Academic Health Care Teaching Clinics and Professional Integrative Health Center

- ☐ **Graduate School of Oriental Medicine Teaching Clinic (GTC)**
- ☐ **Massage Therapy Teaching Clinic (MTC)**
- ☐ **Integrative Health Center (IHC)**

Please take a moment to fill out this form. It will be used to assist us in our marketing efforts and to improve services at the New York College Clinics. Thank you.

How did you hear about the New York College Teaching Clinics?

☐ Friend/Family	☐ Alumni	☐ Health Care Provider Referral
☐ Flyer	☐ Yellow Pages	☐ Health Fair
☐ Current Student	☐ NY College Website	☐ Lecture
☐ Patient	☐ Other Website: ____________	☐ Seminar
☐ Newspaper: __________	☐ __________________________	☐ Other: ___________________
________________________		_______________________

New York College would like to contact you from time to time with special clinic promotions just for our regular patients, information about holistic health and news about the College.

Please fill out your e-mail address to be added to our email list. Your information will never to be shared with or sold to outside parties.

E-Mail Address: ____

Name: ____

Date: __________________

ENTRANCE CASE HISTORY

Please answer all questions

Today's Date:_____________________

First Name	Middle Name	Last Name
Date of Birth	Street Address/ apt #	
City	State	Zip
Home Phone	Cell Phone	Email

Marital Status:					
Single	Married	Separated	Divorced	Widowed	Domestic Partner

Occupation: ____

Gender: ☐ Male ☐ Female Height: __________ Weight: __________

IF UNDER THE AGE OF 18 PARENT'S/GUARDIAN'S NAME IS REQUESTED*:

Mother's Name:		Phone:
Father's Name:		Phone:
Guardian's Name:		Phone:
Emergency Contact:	Relationship:	Phone:

*Minor Consent Form must be completed.

Who referred you to us? ____

Who is your primary health care provider? ____

Address: ____

Main problems you would like us to help you with: ____

____

How long ago did this problem begin? ____

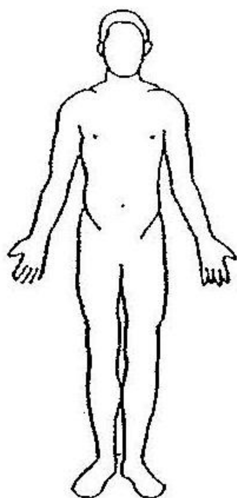
Name(s) of Physician that treated this problem: ____

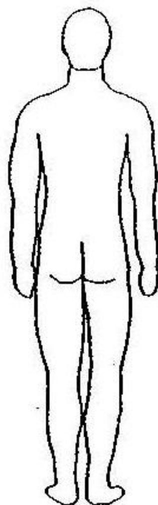
____

Have you been given a diagnosis for this problem? If so, what? ____

____

Please circle areas of pain and injury.
Please be prepared to describe the type and quality of pain.





MEDICAL HISTORY

What kinds of treatment have you tried? ____

____

Have they helped alleviate the condition/problem? ______________________________________

____

Are you currently receiving treatment for your problem? If so, describe: _________________________

____

____

Illnesses: ____

Surgeries: ____

Significant trauma (car accidents, falls, etc): ____

____

Do you or have you ever had any infectious diseases? Please describe: ______________________

____

Medications (prescriptions, over the counter drugs, vitamins & herbs taken in last 3 months):

Medication: _________________________ Reason for taking it: _______________________

Medication: _________________________ Reason for taking it: _______________________

Medication: _________________________ Reason for taking it: _______________________

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Medication: _________________________ Reason for taking it: _______________________

Medication: _________________________ Reason for taking it: _______________________

Medication: _________________________ Reason for taking it: _______________________

Date of last Medical Exam: ______________

Average blood pressure _____/_____ Average pulse rate __________________

Allergies: ____

FAMILY MEDICAL HISTORY

Adopted: ☐ Yes ☐ No

	Age	Health Problems	Age at Death	Cause of Death
Mother				
Father				
Brother/Sister				
Brother/Sister				

Personal birth history (prolonged labor, forceps, caesarean, etc): _____________________________________

