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**AMBULATORY
PATIENT NOTIFICATION RECORD**

I acknowledge that I have been given the following Notices as required by State and Federal regulations:

- New York State Patients' Bill of Rights
- Continuum Notice of Privacy Practices
- New York State Health Care Proxy
- Continuum Summary of Policy on Advance Directives
- Continuum Patient Information on Pain Management

and I consent to share my health information for payment, treatment and hospital operations purposes.

Patient/Personal Representative Signature

Date

Representative Relationship to Patient

Date

Patient: Unable to sign
 Refuses to sign

Employee Signature

Date

PATIENTS' BILL OF RIGHTS

New York State Hospital Code

Section 405.7

PATIENTS' RIGHTS

As a patient in the hospital 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 hospital must provide assistance, including an interpreter.
2. receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation or source of payment.
3. receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
4. receive 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 hospital and in the outpatient clinic.
6. know the names, positions and functions of any hospital staff involved in your care and refuse their treatment, examination or observation.
7. a no smoking room.
8. receive complete information about your diagnosis, treatment and prognosis.
9. receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
10. 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, "Do Not Resuscitate Orders - A Guide for Patients and Families."
11. refuse treatment and be told what effect this may have on your health.
12. refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
13. privacy while in the hospital and confidentiality of all information and records regarding your care.
14. participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge.
15. review your medical record without charge and obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
16. receive an itemized bill and explanation of all charges.
17. complain without fear of reprisals about the care and services you are receiving and to have the hospital respond to you and if you request it, a written response. If you are not satisfied with the hospital's response, you can complain to the New York State Health Department. The hospital must provide you with the Health Department telephone number.
18. authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.
19. 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 hospital.

PATIENTS' RESPONSIBILITIES

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 both as an inpatient, after discharge, and as an outpatient.
5. provide accurate information relating to insurance or other sources of payment. Patients are responsible for assuring prompt payment of their bills.
6. understand that it may become necessary to transfer you to another bed or another floor within the hospital. We apologize for any inconvenience this may cause.
7. be courteous and considerate of other patients and of hospital staff. Patients are expected to assist in maintaining a quiet environment and being respectful of hospital property.
8. honor our No Smoking Policy.
9. be aware of our clinic hours and policies.

If you have any questions regarding your rights and/or responsibilities, please contact a patient representative at the appropriate site:

Beth Israel, Petrie Division - (212) 420-3818

Beth Israel, Phillips Ambulatory Care Center - (212) 844-8748

Beth Israel, Kings Highway Division - (718) 951-3005

Beth Israel, Singer Division - (212) 870-9888

Long Island College Hospital - (718) 780-1919

New York Eye and Ear Infirmary - (212) 979-4795

Roosevelt Hospital - (212) 523-7225

St. Luke's Hospital - (212) 523-3700

**BETH ISRAEL MEDICAL CENTER
ST. LUKE'S-ROOSEVELT HOSPITAL CENTER
LONG ISLAND COLLEGE HOSPITAL
NEW YORK EYE AND EAR INFIRMARY**

NOTICE OF PRIVACY PRACTICE

Effective Date: April 14, 2003

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.

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our hospital, its medical staff, and affiliated health care providers that jointly provide health care services with our hospital. A copy of our current notice will always be posted in our reception area. You will also be able to obtain your own copies by accessing our website at www.wehealnewyork.org, calling our office or asking for one at the time of your next visit.

If you have any questions about this notice or would like further information, please contact the hospital's Patient Relations Office or the hospital's Privacy Officer at 212-523-2162.

WHO WILL FOLLOW THIS NOTICE

The hospital provides health care to patients jointly with physicians and other health care professionals and organizations. The privacy practices described in this notice will be followed by:

- Any health care professional who treats you at any of our locations;
- All employees, medical staff, trainees, students or volunteers at any of our locations;
- Any business associates of our hospital (which are described further below).

IMPORTANT SUMMARY INFORMATION

Requirement For Written Authorization. We will generally obtain your written authorization before using your health information or sharing it with others outside the hospital. You may also initiate the transfer of your records to another person by completing a written authorization form. If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write to Privacy Officer, Continuum Health Partners, Inc., Legal Affairs, 555 West 57th Street, 18th Floor, New York, New York 10019.

Continuum Health Partners, Inc.

