LaSante HEALTH CENTER

672 Parkside Ave, 2nd Floor
Brooklyn, NY 11226

Phone 718.246.5700
Fax 718-889-7132
Email info@lasantehealth.org
Web **lasantehealth.org**
@lasante_health

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name: | First Name: | MI | DOB | SS#

Street Address: | Apt #/ P.O. Box: | City: | State: | ZIP Code:

CONTACT INFORMATION

Primary Phone Number ☐ Home ☐ Cell ☐ Work

Secondary Phone Number ☐ Home ☐ Cell ☐ Work

LaSante may contact me for clinical/appointment reminders by using the following methods (check all that apply):
☐ Email ☐ Text Message (Standard data/messaging rates may apply) ☐ Decline

Email (Please enter n/a if no email, or decline if you choose not to disclose):

Cell phone carrier: ☐ Verizon ☐ iWireless/T-Mobile ☐ US Cellular ☐ AT&T ☐ Other: _____ ☐ Decline

PATIENT DEMOGRAPHICS AND OTHER REQUIRED INFORMATION

This site is a Federally Qualified Health Center (FQHC) which means we receive a federal grant that allows us to provide a discounted fee program to our patients who qualify. We are required to provide certain information to the Bureau of Primary Health Care each year regarding all of our patients. The *only* reason this information is collected is for reporting purposes and we respect that this is personal and confidential information. Your help is very much appreciated.

Please check off all boxes that apply to you (or the patient that is being seen).

Race
☐ White/Caucasian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Black/African American
☐ American Indian/Native Alaskan
☐ Asian
☐ Other: _____

Ethnicity
Do you identify yourself as:
☐ Hispanic or Latino
☐ NOT Hispanic or Latino

Check One
☐ Migrant Worker
☐ Seasonal Worker
☐ Homeless
☐ Not Applicable

Military Status
Are you a Veteran of the U.S. Military?
☐ Yes
☐ No

Living Arrangements Please check one:
☐ Shelter (safe havens, temp overnight housing, armories)
☐ Transitional (center, community, home)
☐ Other (hotel, motel, day-to-day single room occupancy)
☐ Doubling up (living with other people for a temp period and move often)
☐ Street (sidewalk, car, park, doorway, public or abandoned building)
☐ Permanent Residence (own, rent apartment/room/house)

Using the table below, please indicate which column represents your TOTAL family/household income level based on the number of persons included in your household:
(Circle one) A B C D E F

	A	B	C	D	E	F
Family Size	Less than or Equal to	Between	Between	Between	Between	Equal or Greater than
1	12,140	12,141 - 15,175	15,176 - 22,763	22,764 - 39,834	39,835 - 79,669	79,670
2	16,460	16,461 - 20,575	20,576 - 30,863	30,864 - 54,009	54,010 - 108,019	108,020
3	20,780	20,781 - 25,975	25,976 - 38,963	38,964 - 68,184	68,185 - 136,369	136,370
4	25,100	25,101 - 31,375	31,376 - 47,063	47,064 - 82,359	82,360 - 164,719	164,720
5	29,420	29,421 - 36,775	36,776 - 55,163	55,164 - 96,534	96,535 - 193,069	193,070
6	33,740	33,741 - 42,175	42,176 - 63,263	63,264 - 110,709	110,710 - 221,419	221,420
7	38,060	38,061 - 47,575	47,576 - 71,363	71,364 - 124,884	124,885 - 249,769	249,770
8	42,380	42,381 - 52,975	52,976 - 79,463	79,464 - 139,059	139,060 - 278,119	278,120

Primary Language Spoken
☐ English ☐ Hatian Creole
☐ Spanish ☐ French
☐ Arabic ☐ Other: _____

Do you need
☐ An Interpreter
☐ Sign Language
☐ Not Applicable

Gender Identity: Do you think of yourself as:
☐ Male ☐ Female ☐ Female-to-Male/Transgender Male/ Trans Man
☐ Male-to-Female /Transgender Female/ Trans Woman ☐ Genderqueer, neither exclusively male nor female
☐ Other, please specify: _____

Sexual Orientation: Do you think of yourself as:
☐ Straight or Heterosexual ☐ Lesbian, Gay, or Homosexual ☐ Bisexual
☐ Male-to-Female /Transgender Female/ Trans Woman ☐ Genderqueer, neither exclusively male nor female

Employer (Please enter n/a if unemployed, or decline if you choose not to disclose):

