, or questions or complaints about the handling of your medical information, you may contact the Information Privacy Office, in writing or call to submit a report to our Privacy Office. You may also send a written complaint to the Secretary of the United States Department of Health and Human Services. You will not be penalized for filing a complaint.

Bassett Healthcare Network
Privacy Office
One Atwell Road
Cooperstown, NY 13326
1-800-BASSETT
1-800-227-7388

CHANGES TO OUR NOTICE OF PRIVACY PRACTICES

We may change our Notice of Privacy Practices from time to time. The changes will apply to all medical information about you that we have at the time of the change, and to all medical information about you that we keep in the future. Generally, the changes will take effect when they appear in a revised Notice of Privacy Practices. A copy of our current Notice will be posted in our facilities and be available to all patients. Also, a copy can be obtained on our website at www.bassett.org/privacy.

OUR USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Each time you receive services from a hospital, physician or other health care provider, a record of your encounter is made. Typically this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information is often referred to as your health or medical record. This information, linked with your name or other identifying information is used in many ways such as providing care, obtaining payment for your care and running our business. Disclosures of your medical information for purposes described in this Notice may be in writing, orally, electronically, or by facsimile.

As permitted by Health Insurance Portability and Accountability Act of 1996 (HIPAA) and New York State law, we may use or disclose your medical information for several purposes. Here are some examples of how we may use or disclose your medical information. Except as listed below and as permitted by law, we will not use or disclose your medical information without your written authorization. If you give us written authorization, you can cancel that authorization except for uses and disclosures already made based on your authorization.

Treatment: We may use your medical information to provide you with medical care in our facilities or in your home. We also may share your medical information with others who provide care to you, such as hospitals, nursing homes, doctors, nurses, physician assistants, medical and nursing students, therapists, technicians, emergency service and transportation providers, medical equipment providers, pharmacies, and others involved in your care. For example different hospital departments may share your medical information to coordinate your prescriptions, laboratory, x-rays and other medical needs.

Payment: We may use and disclose your medical information as needed to get paid for the medical care that we provide to you or to assist others who care for you to get paid for that care. For example, we may share your medical information with a billing company or with your health insurance plan to obtain prior approval for your care or to make sure your plan will cover your care.

Health Care Operations: We may use or disclose your medical information for our quality assurance activities and as needed to run our health care facilities. We also may use or disclose your medical information to get legal, auditing, accounting and other services and for teaching, business management and planning purposes. We may use your medical information in combination with other patients' medical information to compare our efforts and to learn where we can improve our care and services. We may disclose your information to businesses and individuals (e.g., medical transcription service) who perform services for us involving medical information as long as they agree to protect the privacy of that information.

Media Condition Reports: We may release your medical information for an update to the media if the media requests information about you using your full name. The following information may be disclosed: your condition described in general terms such as "good", "fair", "serious", or "critical". You have the right to request that this information not be released.

Marketing/Appointment reminders/Information about treatment alternatives/Psychotherapy notes: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Most uses or disclosures of psychotherapy notes (when appropriate), uses and disclosures for marketing purposes, and disclosures that constitute a sale of protected health information require your authorization. You have the right to opt out of receiving marketing communications. If you wish to do so, contact the Information Privacy Office at 607-547-7900.

On-Site Contacts: While in our facilities, we may need to contact you by overhead page or ask you to write your name on a sign-in sheet. In these instances, we take reasonable precautions to protect your privacy.

Directory: Unless you notify us that you object, we may use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, a personal representative, or another person responsible for your care, location and general condition.

Communication with family: Unless you object, we, as health professionals, using our best judgment, may disclose to a family member, another relative, a close personal friend, or any other person that you identify, health information relevant to that person's involvement in your care or payment related to your care. We may disclose information about you to disaster relief authorities so that your family can be notified of your location and condition.

Fundraising: We may contact you as a part of a fundraising effort. You have the right to request not to receive subsequent fundraising materials by notifying our Friends of Bassett Office at 607-547-3928 or by email at Friends.office@bassett.org.