Beth Israel
University Hospital and
Manhattan Campus for
the Albert Einstein College
of Medicine

**St. Luke's
Roosevelt**
University Hospital of
Columbia University College
of Physicians & Surgeons

**Long Island
College Hospital**
Primary Clinical Teaching
Affiliate of SUNY—
Health Science Center
at Brooklyn

**NY Eye & Ear
Infirmary**
Affiliated Teaching
Hospital of New York
Medical College

NOTICE OF PRIVACY PRACTICE (CONTINUED)

Exceptions To Written Authorization Requirement. There are some situations when we do not need your written authorization before using your health information or sharing it with others. They are:

- **Exception For Treatment, Payment, And Business Operations.** We may use and disclose your health information to treat your condition, collect payment for that treatment, or run our business operations. In some cases, we also may disclose your health information to another health care provider or payor for its payment activities and certain of its business operations. For more information, see pages 3-4 of this notice.
- **Exception For Patient Directory And Disclosure To Family And Friends Involved In Your Care.** We may include information about you in our Patient Directory or share your health information with family and friends involved in your care. Although we are not required to obtain your written authorization, we will ask you whether you have any objection to the use or disclosure of your health information in this way. For more information, see page 4 of this notice.
- **Exception For Public Need.** We may use or disclose your health information in certain situations to comply with the law or to meet important public needs. For example, we may share your information with public health officials at the New York state or city health departments who are authorized to investigate and control the spread of diseases. For more examples, see pages 4-6 of this notice.
- **Exception If Information Is Completely Or Partially De-Identified.** We may use or disclose your health information if we have removed any information that might identify you so that the health information is "completely de-identified." We may also use and disclose "partially de-identified" information if the person who will receive the information agrees in writing to protect the privacy of the information. For more information, please see page 6 of this notice.

How To Access Your Health Information. You generally have the right to inspect and copy your health information. For more information, please see pages 6-7 of this notice.

How To Correct Your Health Information. You have the right to request that we amend your health information if you believe it is inaccurate or incomplete. For more information, please see page 7 of this notice.

How To Identify Others Who Have Received Your Health Information. You have the right to receive an "accounting of disclosures," which identifies certain persons or organizations to whom we have disclosed your health information in accordance with the protections described in this Notice of Privacy Practices. Many routine disclosures we make will not be included in this accounting, but the accounting will identify many non-routine disclosures of your information. For more information, please see page 7 of this notice.

How To Request Additional Privacy Protections. You have the right to request further restrictions on the way we use your health information or share it with others. We are not required to agree to the restriction you request, but if we do, we will be bound by our agreement. For more information, please see page 8 of this notice.

How To Request More Confidential Communications. You have the right to request that we contact you in a way that is more confidential for you, such as at home instead of at work. We will try to accommodate all reasonable requests. For more information, please see page 8 of this notice.

How Someone May Act On Your Behalf. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

How To Learn About Special Protections For HIV, Alcohol and Substance Abuse, Mental Health And Genetic Information. Special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you will be provided with separate notices explaining how the information will be protected.

How To Obtain A Copy Of This Notice. You have the right to a paper copy of this notice. You may request a paper copy at any time, even if you have previously agreed to receive this notice electronically. To do so, please call our Privacy Officer at 212-523-2162. You may also obtain a copy of this notice from our website at www.wehealnewyork.org, or by requesting a copy at your next visit.

NOTICE OF PRIVACY PRACTICE (CONTINUED)

How To Obtain A Copy Of Revised Notice. We may change our privacy practices from time to time. If we do, we will revise this notice so you will have an accurate summary of our practices. The revised notice will apply to all of your health information. We will post any revised notice in our hospital reception area. You will also be able to obtain your own copy of the revised notice by accessing our website at www.wehealnewyork.org, calling our Privacy Officer at 212-523-2162 or asking for one at the time of your next visit. The effective date of the notice will always be noted in the top right corner of the first page. We are required to abide by the terms of the notice that is currently in effect.