Marital Status
☐ Single
☐ Married
☐ Divorced
☐ Widowed

Student
☐ Full-Time
☐ Part-Time
☐ Not a Student

Employment Status
☐ Full-Time
☐ Part-Time
☐ Unemployed
☐ Retired

LaSante HEALTH CENTER

672 Parkside Ave, 2nd Floor
Brooklyn, NY 11226

Phone 718.246.5700
Fax 718-889-7132
Email info@lasantehealth.org
Web **lasantehealth.org**
@lasante_health

GUARANTOR (Person to be billed, check here if same as patient ☐)

Last Name: | First Name: | MI | DOB | SS#

Street Address: | City: | State: | ZIP Code: | Home Phone: | Cell Phone:

MEDICAL INSURANCE

1. Insurance Company: | Policy Holder Name: | Relationship to Patient: | DOB: | M/F: | Employer: | Zip Code:

2. Insurance Company: | Policy Holder Name: | Relationship to Patient: | DOB: | M/F: | Employer: | Zip Code:

PREFERRED PHARMACY

Name: | Street Address: | City: | State: | ZIP Code: | Phone:

EMERGENCY CONTACT

Last Name: | First Name: | Relationship to Patient: | Phone:

HOW DID YOU HEAR ABOUT US?

Check One

- ☐ Family/Friend
- ☐ Doctor/Hospital
- ☐ Insurance Plan
- ☐ Close to home/work
- ☐ Other: _____

CONSENT FOR TREATMENT AT LASANTE HEALTH CENTER:

1. I am aware that the practice of medicine is not an exact science and that LaSante Health Center offers no guarantees concerning any treatments or examinations I may have here.
2. I authorize LaSante Health Center and its employees to use the information contained in my record for proper medical purposes, and for clinical improvement audits with information that would be de-identified.
3. I authorize the medical staff of LaSante Health Center to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess, diagnose and treat the condition for which I am seeking care. I understand that it is the responsibility of the provider to explain to me the reasons for any particular diagnostic examination, test, or procedure, the available treatment options, and the common risks and anticipated burdens and benefits associated with these options.
4. I understand that the services offered at LaSante Health Center include medical care, optometry, podiatry, mental health, behavioral health, nutrition, and dental care.
5. I undertand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by the provider.

PAYMENT OF BENEFITS AND INFORMATION RELEASE:

I request that payment of authorized insurance benefits be made on my behalf to LaSante Health Center for any services furnished to me by LaSante Health Center. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable to related services. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered by LaSante Health Center.

NOTICE OF PRIVACY PRACTICES:

I ackowledge that I have received or been offered a copy of LaSante Health Center's Notice of Privacy Practices.

SIGNATURE:

By signing below, I acknowledge that I have read the above information, that I understand and agree to the above statements, and that I have been afforded the opportunity to have any questions I might have addressed.

_____ _____

Patient/Guardian Signature | Date

LaSante HEALTH CENTER

672 Parkside Ave, 2nd Floor
Brooklyn, NY 11226

Phone 718.246.5700
Fax 718.246.5750
Email info@lasantehealth.org
Web lasantehealth.org

HIPAA JOINT PRIVACY NOTICE

THIS JOINT 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.

INTRODUCTION

This Joint Notice is being provided to you on behalf of LaSante Health Center (the "Center") and the employees and practitioners that work at the Center with respect to services provided at LaSante Health Center (collectively referred to herein as "We" or "Our"). We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." "Protected health information" or "PHI" includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care. We will share protected health information with one another, as necessary, to carry out treatment, payment or health care operations relating to the services to be rendered at the Center facilities.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain. You can always request a written copy of our most current privacy notice from the Center's Privacy Officer at LaSante Health Center or you can access it on our website at 718-246-5700, x2001.

PERMITTED USES AND DISCLOSURES

We can use or disclose your PHI for purposes of *treatment, payment and health care operations*. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

Treatment means the provision, coordination or management of your health care, including consultations between health care providers relating to your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to contact a physical therapist to create the exercise regimen appropriate for your treatment.

- *Payment* means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage and other utilization review activities. For example, we may need to provide PHI to your Third Party Payor to determine whether the proposed course of treatment will be covered or if necessary to obtain payment. Federal or state law may require us to obtain a written release from you prior to disclosing certain specially protected PHI for payment purposes, and we will ask you to sign a release when necessary under applicable law.