Research: Unless you object, we may use portions of your medical information for research purposes, without your authorization. This might include reviewing medical information in preparation for conducting research (e.g., to help identify a group with specific medical conditions to aid in finding a cure). Medical information used in preparation for conducting research will not leave the institution. Research projects must be cleared through a special approval process before any medical information is made available to the researchers. Researchers will be required to protect the medical information they receive. The established methods for the consent process for all research proposals are subject to the oversight of Bassett's Institutional Review Board (IRB).

Opt Out Options: We may use your medical information when conducting research projects, fundraising events and marketing campaigns, as noted above. We ask that you aid us in our efforts, while being confident that we are protecting your medical information and only using the minimum necessary to carry out these activities. If you do not wish to have us use your medical information for these activities, you may request to "opt-out" by writing to the Privacy Office, Bassett Healthcare, One Atwell Road, Cooperstown, NY 13326.

DISCLOSURES AS REQUIRED BY LAW OR TO ASSIST IN LAW ENFORCEMENT

Organ and tissue donation and transplant reports: We may release medical information as required by regulatory organizations as necessary to facilitate organ and tissue donation and transplant.

Funeral Directors: We may release medical information to funeral directors consistent with applicable law to enable them to carry out their duties.

Workers compensation or other rehabilitative activities reporting: We may release medical information as required by law to insurers to provide benefits for work-related or victim injuries or illnesses.

Community/public health activities and reports: As required by law, we may disclose your health information to public health or legal authorities charge with preventing or controlling disease, injury, disability, abuse or neglect, and health and vital statistics.

Administrative oversight: We may disclose health information to health oversight agencies and/or public health authorities such as the Department of Health for activities such as audits, investigations, licensure, or determining cause of death.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Correctional Institution: If you are an inmate of a correctional institution, or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

YOUR INDIVIDUAL RIGHTS

Access and Copies: In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. We will process your request based on NYS Patient Access Law within 10 days of receipt of your request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies as permitted by law. If we deny your request to review or obtain a copy of your medical information, you may submit a written request for a review of that decision. If your medical information is maintained by us in electronic format, you have the right to receive a copy of your medical information in an electronic form and format requested by you, if it is readily producible, or if not, in a readable electronic form or format agreed to by you and us. You will be charged a reasonable cost-based fee to create and copy the electronic medical information.

Amendments: If you believe that information in your record is incorrect or that information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reasons for requesting the amendment. We may deny your request to amend a record if the information was not created by us, if our information is complete and accurate, is not part of the medical information kept by or for the hospital or is not part of the information that you would be permitted to inspect and copy under certain circumstances.

Disclosure List: You have the right to obtain a list of non-routine disclosures of your medical information (those other than for treatment, payment and health care operations) that we made without your authorization. You may submit a written request for a time period up to six years from the date of disclosure. Your first request in a 12-month period is free. After that, we may charge for additional requests.

Notification: You will be notified following a breach of your unsecured medical information.

Confidentiality: You have the right to request that your medical information be shared with you in a confidential manner, such as at home rather than at work by notifying us in writing of the specific way or location for us to use to communicate with you.

Restrictions: You have the right to request that we restrict disclosure of your medical information to a health plan if disclosure is for payment or healthcare operations and pertains to a health care item or service for which you or someone on your behalf paid for in full. You may submit a written request to restrict how we use or disclose medical information about you. We will send you a written response informing you about our ability to honor your request.

Who to Contact: To exercise any of the rights described above, please send a written request to our Privacy Office at One Atwell Road, Cooperstown, NY 13326 or by downloading and completing the coordinating form located on www.bassett.org/privacy. If you do not have access to a computer then you may call our Privacy Office at 1-607-547-7900 and request a form be mailed to you. Completed forms can be mailed to our address above, or faxed to 607-547-6949.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required or allowed by law. Other uses and disclosures not described in this notice will be made only with your written authorization.

AFFIX PT LABEL

I acknowledge receipt of the Bassett Healthcare Network Notice of Privacy Practices:

Name (Print): _____

Date of Birth: _____

Address: _____

City, State, Zip: _____

Signature: _____

Please tear off and mail to: Privacy Office • Bassett Healthcare Network • One Atwell Road • Cooperstown, NY 13326

NOTICE OF PRIVACY PRACTICES

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