How To File A Complaint. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact Louis I. Schenkel, Privacy Officer, Continuum Health Partners, Inc., Legal Department, 555 West 57th Street, New York, New York 10019, telephone number, 212-523-2162. *No one will retaliate or take action against you for filing a complaint.*

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

- information indicating that you are a patient at the hospital or receiving treatment or other health-related services from our hospital;
- information about your health condition (such as a disease you may have);
- information about health care products or services you have received or may receive in the future (such as an operation); or
- information about your health care benefits under an insurance plan (such as whether a prescription is covered);

when combined with:

- demographic information (such as your name, address, or insurance status);
- unique numbers that may identify you (such as your social security number, your phone number, or your driver's license number); and
- other types of information that may identify who you are.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

For your information, we have included below a more detailed explanation of how we may use and disclose your health information without your written authorization.

1. Treatment, Payment And Business Operations

We may use your health information or share it with others in order to treat your condition, obtain payment for the treatment, and run our business operations. In some cases, we may also disclose your health information for payment activities and certain business operations of another health care provider or payor. Below are further examples of how your information may be used and disclosed for these purposes.

Treatment. We may share your health information with doctors or nurses at the hospital who are involved in taking care of you, and they may in turn use that information to diagnose or treat you. A doctor at our hospital may share your health information with another doctor inside our hospital, or with a doctor at another hospital, to determine how to diagnose or treat you. Your doctor may also share your health information with another doctor to whom you have been referred for further health care.

Payment. We may use your health information or share it with others so that we may obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after we have treated you, or to determine whether it will cover your treatment. We might also need to inform your health insurance company about your health condition in order to obtain pre-approval for your treatment, such as admitting you to the hospital for a particular type of surgery. Finally, we may share your information with other health care providers and payors for their payment activities.

NOTICE OF PRIVACY PRACTICE (CONTINUED)

Business Operations. We may use your health information or share it with others in order to conduct our business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide for you. Finally, we may share your health information with other health care providers and payors for certain of their business operations if the information is related to a relationship the provider or payor currently has or previously had with you, and if the provider or payor is required by federal law to protect the privacy of your health information.

Appointment Reminders, Treatment Alternatives, Benefits And Services. In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for treatment or services at our facility. We may also use your health information in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

Fundraising. To support our business operations, we may use demographic information about you, including information about your age and gender, where you live or work, and the dates that you received treatment, in order to contact you to raise money to help us operate. We may also share this information with a charitable foundation that will contact you to raise money on our behalf.

Business Associates. We may disclose your health information to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company. Another example is that we may share your health information with an accounting firm, law firm or risk management organization that provides professional advice to us about how to improve our health care services and comply with the law. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information.

Continuum Hospitals Cooperate With One Another in Treating Patients. In handling your medical information, the hospitals and entities that make up Continuum Health Partners, Inc. treat themselves as a unified health care provider and may share your health information as needed to treat you, to seek payment from your health insurer, and to conduct day-to-day operations.

2. Patient Directory/Family and Friends

We may use your health information in, and disclose if from, our Patient Directory, or share it with family and friends involved in your care. We will always give you an opportunity to object unless there is insufficient time because of a medical emergency (in which case we will discuss your preferences with you as soon as the emergency is over). We will follow your wishes unless we are required by law to do otherwise.

Patient Directory. If you do not object, we will include your name, your location in our facility, your general condition (e.g., fair, stable, critical, etc.) and your religious affiliation in our Patient Directory while you are a patient in the hospital or one of the facilities listed at the beginning of this notice. This 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 he or she doesn't ask for you by name.

Family and Friends Involved In Your Care. If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for that care. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition here at the hospital, or about the unfortunate event of your death. In some cases, we may need to share your information with a disaster relief organization that will help us notify these persons.

3. Public Need

We may use your health information, and share it with others, to comply with the law or to meet important public needs that are described below.

As Required By Law. We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if notice is required by law.

NOTICE OF PRIVACY PRACTICE (CONTINUED)

Public Health Activities. We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury or disability. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law permits us to do so. And finally, we may release some health information about you to your employer if your employer hires us to provide you with a physical exam and we discover that you have a work-related injury or disease that your employer must know about in order to comply with employment laws.

Victims Of Abuse, Neglect Or Domestic Violence. We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence. For example, we may report your information to government officials if we reasonably believe that you have been a victim of such abuse, neglect or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

Health Oversight Activities. We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Product Monitoring, Repair And Recall. We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

Lawsuits And Disputes. We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute.

Law Enforcement. We may disclose your health information to law enforcement officials for the following reasons:

- To comply with court orders or laws that we are required to follow;
- To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person;
- If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your agreement because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
- If we suspect that your death resulted from criminal conduct;
- If necessary to report a crime that occurred on our property; or
- If necessary to report a crime discovered during an offsite medical emergency (for example, by emergency medical technicians at the scene of a crime).