- *Health care operations* means the support functions of the Center, related to *treatment* and *payment*, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your PHI to evaluate the performance of our staff when caring for you. We may also combine PHI about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose PHI for review and learning purposes. In addition, we may remove information that identifies you so that others can use the de-identified information to study health care and health care delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may also use your PHI in the following ways:

- To provide appointment reminders for treatment or medical care.

- To tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.

To your family or friends or any other individual identified by you to the extent directly related to such person's involvement in your care or the payment for your care. We may use or disclose your PHI to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or

672 Parkside Ave, 2nd Floor
Brooklyn, NY 11226

Phone 718.246.5700
Fax 718.246.5750
Email info@lasantehealth.org
Web lasantehealth.org

friends is in your best interest, taking into account the circumstances and based upon our professional judgment.

- [We may include certain limited PHI in the Center directory. This may include your name, location at the Center, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they do not ask for you by name. You may request not to be listed in the directory.]

- When permitted by law, we may coordinate our uses and disclosures of PHI with public or private entities authorized by law or by charter to assist in disaster relief efforts.

- We will allow your family and friends to act on your behalf to pick-up filled prescriptions, medical supplies, X-rays, and similar forms of PHI, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

- We may contact you as part of our fundraising and marketing efforts as permitted by applicable law. You have the right to opt out of receiving such fundraising communications.

- We may use or disclose your PHI for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all patients who received a particular medication. All research projects are subject to a special approval process which balances research needs with a patient's need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.

  We will use or disclose PHI about you when required to do so by applicable law. In accordance with applicable law, we may disclose your PHI to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer or LaSante Health Center as required by applicable law.

Note: Incidental uses and disclosures of PHI sometimes occur and are not considered to be a violation of your rights. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

SPECIAL SITUATIONS

Subject to the requirements of applicable law, we will make the following uses and disclosures of your PHI:

- Organ and Tissue Donation. If you are an organ donor, we may release PHI to organizations that handle organ procurement or transplantation as necessary to facilitate organ or tissue donation and transplantation.

- Military and Veterans. If you are a member of the Armed Forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

- Worker's Compensation. We may release PHI about you for programs that provide benefits for work-related injuries or illnesses.

- Public Health Activities. We may disclose PHI about you for public health activities, including disclosures:

  to prevent or control disease, injury or disability;
  to report births and deaths;
  to report child abuse or neglect;
  to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if the patient agrees or when required or authorized by law.

- Health Oversight Activities. We may disclose PHI to federal or state agencies that oversee our activities (e.g., providing health care, seeking payment, and civil rights).

  Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI subject to certain limitations.

- Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

  In response to a court order, warrant, summons or similar process;

LaSante HEALTH CENTER

672 Parkside Ave, 2nd Floor
Brooklyn, NY 11226

Phone 718.246.5700
Fax 718.246.5750
Email info@lasantehealth.org
Web lasantehealth.org

To identify or locate a suspect, fugitive, material witness, or missing person;

About the victim of a crime under certain limited circumstances;

About a death we believe may be the result of criminal conduct;

About criminal conduct on our premises; or

In emergency circumstances, to report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime.

- Coroners, Medical Examiners and Funeral Directors. We may release PHI to a coroner or medical examiner. We may also release PHI about patients to funeral directors as necessary to carry out their duties.

- National Security and Intelligence Activities. We may release PHI about you to authorized federal officials for intelligence, counterintelligence, other national security activities authorized by law or to authorized federal officials so they may provide protection to the President or foreign heads of state.

- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI about you to the correctional institution or law enforcement official.

- This release would be necessary (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

- Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose PHI if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual.

***Note*: HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records and other specially protected health information may enjoy certain special confidentiality protections under applicable state and federal law. Any disclosures of these types of records will be subject to these special protections.**

OTHER USES OF YOUR HEALTH INFORMATION

Certain uses and disclosures of PHI will be made only with your written authorization, including uses and/or disclosures: (a) of psychotherapy notes (where appropriate); (b) for marketing purposes; and (c) that constitute a sale of PHI under the Privacy Rule. Other uses and disclosures of PHI not covered by this notice or the laws that apply to us will be made only with your written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

1. You have the right to request restrictions on our uses and disclosures of PHI for treatment, payment and health care operations. However, we are not required to agree to your request unless the disclosure is to a health plan in order to receive payment, the PHI pertains solely to your health care items or services for which you have paid the bill in full, and the disclosure is not otherwise required by law. To request a restriction, you may make your request in writing to the Privacy Officer.

