BMS FAMILY HEALTH AND WELLNESS CENTERS
592 Rockaway Avenue Brooklyn, New York 11212

HIPAA PRIVACY RULE COMPLIANCE

FORM OF CONSENT

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT INFORMATION:

Patient's Name: _____

Patient's Address: _____

Patients' Telephone Number: _____

Patient's Medical Record Number: _____

Acknowledgment of Receipt: I, the undersigned patient or other person legally authorized to act for the patient, have been provided with a copy of ***the Notice of Privacy Practices for Protected Health Information,*** and I have had the right to review the ***Notice*** prior to signing this ***Consent.***

Consent for Use and Disclosure of Protected Health Information: I, the undersigned patient or other person legally authorized to act for the patient, understand and agree that all health information concerning the above-named patient ***("Protected Health Information")*** shall remain the property of BMS Family Health and Wellness Centers. I consent to the use and disclosure of such Protected Health Information as described in BMS Family Health and Wellness Center's ***Notice of Privacy Practices for Protected Health Information.*** Except for the reasons described in the ***Notice,*** I may revoke this *Consent* in writing at any time using the procedure in the ***Notice.***

This is to certify that I, the undersigned patient or other person legally authorized to act for the patient, have read this ***Consent for Use and Disclosure of Protected Health Information and Acknowledgment of Receipt of Notice of Privacy Practices,*** understand its content, and accept its terms. I agree that this ***Consent*** supersedes any and all previous consents, authorizations, releases, and other written legal permissions signed by me regarding use and disclosure of the Protected Health Information covered by this ***Consent,*** and I release BMS Family Health and Wellness Centers and its health care providers from all liabilities related to their compliance with this ***Consent.***

Basis of Authority to Act for Patient ☐Patient ☐Parent ☐Guardian ☐Legal Representative

_____
Signature of Patient, Patient's Parent, Guardian, or Authorized Legal Representative

_____
Printed Name of Patient's Representative

_____
Address of Patient's Representative

_____
Telephone Number of Patient's Representative

_____
Date

EFFECTIVE DATE. April 14,2003 **REVISION DATE. April 2, 2025**

☐ BMS MAIN	☐ BMS @ BRISTOL	☐ BMS @ ASHFORD	☐ BMS URGENT CARE	☐ BMS @ JEFFERSON SBHC
592 Rockaway Avenue Brooklyn, NY 11212 718-345-5000	259 Bristol Street Brooklyn, NY 11212 718-345-5000	650 Ashford Street Brooklyn, NY 11207 718-345-5000	407 Dumont Avenue Brooklyn, NY 11212 347-842-2905	400 Granville Payne Avenue Brooklyn, NY 11207 347-505-1800

PATIENT REGISTRATION AND GENERAL CONSENT FORM

MR #: _____

DEMOGRAPHIC INFORMATION: PLEASE PRINT IN UPPERCASE LETTERS

Last Name: _____ **First Name:** _____ **Maiden Name:** _____

Middle Name: _____ **Other Name:** _____ **Date of Birth (MM/DD/YYYY):** _____

Social Security #: _____ **Home Telephone:** _____ **Mobile Phone:** _____

Address: _____ **Apt #:** _____ **City/State/Zip Code:** _____ **Email Address:** _____

I Consent to Receive Emails Regarding My Appointments, Health Information, Prescription Notifications, Announcements, and Billing ☐**YES** ☐**NO**

I Consent to Receive Text Messages Regarding My Appointments, Health Information, Prescription Notifications, Announcements, and Billing ☐**YES** ☐**NO**

LANGUAGE PREFERENCE ☐English ☐Spanish ☐Creole ☐French ☐American Sign Language (ASL) ☐Other (Please Specify) _____

LANGUAGE INTERPRETATION NEEDED ☐Yes ☐No ☐Not Sure

RACE:
☐ Black or African American ☐White ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific Islander ☐Other (Please Specify) _____ ☐Prefer Not to Disclose

ETHNICITY: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Prefer Not to Disclose

SEXUAL IDENTITY: ☐Heterosexual (Straight) ☐Lesbian ☐Gay ☐Bisexual ☐Queer ☐Pansexual ☐Asexual ☐Questioning/Unsure ☐Other (Please Specify) _____ ☐Prefer Not to Disclose

GENDER IDENTITY: ☐Male ☐Female ☐Transgender Male (Female-to-Male) ☐Transgender Female (Male-to-Female) ☐Genderqueer/Gender Non-Conforming ☐Non-Binary ☐Other (Please Specify) _____ ☐ Prefer Not to Disclose

ASSIGNED SEX AT BIRTH: ☐Male ☐Female ☐Prefer Not to Disclose

MARITAL STATUS: ☐Single ☐Married ☐Domestic Partnership ☐Divorced ☐Widowed ☐Separated ☐Prefer Not to Disclose

FINANCIAL DATA: Family Household Size: _____ Family Income (**ANNUALLY**) **$** _____

☐Employed ☐Unemployed ☐Retired ☐Other (Please Specify):_____

EMPLOYER Occupation: _____ Business Address: _____ Business Phone: _____

THIRD PARTY PAYMENT INFORMATION:

Insurance Relation: ☐Self ☐Spouse ☐Child ☐Other (Please Specify) _____

Insured Name: _____ Insured Date of Birth (MM/DD/YYYY): _____

Insurance Name: _____ Insurance ID No. _____ Date of Expiration _____

Consent: I hereby authorize the BMS Family Health & Wellness Centers to administer such medications and immunizations and to perform such diagnostic procedures as may be necessary for proper health and dental care.