To Avert A Serious And Imminent Threat To Health Or Safety. We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling), or if we determine that you escaped from lawful custody (such as a prison or mental health institution).

National Security And Intelligence Activities Or Protective Services. We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

Military And Veterans. If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Inmates And Correctional Institutions. If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

NOTICE OF PRIVACY PRACTICE (CONTINUED)

Workers' Compensation. We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

Coroners, Medical Examiners And Funeral Directors. In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.

Organ And Tissue Donation. In the unfortunate event of your death, we may disclose your health information to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

Research. In most cases, we will ask for your written authorization before using your health information or sharing it with others in order to conduct research. However, under some circumstances, we may use and disclose your health information without your written authorization if we obtain approval through a special process to ensure that research without your written authorization poses minimal risk to your privacy. Under no circumstances, however, would we allow researchers to use your name or identity publicly. We may also release your health information without your written authorization to people who are preparing a future research project, so long as any information identifying you does not leave our facility. In the unfortunate event of your death, we may share your health information with people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you.

4. Completely De-identified Or Partially De-identified Information.

We may use and disclose your health information if we have removed any information that has the potential to identify you so that the health information is "completely de-identified." We may also use and disclose "partially de-identified" health information about you if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will **not** contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

5. Incidental Disclosures

While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION

We want you to know that you have the following rights to access and control your health information. These rights are important because they will help you make sure that the health information we have about you is accurate. They may also help you control the way we use your information and share it with others, or the way we communicate with you about your medical matters.

1. Right To Inspect And Copy Records

You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the hospital's Medical Records Department or physician office that has your records. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. The standard fee is \$0.75 per page and must generally be paid before or at the time we give the copies to you.

We will respond to your request for inspection of records within 10 days. If we need additional time to respond to a request for copies, we will notify you within the time frame above to explain the reason for the delay and when you can expect to have a final answer to your request.

NOTICE OF PRIVACY PRACTICE (CONTINUED)

Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide you with a summary of the information instead. We will also provide a written notice that explains our reasons for providing only a summary, and a complete description of your rights to have that decision reviewed and how you can exercise those rights. The notice will also include information on how to file a complaint about these issues with us or with the Secretary of the Department of Health and Human Services. If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we cannot let you inspect or copy.

2. Right To Amend Records

If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept in our records. To request an amendment, please write to the hospital's Medical Records Department or physician office where your records are maintained. Your request should include the reasons why you think we should make the amendment. Ordinarily we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.

3 Right To An Accounting Of Disclosures

After April 14, 2003, you have a right to request an "accounting of disclosures" which identifies certain other persons or organizations to whom we have disclosed your health information in accordance with applicable law and the protections afforded in this Notice of Privacy Practices. An accounting of disclosures does not describe the ways that your health information has been shared within and between the hospital and the facilities listed at the beginning of this notice, as long as all other protections described in this Notice of Privacy Practices have been followed (such as obtaining the required approvals before sharing your health information with our doctors for research purposes).

An accounting of disclosures also does not include information about the following disclosures:

- Disclosures we made to you or your personal representative;
- Disclosures we made pursuant to your written authorization;
- Disclosures we made for treatment, payment or business operations;
- Disclosures made from the patient directory;
- Disclosures made to your friends and family involved in your care or payment for your care;
- Disclosures that were incidental to permissible uses and disclosures of your health information (for example, when information is overheard by another patient passing by);
- Disclosures for purposes of research, public health or our business operations of limited portions of your health information that do not directly identify you;
- Disclosures made to federal officials for national security and intelligence activities;
- Disclosures about inmates to correctional institutions or law enforcement officers;
- Disclosures made before April 14, 2003.

To request an accounting of disclosures, please write to the hospital's Medical Records Department or physician office where your records are maintained. Your request must state a time period within the past six years (but after April 14, 2003) for the disclosures you want us to include. For example, you may request a list of the disclosures that we made between January 1, 2004 and January 1, 2005. You have a right to receive one accounting within every 12 month period for free. However, we may charge you for the cost of providing any additional accounting in that same 12 month period. We will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred.