2. You have the right to reasonably request to receive confidential communications of your PHI by alternative means or at alternative locations. To make such a request, you may submit your request in writing to the Privacy Officer.

3. You have the right to inspect and copy the PHI contained in our records, except:

(i) for psychotherapy notes, (i.e., notes that have been recorded by a mental health professional documenting counseling sessions and have been separated from the rest of your medical record);

(ii) for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;

(iii) for PHI involving laboratory tests when your access is restricted by law;

(iv) if you are a prison inmate, and access would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, any officer, employee, or other person at the correctional institution or person responsible for transporting you;

(v) if we obtained or created PHI as part of a research study, your access to the PHI may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;

LaSante HEALTH CENTER

672 Parkside Ave, 2nd Floor
Brooklyn, NY 11226

Phone 718.246.5700
Fax 718.246.5750
Email info@lasantehealth.org
Web lasantehealth.org

(vi) for PHI contained in records kept by a federal agency or contractor when your access is restricted by law; and

(vii) for PHI obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information.

In order to inspect or obtain a copy your PHI, you may submit your request in writing to the Medical Records Custodian. If you request a copy, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

We may also deny a request for access to PHI under certain circumstances if there is a potential for harm to yourself or others. If we deny a request for access for this purpose, you have the right to have our denial reviewed in accordance with the requirements of applicable law.

4. You have the right to request an amendment to your PHI but we may deny your request for amendment, if we determine that the PHI or record that is the subject of the request:

(i) was not created by us, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;

(ii) is not part of your medical or billing records or other records used to make decisions about you;

(iii) is not available for inspection as set forth above; or is accurate and complete.

(iv) In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records. In order to request an amendment to your PHI, you must submit your request in writing to Medical Record Custodian at the Center, along with a description of the reason for your request.

5. You have the right to receive an accounting of disclosures of PHI made by us to individuals or entities other than to you for the six years prior to your request, except for disclosures:

(i) to carry out treatment, payment and health care operations as provided above;

(ii) incidental to a use or disclosure otherwise permitted or required by applicable law;

(iii) pursuant to your written authorization;

(iv) for the directory or to persons involved in your care or for other notification purposes as provided by law;

(v) for national security or intelligence purposes as provided by law;

(vi) to correctional institutions or law enforcement officials as provided by law;

(vii) as part of a limited data set as provided by law.

To request an accounting of disclosures of your PHI, you must submit your request in writing to the Privacy Officer of LaSante Health Center. Your request must state a specific time period for the accounting (e.g., the past three months). The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

6. You have the right to receive a notification, in the event that there is a breach of your unsecured PHI, which requires notification under the Privacy Rule.

COMPLAINTS

If you believe that your privacy rights have been violated, you should immediately contact the LaSante Health Center's Privacy Officer at *718-246-5700*, x2001. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of the U. S. Department of Health and Human Services.

CONTACT PERSON

If you have any questions or would like further information about this notice, please contact the LaSante Health Center's *Privacy Officer* at 718-246-5700, x2001.

This notice is effective as of August 15, 2017.

LaSante HEALTH CENTER

672 Parkside Ave, 2nd Floor
Brooklyn, NY 11226

Phone 718.246.5700
Fax 718.246.5750
Email info@lasantehealth.org
Web lasantehealth.org

RECEIPT OF HIPAA JOINT PRIVACY NOTICE ACKNOWELDGEMENT FORM

NOTICE TO PATIENT:

We are required to provide you with a copy of our Notice of HIPAA Joint Privacy, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Signature of Patient:_____ Date: _____

Signature of Guardian: _____ Date: _____

FOR OFFICE USE ONLY:

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign

Due to an emergency situation it was not possible to obtain an acknowledgement. We weren't able to communicate with the patient.