Childhood health: ____

Location of upbringing: ____

Current emotional health: ____

Current quality of life: ____

Stress level of occupation: ____

Have you had any unusual stresses lately? ____

Your favorite time of year: _________________________ Your least favorite time of year: _____________

Hobbies and recreational habits: ____

Do you exercise regularly? __________ Describe: ________________________________

____

Have you traveled abroad in the past year? _______ Where? ________________________________

PERSONAL MEDICAL HISTORY

Significant Illnesses

- ☐ Cancer
- ☐ Hepatitis
- ☐ HIV (AIDS)
- ☐ Allergies
- ☐ Asthma
- ☐ Seizures
- ☐ Heart Disease
- ☐ Weight Problems
- ☐ Tuberculosis
- ☐ Herpes
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Venereal Disease
- ☐ Addictive Disorders
- ☐ High Blood Pressure
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Mental Illness
- ☐ Other: ________________

____

____

Please check if you have experienced any of the following in the last three months:

General

- ☐ Poor Appetite
- ☐ Fever(s)
- ☐ Change in Appetite
- ☐ Tremors
- ☐ Cravings
- ☐ Headaches
- ☐ Localized Weakness
- ☐ Insomnia
- ☐ Strong Thirst
- ☐ Poor Balance
- ☐ Chills
- ☐ Sudden Energy Drop
- ☐ Peculiar Taste
- ☐ Peculiar Smells
- ☐ Bleeding
- ☐ Weight Gain
- ☐ Joint Pain
- ☐ Hearing Loss
- ☐ Sweat Easily
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Depression
- ☐ Emotional Changes
- ☐ Bruising

Skin & Hair

- ☐ Rashes
- ☐ Eczema
- ☐ Recent Moles
- ☐ Itching
- ☐ Hair Loss
- ☐ Hives
- ☐ Change in Skin Texture
- ☐ Dandruff
- ☐ Change in Hair Texture
- ☐ Ulcers
- ☐ Acne
- ☐ Psoriasis

Head, Eyes, Ears, Nose and Teeth

- ☐ Dizziness
- ☐ Sore Throat
- ☐ Eye Strain
- ☐ Grinding Teeth
- ☐ Cataracts
- ☐ Blurred Vision
- ☐ Eye Pain
- ☐ Ringing in Ears
- ☐ Gum Problems
- ☐ Sores on Tongue
- ☐ Floaters
- ☐ Concussions
- ☐ Jaw Click
- ☐ Earaches
- ☐ Sinus Problems
- ☐ Night Blindness
- ☐ Mouth Ulcers
- ☐ Spots in Front of Eyes
- ☐ Poor Hearing
- ☐ Migraines
- ☐ Glasses
- ☐ Poor Vision
- ☐ Headaches
- ☐ Facial Pain
- ☐ Toothache
- ☐ Nose Bleed
- ☐ Color Blindness
- ☐ Glaucoma

Respiratory

- ☐ Cough
- ☐ Bronchitis
- ☐ Easily Winded
- ☐ Cough Blood
- ☐ Asthma
- ☐ Phlegm
- ☐ Short of Breath
- ☐ Pain Breathing
- ☐ Wheeze

Cardiovascular

- ☐ Blood Clots
- ☐ Dizziness
- ☐ Hands Swell
- ☐ Cold Sweats
- ☐ High Blood Pressure
- ☐ Fainting
- ☐ Chest Pain
- ☐ Swelling of Feet
- ☐ Palpitations
- ☐ Cold Hands/Feet
- ☐ Low Blood Pressure
- ☐ Shortness of Breath
- ☐ Irregular Heartbeat
- ☐ Difficulty Breathing
- ☐ Phlebitis

Gastrointestinal

- ☐ Nausea
- ☐ Belching
- ☐ Diarrhea
- ☐ Indigestion
- ☐ Bloating
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Parasites
- ☐ Blood in Stools
- ☐ Abdominal Pain
- ☐ Bad Breath
- ☐ Intestinal Gas
- ☐ Vomiting
- ☐ Black Stools
- ☐ Gastric Ulcers