Ordinarily we will respond to your request for an accounting within 60 days. If we need additional time to prepare the accounting you have requested, we will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting. In rare cases, we may have to delay providing you with the accounting without notifying you because a law enforcement official or government agency has asked us to do so.

NOTICE OF PRIVACY PRACTICE (CONTINUED)

4. Right To Request Additional Privacy Protections

You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, or run our business operations. You may also request that we limit how we disclose information about you to family or friends involved in your care. For example, you could request that we not disclose information about a surgery you had. To request restrictions, please write to Privacy Officer, Continuum Health Partners, Inc., Legal Affairs, 555 West 57th Street, 18th Floor, New York, New York 10019. Your request should include (1) what information you want to limit; (2) whether you want to limit how we use the information, how we share it with others, or both; and (3) to whom you want the limits to apply.

Please be aware that we are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law.

5. Right To Request Confidential Communications

You have the right to request that we communicate with you about your medical matters in a more confidential way by requesting that we communicate with you by alternative means or at alternative locations. For example, you may ask that we contact you at home instead of at work. To request more confidential communications, please write to the hospital's Medical Records Department or your treating physician's office. *We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.* Please specify in your request how or where you wish to be contacted, and how payment for your health care will be handled if we communicate with you through this alternative method or location.

Health Care Proxy

(1) I, _____

hereby appoint _____
(name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) **Optional: Alternate Agent**

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint

(name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions)*:

(4) **Optional:** I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary)*:

In order for your agent to make health care decisions for you about artificial nutrition and hydration (*nourishment and water provided by feeding tube and intravenous line*), your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

HEALTH CARE PROXY (CONTINUED)

(5) Your Identification (please print)

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of: (check any that apply)

Any needed organs and/or tissues

The following organs and/or tissues _____

Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses (Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date _____ Date _____

Name of Witness 1 Name of Witness 2

(print) _____ (print) _____

Signature _____ Signature _____

Address _____ Address _____

About the Health Care Proxy

This is an important legal form. Before signing this form, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, except to the extent you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless you say otherwise, your agent will be allowed to make all health care decisions for you, including decisions to remove or withhold life-sustaining treatment.
3. Unless your agent knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube), he or she will not be allowed to refuse those measures for you.
4. Your agent will start making decisions for you when doctors decide that you are not able to make health care decisions for yourself.

You may write on this form any information about treatment that you do not desire and /or those treatments that you want to make sure you receive. Your agent must follow your instructions (oral and written) when making decisions for you.

If you want to give your agent written instructions, do so right on the form. For example, you could say:

*If I become terminally ill, I **do/don't** want to receive the following treatments.....*

*If I am in a coma or unconscious, with no hope of recovery, then I **do/don't** want.....*

*If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I **do/don't** want...*

I have discussed with my agent my wishes about _____ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is **not** a complete list of treatments about which you may leave instructions.

- artificial respiration
- artificial nutrition and hydration (nourishment and water provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antipsychotic medication
- electric shock therapy
- antibiotics
- surgical procedures
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

Talk about choosing an agent with your family and/or close friends. You should discuss this form with a doctor or another health care professional, such as a nurse or social worker, before you sign it to make sure that you understand the types of decisions that may be made for you. You may also wish to give your doctor a signed copy. **You do not need a lawyer to fill out this form.**

You can choose any adult (over 18), including a family member, or close friend, to be your agent. If you select a doctor as your agent, he or she may have to choose between acting as your agent or as your attending doctor; a physician cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. You should ask staff at the facility to explain those restrictions.

You should tell the person you choose that he or she will be your health care agent. You should discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.

Even after you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object. You can cancel the control given to your agent by telling him or her or your health care provider orally or in writing.

Filling Out The Proxy Form

- Item (1) Write the name, home address and telephone number of the person you are selecting as your agent.
- Item (2) If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.
- Item (3) Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.
- Item (4) If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: *I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.*

If you wish to make more specific instructions, you could say:

If I become terminally ill, I do/don't want to receive the following types of treatments....

If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don't want the following types of treatments:....

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want the following types of treatments:....