Other (Please provide specific details):

_____

_____

Signature of Employee:_____ Date: _____

LaSante HEALTH CENTER

672 Parkside Ave, 2nd Floor
Brooklyn, NY 11226

Phone 718.246.5700
Fax 718.246.5750
Email info@lasantehealth.org
Web lasantehealth.org

PATIENT BILL OF RIGHTS

Public Health Law (PHL) 2803 (1)(g) Patient's Rights, 10NYCRR, 405.7,405.7(a)(1), 405.7(c)

As a patient in a Health Center in New York State, you have the right, consistent with law, to:

1. Understand and use these rights. If for any reason you do not understand or you need help, the Health Center MUST provide assistance, including an interpreter.
2. Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, source of payment, or age.
3. Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
4. Reveive emergency care if you need it.
5. Be informed of the name and position of the doctor who will be in charge of your care in the Health Center. Know the names, positions and functions of any Health Center staff involved in your care and refuse their treatment, examination or observation.
6. A no smoking room.
7. Receive Complete information about your diagnosis, treatment and prognosis.
8. Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risk and benefits of the procedure or treatment.
   Receive all the information you need to give informed consent for an order not to resuscitate. You also have the Right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Deciding About Health Care— A Guide for Patients and Families."
9. Refuse treatment and be told what effect this may have on your health.
10. Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
    Privacy while in the Health Center and confidentiality of all information and records regarding your care.
11. Participape in all decisions about your treatment and discharge from the Health Center. The Health Center must provide you with a written discharge plan and written description of how you can appeal your discharge.
    Review your medical record without charge. Obtain a copy of your medical record for which the Health Center can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
    Receive an itemized bill and explanation of all charges.
12. Complain without fear of reprisals about the care and services you are receiving and to have the Health Center respond to you and if you request it, a written response. If you are not satisfied with the Health Center's response, you can complain to the New York State Health Department. The Health Center must provide you with the State Health Department telephone number.
13. Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.
14. Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the Health Center.

As a patient at the Lasante Health Center, Inc., you have the following rights. If for any reason you do not understand or need help in interpreting these rights, we will provide assistance for you (including an interpreter).

You have the right to:

1. Receive services without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or sponsor
2. Be treated with consideration, respect and dignity, including privacy in treatment
3. Be informed of the services available at Lasante
4. Be informed of the provisions for off-hour emergency coverage
5. Be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care
6. Receive an itemized copy of your account statement, upon request
7. Obtain from your health care practitioner, or the health care practitioner's delegate, complete and current information concerning your diagnosis, treatment and prognosis in terms you can be reasonably expected to understand
8. Receive from your physician information necessary to give informed consent prior to the start of any none-mergency procedure or treatment or both. An informed consent shall include, at a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision
9. Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of your action
10. Refuse to participate in experimental research
11. Voice grievances and recommend changes in policies and services to Lasante's staff, Lasante's management and the New York State Department of Health without fear of reprisal
12. Express complaints about the care and services provided and to have Lasante investigate such complaints. Lasante is responsible for providing you or your designee with a written response within 30 days if you request indicating the findings of the investigation. Lasante is also responsible for notifying you or your designee that if you are not satisfied by Lasante's response, you may complain to the New York State Department of Health's Office of Health Systems Management by calling 800-804-5447.
13. Privacy and confidentiality of all information and records pertaining to your treatment
14. Approve or refuse the release or disclosure of the contents of your medical record to any health-care practitioner and/or health-care facility except as required by law or third-party payment contract
15. Access your medical record pursuant to the provisions of section 18 of the Public Health Law, and Subpart 50-3 of this Title.
16. Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors
17. Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from Lasante.

If you have any complaints or concerns about the care you receive at LaSante Health Center, please contact the complaint hotline of the NYSDOH 1.800.804.5447

LaSante HEALTH CENTER

672 Parkside Ave, 2nd Floor
Brooklyn, NY 11226

Phone 718.246.5700
Fax 718.246.5750
Email info@lasantehealth.org
Web lasantehealth.org

PATIENTS RESPONSIBILITY

This statement of Patients' Responsibilities was designed to demonstrate that mutual respect and cooperation are basic to the delivery of quality health care services.

When you are a patient, it is your responsibility to:

1. Provide accurate and complete information about your past illnesses, hospitalizations, medications and other matters relating to your health.
2. Tell your doctor or nurse if you do not understand your treatment or what you are expected to do.
3. Tell your doctor or nurse if there is a change in your condition or if problems arise during your treatment.
4. Follow the treatment plan recommended by your doctor.
5. Provide accurate information relating to insurance or other sources of payment. Patients are responsible for assuring prompt payment of their bills.
6. Be courteous and considerate of other patients and of Health Center staff. Patients are expected to assist in maintaining a quiet environment and being respectful of Health Center property.
7. Honor our No Smoking Policy.
8. Be aware of our clinic hours and policies.

IF YOU HAVE ANY QUESTIONS REGARDING YOUR RIGHTS AND/OR RESPONSIBILITIES, PLEASE ASK THE STAFF AT THE FRONT DESK.