Genito-Urinary

- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Unable to Hold Urine
- ☐ Urgent Urination
- ☐ Frequent Night Urination
- ☐ Discolored Urination
- ☐ Scanty Urination
- ☐ Genital Sores
- ☐ Blood in Urine
- ☐ Impotence
- ☐ Kidney Stones
- ☐

Gynecology & Pregnancy

- ☐ Irregular Periods
- ☐ Clots
- ☐ Painful Periods
- ☐ Light Flow
- ☐ Heavy Flow
- ☐ Vaginal Discharge
- ☐ Duration of Flow _______
- ☐ Difficult Births __________
- ☐ Fertility Problems _______
- ☐ Age of First Menses ______
- ☐ Date of Last Menses _____
- ☐ PMS
- ☐ Vaginal Sores
- ☐ Currently Pregnant Due____
- ☐ # of Births _____________
- ☐ # of Miscarriages _______
- ☐ # of Pregnancies ________
- ☐ # of Premature Births ____
- ☐ # of Abortions __________
- ☐ Date of Last Exam: ______

Neuro-Psychological

- ☐ Seizures
- ☐ Depression
- ☐ Poor Memory
- ☐ Disoriented
- ☐ Areas of Numbness
- ☐ Loss of Balance
- ☐ Lack of Coordination
- ☐ Migraines
- ☐ Concussion
- ☐ Mood Swings
- ☐ Anxiety
- ☐ Easily Angered
- ☐ Dizziness
- ☐ Stress
- ☐ Irritable
- ☐ Headaches

Have you ever received psychiatric treatment? ☐ Yes ☐ No

Have you ever considered or attempted suicide? ☐ Yes ☐ No

Do you have nervous habits? ____

Do you have any other problems you would like us to be aware of? _______________________________

____

Allergies

Do you have itchy ear canals?	☐ Sometimes	☐ Often	☐ Never
Do you have itchy eyes?	☐ Sometimes	☐ Often	☐ Never
Do you have itchy palate or back of the throat?	☐ Sometimes	☐ Often	☐ Never
Do you seem to be tired, weak or get fatigued more	☐ Sometimes	☐ Often	☐ Never
Do you have problems with muscle or joint aches,	☐ Sometimes	☐ Often	☐ Never
Have you ever been treated or tested for	☐ Sometimes	☐ Often	☐ Never

List anything (drugs, food, chemicals, animals, dust, etc) that has caused you an allergic reaction:

Muscular Skeletal

- ☐ Neck Pain
- ☐ Scoliosis
- ☐ Hip Pain
- ☐ Recent Sprains
- ☐ Hand/Wrist Pain
- ☐ Back Pain
- ☐ Shoulder Pain
- ☐ Arthritis
- ☐ Weak Joints
- ☐ Joint Pain
- ☐ Knee Pain
- ☐ Muscle Weakness
- ☐ Injuries
- ☐ Muscle Spasms
- ☐ Muscle Cramping
- ☐ Muscle Soreness
- ☐ Foot/Ankle Pain

LifeStyle

Do you regularly smoke? ☐ Cigarettes ☐ Cigars ☐ Pipe
If yes, for how many years? _____ How many per day? _____

Do you regularly drink alcoholic beverages?

Liquor:	☐ 1oz. per day	☐ 2oz. per day	☐ over 2oz. per day
Beer:	☐ 12oz. or 1 per day	☐ 24oz. or 2 per day	☐ 48oz. or over 4 per day
Wine:	☐ less than 6oz. per day	☐ 6oz./day	☐ over 12oz. per day

Do you regularly drink coffee? ☐ Yes ☐ No
How many per day: Regular ______ Decaffeinated ______

MALE UROLOGY IS FOR ACUPUNCTURE PATIENTS ONLY

Male Urology

Have you been treated for genital problems?	☐ Yes	☐ No
Do you have genital herpes?	☐ Yes	☐ No
Do you have discharge from the penis?	☐ Yes	☐ No
Do you have a hernia (rupture)?	☐ Yes	☐ No
Are you experiencing a prostate problem?	☐ Yes	☐ No

Explain: ____

Do you have any difficulties of a sexual nature? ☐ Sometimes ☐ Often ☐ Never

If yes, check the following that apply:

- ☐ Premature ejaculation
- ☐ Painful intercourse
- ☐ Loss of erection
- ☐ Other: _______ _____________
- ☐ Failure to reach orgasm
- ☐ Lack of desire
- ☐ Sexual anxiety

ALL THE FOLLOWING QUESTIONS ARE FOR ALL PATIENTS

Do you use illicit drugs socially? ☐ Yes ☐ No

List drugs and frequency: ____

____

____

List all exercise, physical activities and frequency (Hobbies, sports, etc.): ______________

____

____

Nutrition

List all the foods which disagree with you: ______________________________

____

____

____

List your favorite, craved or particularly enjoyed foods and beverages: ______________

____

____

____

Intake per day:

Mark each of the following food items according to the frequency by which it is consumed:

Item	Never	1+ per day	1-3 per wk	3-6 per wk
Coffee				
Decaf. Coffee				
White Sugar				
Artif. Sweetener				
Tea				
Herbal Tea				
Salt				
Pepper				
Soda				
Diet Soda				
Chocolate				
Candy				
Fruit Juice				
Cake				
Cookies				
Milk				
Ice Cream				
Cheese				
Fried Foods				

Item	Never	1+ per day	1-3 per wk	3-6 per wk
White Bread				
Whole Grain				
White Rice				
Pasta				
Beef				
Veal				
Pork				
Deli Meats				
Canned Foods				
Chicken				
Shellfish				
Vegetables				
Raw Fish				
Eggs				
Fish				
Tuna				
Cooked Tomato				
Turkey				

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.*

I. What this Is

This Notice describes the privacy practices of the New York College of Health Professions' Professional/Student/Herbal Clinics ("Clinics").

II. Our Privacy Obligations

The Clinics choose to maintain the privacy of health information about you ("**Protected Health Information**" or "**PHI**") and to provide you with this Notice of our duties and privacy practices with respect to PHI. When we use or disclose PHI, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure)†

III. Permissible Uses and Disclosures Without Your Written Authorization

In certain situations, which we will describe in Section IV below, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures:

A. Uses and Disclosures For Treatment, Payment and Health Care Operations. We may use and disclose PHI in order to treat you and conduct our "clinic care operations" (e.g., internal administration, quality improvement, and customer service) as detailed below:

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*The Clinics do not transmit any health care information in electronic form outside the Clinics. The Clinics do not file claims to any health plans, private or Medicare/Medicaid, or utilized a billing service or clearinghouse to file on their behalf. Nothing in these privacy procedures should be construed to voluntarily or involuntarily waive New York College of Health Professions status as a "non covered entity" under HIPAA. The HIPAA regulations are used merely as a guide for accepted privacy practices.

- Treatment. We use and disclose PHI to provide treatment and other services to you-for example, herbal treatments. In addition, 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. We may also disclose PHI to other practitioners involved in your treatment.

- Payment. We do not use and disclose PHI to obtain payment for services that we provide to you-for example, we do not make claims or obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of health care.

- Health Care Operations. We may use and disclose PHI for our clinic operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the treatment that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our practitioners, students, and providers. We may disclose PHI to our office manager in order to resolve any complaints you may have and ensure that you have a pleasant visit with us.

We may also disclose PHI to your other health care providers when such PHI is required for them to treat you or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance.

B. Disclosure to Relatives Close Friends and Other Caregivers. We may use or disclose PHI to a family member, other relative, a close personal friend, or any other person identified by you when you are present for, or otherwise available prior to, the disclosure. If you object to such uses or disclosures, please notify the Office Manager.

If you are not present, you are incapacitated, or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interest. If we disclose information to a family member, other relative, or a close personal friend, we would disclose only information that is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclose PHI in order to notify (or assist in notifying) such persons of your location, general condition, or death.

C. Public Health Activities. We may disclose PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer, as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

D. Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect, or domestic violence, we may disclose PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

E. Health Oversight Activities. We may disclose PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs.

F. Judicial and Administrative Proceedings. We may disclose PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

G. Law Enforcement Officials. We may disclose PHI to the police or other law enforcement officials, as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

H. Decedents. We may disclose PHI to a coroner or medical examiner, as authorized by law.

I. Organ and Tissue Procurement. We may disclose PHI to organizations that facilitate organ, eye, or tissue procurement, banking or transplantation.

