Cerebral Palsy Association of Nassau County, Inc.

380 Washington Avenue Roosevelt, New York 11575

CONSUMER DEMOGRAPHIC/ INSURANCE INFORMATION

Patient Demographic Information		
Patient Name:		
Address:		
Home Phone:	Cell Phone:	Work Phone:
Email:		
Date of Birth:	Social Security Number:	
Preferred Language:		
Race:		
Ethnicity:		
Guardianship Information		
Are you your own Guardian?	Yes ☑	No ☐
If no, name of Legal Guardian:		
Relationship to Patient:		
Program Information		
Program Patient is attending:		
School Patient is attending:		
Emergency Contact Information		
Name:	Relation to Patient:	
Phone:	Email:	
Primary Insurance Information		
Primary Insurance Carrier:	Policy Number:	
Policy Holder's Name:	Relation to Patient:	
Policy Holder's Address:		
Policy Holder's Date of Birth:	Email:	
Secondary Insurance Information		
Secondary Insurance Carrier:	Policy Number:	
Policy Holder's Name:	Relation to Patient:	
Policy Holder's Address:		
Policy Holder's Date of Birth:	Email:	
Tertiary Insurance Information		
Tertiary Insurance Carrier:	Policy Number:	
Policy Holder's Name:	Relation to Patient:	
Policy Holder's Address:		
Policy Holder's Date of Birth:	Email:	

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VERIFICATION OF RECEIPT OF HEALTH INFORMATION PRIVACY PRACTICES

By signature below, I verify that I have received a copy of the Health Information Privacy Practices of the Cerebral Palsy Association of Nassau County, Inc. (CPN).

_____

Signature of Person or Personal Representative

_____

Date

_____

Printed Name of Person or Personal Representative

_____

Description of Personal Representative's Authority

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CONSENT FOR MEDICAL SERVICES

1. **Permission.** I hereby authorize Cerebral Palsy Association of Nassau County, Inc (CPN) to provide Medical Care Services for:

   _____

   (Name of Patient)

   These services may include the performance of any routine diagnostic evaluation, tests and procedures, including but not limited to: the administration and/or injection of pharmaceutical products; including immunizations and medications; and the drawing of blood specimens, which is deemed advisable by, and to be rendered under the suspension of a licensed health care professional providing medical services on behalf of Cerebral Palsy Association of Nassau County, Inc. and/or its related clinics/facilities.

2. **Benefits and Alternatives.** The medical personnel has fully explained to me the nature and purposes of the procedures, evaluation, and course of treatment, and has informed me of expected benefits and complications, attendant discomforts and risks that may arise, as well as alternatives to the proposed treatment and the risks and consequences that are attendant to the performance of any services, which have been explained to me.

3. **No Guarantees.** I acknowledge that no guarantees or assurances have been made to me concerning the results of the services.

4. **Duration.** I understand that this consent form will be valid and remain in effect as long as I receive the services at CPN.

5. **Understanding of the form.** I confirm that I have read and fully understand this consent form. I have been given an opportunity to ask questions and all my questions have been answered to my satisfaction.

*The signature of the Patient must be obtained unless the Patient is an unemancipated minor under the age of 18 or is otherwise incompetent to sign.

Patient/Relative/Guardian:		
(Signature)	(Print Name)	Date:
Relationship to Patient (*if signed by person other than the Patient*)		
Witness/Interpreter: *(Signature & Print Name)*		Date:
MEDICAL PERSONNEL CERTIFICATION		
I hereby certify that I have explained the nature, purpose, benefits, risks of and alternatives to the proposed services, have offered to answer any questions and have answered such questions. I believe that the Patient/Relative/Guardian understands what I have explained and answered.		
Signature	Print Name	Date:

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PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

In general, the HIPPA privacy rule is designed to protect your privacy as a consumer of Cerebral palsy .Association of Nassau County, Inc. (CPN). HIPPA stands for Health Insurance Portability and Accountability .Act. Under HIPP.\ you have the right to request that communications with you be confidential and by the means of your selection. We, at CPN, assume that we may contact you by telephone at your home and at your work, and in writing at your home, unless you instruct us otherwise. Once we agree to your request, we are obligated to honor it, except if an emergency arises.

Patient's Name_____

I wish to be contacted in the following manner (check all that apply):

☐ At my home/cell telephone number: (H) _____ /(C)_____

☐ O.K. to leave message with detailed information ☐ Leave message with call-back number only

☐ At my work telephone number:

_____

☐ O.K. to leave message with detailed information

☐ Leave message with call-back number only

Written communication:

☐ O.K. to mail to my home address: _____

☐ O.K. to mail to my work/office address: _____

☐ O.K. to fax to this number: _____

I understand that CPN may need to contact me by letter or telephone and may do so at the following address and telephone number, if none of the above is checked:

Name of contact person: _____

Address: ----------

Telephone number: _____

Patient/Relative/Guardian:		
(Signature)	**(Print Name)**	**Date:**