I have discussed with my agent my wishes about _____ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- artificial respiration
- artificial nutrition and hydration (nourishment and water provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antipsychotic medication
- electric shock therapy
- antibiotics
- surgical procedures
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

- Item (5) You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.
- Item (6) You may state wishes or instructions about organ and/or tissue donation on this form. A health care agent cannot make a decision about organ and/or tissue donation because the agent's authority ends upon your death. The law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your spouse, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death, or any other legally authorized person.
- Item (7) Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

SUMMARY OF POLICY ON ADVANCE DIRECTIVES

It is our policy to honor decisions made by patients receiving medical care, including decisions to accept or refuse medical or surgical treatment, and to honor the advance directives of patients, including living wills, health care proxies, and oral statements, to the full extent permitted by law. Copies of our Health Care Proxy policy, Do Not Resuscitate policy and Policy on Oral and Written Advance Directives are available upon request. We encourage each patient or family member to discuss these issues with the patient's attending physician.

PLANNING IN ADVANCE FOR YOUR MEDICAL TREATMENT

New York State Department of Health 12/91

YOUR RIGHT TO DECIDE ABOUT TREATMENT

Adults in New York State have the right to accept or refuse medical treatment, including life-sustaining treatment. Our Constitution and state laws protect this right. This means that you have the right to request or consent to treatment, to refuse treatment before it has started, and to have treatment stopped once it has begun.

PLANNING IN ADVANCE

Sometimes because of illness or injury people are unable to talk to a doctor and decide about treatment for themselves. You may wish to plan in advance to make sure that your wishes about treatment will be followed if you become unable to decide for yourself for a short or long time period. If you don't plan ahead, family members or other people close to you may not be allowed to make decisions for you and follow your wishes.

In New York State, appointing someone you can trust to decide about treatment if you become unable to decide for yourself is the best way to protect your treatment wishes and concerns. You have the right to appoint someone by filling out a form called a Health Care Proxy. A copy of the form and information about the Health Care Proxy are available from your health care provider.

If you have no one you can appoint to decide for you, or do not want to appoint someone, you can also give specific instructions about treatment in advance. Those instructions can be written, and are often referred to as a Living Will.

You should understand that general instructions about refusing treatment, even if written down, may not be effective. Your instructions must clearly cover the treatment decisions that must be made. For example, if you just write down that you do not want "heroic measures," the instructions may not be specific enough. You should say the kind of

treatment that you do not want, such as a respirator or chemotherapy, and describe the medical condition when you would refuse the treatment, such as when you are terminally ill or permanently unconscious with no hope of recovering. You can also give instructions orally by discussing your treatment wishes with your doctor, family members or others close to you.

Putting things in writing is safer than simply speaking to people, but neither method is as effective as appointing someone to decide for you. It is often hard for people to know in advance what will happen to them or what their medical needs will be in the future. If you choose someone to make decisions for you, that person can talk to your doctor and make decisions that they believe you would have wanted or that are best for you, when needed. If you appoint someone and also leave instructions about treatment in a Living Will, in the space provided on the Health Care Proxy form itself, or in some other manner, the person you select can use these instructions as guidance to make the right decision for you.

DECIDING ABOUT CARDIOPULMONARY RESUSCITATION

Your right to decide about treatment also includes the right to decide about cardiopulmonary resuscitation (CPR). CPR is emergency treatment to restart the heart and lungs when your breathing or circulation stops.

Sometimes doctors and patients decide in advance that CPR should not be provided, and the doctor gives the medical staff an order not to resuscitate (DNR order). If your physical or mental condition prevents you from deciding about CPR, someone you appoint, your family members, or others close to you can decide. A brochure on CPR and your rights under New York law is available from your health care provider.