J. Research. We may use or disclose PHI without your consent or authorization if an Institutional Review Board/Privacy Board approves a waiver of authorization for disclosure.

K. Health or Safety. We may use or disclose PHI to prevent or lessen a serious and imminent threat to a person or the public's health or safety.

L. Specialized Government Functions. We may use and disclose PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances required by law.

M. Workers' Compensation. We may disclose PHI, as authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs.

N. As required by law. We may use and disclose PHI when required to do so by any other law not already referred to in the preceding categories.

IV. Use and Disclosures Requiring Your Written Authorization

A. Use or Disclosure with Your Authorization. For any purpose other than the ones described in Section **III,** we only may use or disclose PHI when you give us your authorization on our authorization form **("Your Authorization").** For instance, you will need to execute an authorization form before we can send your PHI to your life insurance company, to your child's camp or school, or to the attorney representing the other party in litigation in which you are involved.

B. Special Authorization. Confidential HIV-related information (for example, information regarding whether you have ever been the subject of an HIV test, have HIV infection, have HIV-related illness, or have AIDS, or any information which could indicate that you have ever been potentially exposed to HIV) will never be used or disclosed to any person without your specific written authorization, except to certain other persons who need to know such information in connection with your care, and, in certain limited circumstances, to public health or other government officials (as required by law), to persons specified in a special court order, or to certain persons with whom you have had sexual contact or have shared needles or syringes (in accordance with a specified process set forth in New York State law). This special written authorization is a New York State approved form which is a separate document from Your Authorization.

V, Your Individual Rights

A. For Further Information or Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to PHI, you may contact our Privacy Compliance Officers. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Compliance Officers will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with either us or the Director.

B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of PHI (1) for treatment, payment, and other treatment operations; (2) to individuals (such as a family member, other relative, close personal friend, or any other person identified by you) involved with your care or with payment related to your care; or (3) to notify or assist in the notification of such individuals regarding your location and general condition. All requests for such restrictions must be made in writing. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from our Office Manager and submit the completed form to the Office Manager. We will send you a written response.

C. Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

D. Right to Inspect and Copy Your Health Information. You may request access to your treatment file maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you desire access to your records, please obtain a record request form from the Office Manager and submit the completed form to the Office Manager. If you request copies, we will charge you **$.75 (seventy-five cents)** for each page. We will also charge you for our postage costs, if you request that we mail the copies to you.

E. Right to Revoke Your Authorization. You may revoke Your Authorization or Your Special Authorization, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Office Manager identified below. **[A form of Written Revocation is available upon request from the Office Manager.]**

F. Right to Amend Your Records. You have the right to request that we amend PHI maintained in your clinic record file. If you desire to amend your records, please obtain an amendment request form from the Office Manager and submit the completed form to the Office Manager. All requests for amendments must be in writing. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

G. Right to Receive An Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, we will charge you **$.75 (seventy-five cents)** per page of the accounting statement.

H. Right to Receive Paper Copy of this Notice. Upon written request, you may obtain a paper copy of this Notice, even if you agreed to receive such notice electronically.

VI. Effective Date and Duration of This Notice

A. Effective Date. This Notice is effective on April 14, 2003.

B. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in waiting areas of the Clinics. You may also obtain any revised notice by contacting the Office Manager.

VII. Office Manager

You may contact the Office Manager at New York College of Health Professions, 6801 Jericho Turnpike, Syosset, NY 11791.

By signing below, I hereby acknowledge receipt of the Clinics' Notice of Privacy Practices.

Date

Patient's Name

Patient's Signature

FOR USE BY COLLEGE STAFF ONLY
☐ Patient refused to sign
☐ Patient unable to sign
Employee's Initials
Today's Date

Form 104
Update 08/07

NOTICE OF PRIVACY PRACTICES

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By signing below I hereby acknowledge receipt of New York College of Health Professions' Professional/Student/Herbal Clinics' Notice of Privacy Practices.