Signature: _____ **Date:** _____

Pregnant Minor's Signature: _____ **Date:** _____

Guardian Information:
If Minor, Under 18 Years Old, Signature of Guardian: _____ **Relationship to Patient:** _____ **Date:** _____

In Case of Emergency, Notify:

Name: _____ **Relationship:** _____ **Telephone:** _____

Address: _____

***Sliding Fee Scale available to all based on family size and income. No patients are denied services due to insurance or immigration status or ability to pay.**

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MR #: _____

HOUSEHOLD INFORMATION

Type of Household- Please Select One:

☐ Single (18+)	☐ Single (18+) with Child(ren)	☐ Married
☐ Married with Child(ren)	☐ Foster Child	☐ Unattached Child (19)
☐ Child Head of Household (<18)	☐ Widow/Widower	☐ With Significant Other
☐ With Significant Other & Child(ren)		

Agricultural Worker- Please Select One:

☐ Migrant	☐ Seasonal

Living Arrangements (if homeless)- Please Select One:

☐ Shelter	☐ Transitional	☐ Doubling Up
☐ Street	☐ Unknown	☐ Other (Please Specify_____

Reason for Homelessness- Please Select One:

☐ Eviction	☐ Unemployment	☐ Disaster Displacement
☐ Abuse	☐ Mental Impairment	☐ Substance Abuse
☐ Physical Impairment	☐ Other (Please Specify_____	

Source of Income-Please Select One:

☐ Employment	☐ AFDC	☐ SSD SSI
☐ None	☐ SSA	☐ Unemployment
☐ Workers Compensation	☐ Pension/Retirement	☐ VA Benefits
☐ Alimony/Child Support	☐ Other (Please Specify) _____	

Referred by- Please Select One:

☐ Advertisement	☐ Self-Referral	☐ Primary Care Physician
☐ Word of Mouth	☐ Insurance Company	☐ Hospital
☐ Patient in the Practice	☐ Other (Please Specify) _____	

Print Name: _____

Signature: _____

Date: _____

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PATIENT REGISTRATION AND GENERAL CONSENT FORM MR #: _____

PARENT/GUARDIAN AUTHORIZATION FORM FOR UTILIZATION OF SERVICES

I, _____, the Parent/Guardian or an Authorized Legal Representative, hereby give permission for my child (13-17 years old), to be seen for routine medical services at this facility when accompanied by one of the following person(s) named below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Print Name: _____
Parent/Guardian or Authorized Legal Representative

Signature: _____
Parent/Guardian or Authorized Legal Representative

Date: _____

Please note that all authorized representatives accompanying child are required to present a valid picture ID.

This form MUST be updated annually.

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PATIENT REGISTRATION AND GENERAL CONSENT FORM

MR #: _____

AUTHORIZED REQUESTER FORM

I _____, of _____
Patient Address

Do authorize _____, _____
Authorized Requester Relationship to Patient

to pick up the following medical record documents on my behalf.

My Authorized Requester may only receive the following documents on my behalf.

☐Referral Documents for Tests and Procedures

☐Prescription Copies

☐M11Q Form

I understand this document only permits my Authorized Requester to receive the document(s) listed and checked off.

PLEASE NOTE: I may revoke this document at any time.

Patient Signature: _____ Date: _____

THIS DOCUMENT WILL EXPIRE 12 MONTHS AFTER IT IS SIGNED BY THE PATIENT AND REQUESTER.

Authorized Requester's _____ Date_____
Signature

Authorized Requester's _____
Address

Authorized Requester's _____
Telephone #

PLEASE NOTE THAT ALL AUTHORIZED REQUESTERS ARE REQUIRED TO PRESENT A VALID PICTURE ID AT ALL TIMES

FOR OFFICIAL USE ONLY

Authorized Requester Picture ID on file ☐YES ☐NO

Staff's Signature _____ _____
Print Name Signature

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PATIENT REGISTRATION AND GENERAL CONSENT FORM

MR #: _____

RESPONSIBLE TO PAYMENT FORM

Thank you for choosing BMS Family Health and Wellness Centers as your healthcare facility. We are committed to providing and promoting integrative and high quality medical, dental, and social services to enable every individual and family to achieve total health.

OFFICE VISITS & OFFICE SERVICES:

Please be advised payment of your bill is part of your treatment and care.

You are responsible for payment of any deductible, co-payment and/or co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. Upon request, a member of our Patient Services staff will connect you with your insurance to discuss any deductibles and out of pocket expenses you are responsible for as outlined by your insurance plan. Providers are prohibited from charging any additional amount for a service billed to the Medicaid and Medicare program. We cannot charge additionally for treatment services that are not covered by the program; or are more costly without entering into a written ***"private pay arrangement"*** before treatment which precludes any payment by the Medicaid and Medicare program. For Managed Care participants, you may have to pay for any service that your Primary Care Physician (PCP) does not approve. Also, prior to services rendered, you agree to be a "private pay" or "self-pay" patient you will have to pay for the service. This includes non-covered services (defined in your plan member handbook), unauthorized services and services by provider(s) who are not part of your insurance plan.

HOW MAY I PAY?

We accept payment by Cash, VISA, MasterCard, Discover or American Express with a copy of a valid photo ID.

ACKNOWLEDGEMENT:

I have read, understand and agree to the above Payment Policy. I understand that my co-payment, co-insurance and deductibles are due and payable at the time of service. I understand I must be knowledgeable of my insurance coverage, exclusions and my responsibilities.

- I authorize my insurance benefits be paid directly to Brownsville Community Development Corporation d/b/a BMS Family Health and Wellness Centers.

_____	_____	_____
Date	Patient's Name	Patient/ Guardian's Signature
_____	_____	
Date	Staff's Signature	

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