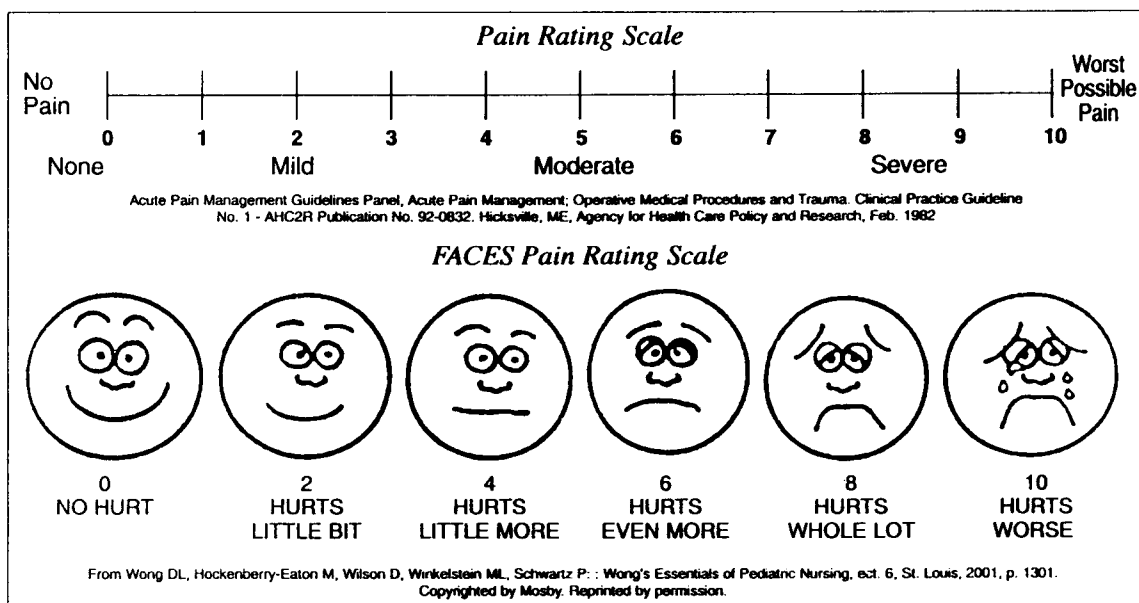
CONTINUUM HEALTH PARTNERS

PATIENT INFORMATION ON PAIN MANAGEMENT

We are committed to recognizing and treating your pain using medicines and treatments that will provide the best level of relief. As the patient, you have valuable information regarding your pain to give to the staff. Remember that you know your pain best.

Always tell your doctor, nurse *or* other staff member when you are having pain. Don't be afraid to ask for pain medicine. Many people are so worried about "getting hooked" *or* addicted that they don't talk about their pain or take the medicines that are prescribed. In most cases, addiction is not a concern and medicines can, and should, be taken to relieve pain. If you have concerns about addiction, you should speak openly about them to your doctors and nurses. Managing pain is an important aspect of getting well.

The nurses and doctors will ask questions about the intensity (how strong), location and the type (throbbing, burning, aching) of pain you may be experiencing. We often ask you to rate the intensity of pain, using a **pain scale**. The pain scale is used in evaluating the pain and also in evaluating the effectiveness of pain medications or treatments. The **pain scale** uses numbers from 0 (no pain) to 10 (the worst pain possible) or pictures of faces that show various levels of pain intensity.



It is helpful for you to know that pain control is important in providing you with the comfort and strength to heal and get well. We know that patients who have their pain well controlled generally tend to recover better and faster.

We can provide a variety of options in the prevention and management of pain. Some of these options are:

- pain medication by mouth (pills) or skin patch
- pain medicine given by injection into a muscle
- pain medicine given into a vein

PATIENT INFORMATION ON PAIN MANAGEMENT (CONTINUED)

- pain medicine given through a PCA (Patient Controlled Analgesia) pump: This is a machine that contains pain medicine. It has a button that you can push to give yourself a dose of pain medicine when you need it (within the limits ordered by your doctor).
- Regional Anesthesia and Spinal Medications: local anesthetics and/or pain medicine is injected into the spine or other areas to relieve pain or numb a part of the body for a period of time
- There are also methods that can assist in the relief of pain that don't involve medicines at all, such as: relaxation techniques, hot or cold packs, rest, deep breathing exercises, proper positioning in the bed or chair and the positive effects of using distraction techniques such as music, television and visitors.

No matter which pain management therapy you use, remember some important facts:

- Discuss pain management therapy with your health care providers. Let them know your allergies, previous experience with pain medicines, other medications that you are taking and your health history.
- Tell the staff how strong or severe your pain is. Let them know what makes it better and what makes it worse.
- Ask for pain medication when you need it or before doing an activity that may cause pain—**don't wait until the pain is too strong or out of control**
- Give the pain medication time to work. Ask the staff when you can expect to feel some relief from the pain.
- Use rest, deep breathing and other non-drug treatments to *help* your pain.
- Tell the staff how you are feeling. Let them know if or how effective the pain management therapy is. Tell them if you are experiencing any unexpected or unacceptable effects from your pain management therapy.

Your health care provider knows how to assess and treat your pain. If you have any questions or need further information, speak with your nurse or doctor.