______________________ ____________________________________

Date Patient's Signature

Form 104A
Update 08/07

STUDENT CLINIC TREATMENT POLICY AGREEMENT

Thank you for your participation in our teaching clinics. Our goal is to provide you with excellent care while providing our students a quality teaching experience.

Student Clinicians have specific requirements that they must fulfill in order to graduate. Your support and understanding in helping them achieve these requirements are greatly appreciated.

The Student Clinics' office staff will make every effort to accommodate your needs; however, please be aware that the following guidelines will apply to all patients:

- Patients are assigned on the basis of student seniority.
- New York College will make every effort to accommodate requests for follow-up treatments with the same Student Clinician; however, Clinic schedules may change and treatment by a different Student Clinician is possible. In the event that you are unable to receive treatment with the same Student Clinician you always have the option to reschedule.
- Acupuncture patients are treated in curtain or screen enclosed areas where conversations may be overheard in the surrounding areas.
- All of the Student Clinicians need to fulfill the same requirements; therefore, requests for gender or other preferences cannot be honored.
- The modality of treatment given (Asian or Swedish) is solely at the discretion of the Clinic Supervisor and the Student Clinician.
- For your health and safety we may require a physician's clearance prior to treatment.
- A clinical hour is 50 minutes for massage and approximately 1 ½ hours for acupuncture. Patients must arrive on time. Patients arriving more than 15 minutes late may lose their appointments for that day. Treatments must end at the scheduled time regardless of the time they began.
- Patients who repeatedly miss appointments without calling to cancel will be removed from the schedule for the remainder of the term.
- New patients are asked to arrive 30 minutes before their scheduled appointment (if they have not filled out intake forms at home) in order to complete intake and confidentiality paperwork. These forms must be filled out completely as they are necessary for assessment.
- Established patients may be asked periodically to update their health information.
- The Massage Clinic does not treat anyone under the age of 17 and at age 17 only with parental consent. Acupuncture clinic treats patients under the age of 18 but must be accompanied by parent and have parental consent.
- Inappropriate action or language is cause for immediate termination of a treatment. New York College reserves the right to refuse service or terminate treatments at any time without cause.
- New York College is not responsible for any personal belongings left behind at the Student Clinic.

I have read and agree to the above guidelines:

Patient Name:_________________________**Signature:**_______________________________________

Date: _________________

New York COLLEGE OF HEALTH PROFESSIONS

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION*

With this consent, New York College of Health Professions' Professional/Student/Herbal Clinics ("Clinics") may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to the Clinics' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Clinics reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer at New York College of Health Professions, 6801 Jericho Turnpike, Syosset, NY 11791.

With my consent, the Clinics may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the Clinics in carrying out TPO, such as appointment reminder, and any call pertaining to my clinical care.
With my consent, the Clinics may mail to my home or other designated location any items that assist the Clinics in carrying out TPO, such as appointment reminder cards, as long as they are marked "Personal and Confidential".

I have the right to request that the Clinics restrict how it uses or discloses my PHI to carry out TPO. However, the Clinics are not required to agree to my requested restrictions, but if it does, it is bound by this Agreement.

By signing this form, I am consenting to the Clinics use and disclosure of my PHI to carry out TPO.

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* The Clinics do not transmit any health care information in electronic form outside the Clinics. The Clinics do not file claims to any health plans, private or Medicare/Medicaid, or utilize a billing service or clearinghouse to file on their behalf. Nothing in these privacy procedures should be construed to voluntary or involuntarily waive New York College of Heath Professions status as a "non covered entity" under HIPAA. The HIPAA regulations are used merely as a guide for accepted privacy practices.

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When my information is used or disclosed pursuant to this Authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the applicable privacy laws. I have the right to revoke this Authorization in writing except to the extent that the Clinics have acted in reliance upon this authorization. My written revocation must be submitted to the Clinics' Privacy Officer at New York College of Health Professions, 6801 Jericho Turnpike, Syosset, NY 11791.

_________________ Date

____ Signature of Patient or Legal Guardian

____ Relationship to Patient

____ Patient's Name

____ Print Name of Patient or Legal Guardian

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