# Application For Medical Services

GCIU 21

## THE SIDNEY HILLMAN HEALTH CENTER OF ROCHESTER

750 EAST AVENUE • ROCHESTER, NEW YORK 14607 • (585) 473-2000 • TOLL FREE 800-383-3797
(Serving members of the Rochester Regional Joint Board)

FOR OFFICE USE
APPROVAL
CARDS CHECKED ☐

Member's Health Center No.

**PHYSICAL EXAMINATION** ☐
**COMPLETE EYE EXAMINATION** ☐
**MEDICAL VISITS ONLY** ☐

**EYE POLICY STATEMENT:**
ONE COMPLETE EYE EXAM EVERY TWO YEARS. MORE FREQUENT EXAMINATIONS CAN BE ARRANGED IF NEEDED IN INDIVIDUAL CASES FOR MEDICAL REASONS.

1. Patient's Data: Mr. ☐ Mrs. ☐ Ms. ☐ SS#: ___ – ___ – ____ DOB ___ – ___ – ____

(first name) (last name)

Patient's Name

Street Address

City-State

Zip Code ____ – ____ Home Phone ___ – ___ – ____

E-Mail: _____ Cell ___ – ___ – ____

2. Patient's Medicare No. ___ – ___ – ____ – ___

Patient's Travelers Medicare No.

3. Patient is covered by: ☐ BC/BS ☐ Athem ☐ Blue Choice ☐ Blue Choice Senior ☐ MediCare Blue Choice
☐ EMPIRE BC/BS ☐ MVP ☐ MVP GOLD ☐ Other, please specify _____

Policy No. **(PLEASE ATTACH COPY OF INSURANCE IDENTIFICATION CARDS)**

4. Sidney Hillman Participating Primary Care Physician _____

If you already have an appointment(s) with your Primary Care Physician, please list date(s)_____ and time(s)_____

5. Sidney Hillman Participating Eye Doctor _____

If you already have an appointment(s) with your Eye Doctor please list date(s)_____ and time(s) _____

6. If it is important that appointment be on a special day, please state the day & time _____

*Foreign language requirement, *if available* (See note below) _____

7. If you are a spouse list member's name _____

Member's Employer _____ Check here if retired ☐

Union Health Steward _____ Member's Clock No.

**AUTHORIZATION TO RELEASE INFORMATION**

I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL OR CLINIC TO GIVE ALL INFORMATION REGARDING MY HEALTH TO THE SIDNEY HILLMAN HEALTH CENTER OF ROCHESTER AND I FURTHER AUTHORIZE THE SIDNEY HILLMAN HEALTH CENTER OF ROCHESTER AND ITS COOPERATING PHYSICIANS TO GIVE ANY INFORMATION REGARDING MY HEALTH TO ANY PRIVATE PHYSICIAN I MAY HAVE, UNLESS OTHERWISE RESTRICTED AS FOLLOWS;

**PLEASE NOTE:** INFORMATION PERTAINING TO A MEMBER'S HEALTH IS NOT AVAILABLE TO MEMBERS OR OFFICIALS OF THE UNION OR TO AN EMPLOYER. EXCEPT TO ASSIST IN SCHEDULING OR BILLING ISSUES. USE THE FORM ON THE REVERSE SIDE IF YOU WOULD LIKE THE HEALTH CENTER TO PROVIDE YOUR CONFIDENTIAL INFORMATION TO A FAMILY MEMBER OR OTHER REPRESENTATIVE. IT IS HELD IN STRICTEST CONFIDENCE AT THE HEALTH CENTER AND WILL BE AVAILABLE ONLY TO THOSE IN THE MEDICAL PROFESSION IN ACCORDANCE WITH CURRENT REGULATIONS.

**I HAVE READ THE FOREGOING AND ALL STATEMENTS AND REPRESENTATIONS MADE BY ME ARE TRUE AND CORRECT. I AGREE THAT, IN THE EVENT I FAIL TO KEEP A SCHEDULED APPOINTMENT, I SHALL BE RESPONSIBLE TO PAY TO THE HEALTH CENTER ANY EXPENSES INCURRED BY IT AS A RESULT OF SUCH FAILURE.**

PATIENT'S SIGNATURE _____ DATE _____

MEMBER'S SIGNATURE (if patient is not the member) _____

**UNION HEALTH STEWARD PLEASE NOTE**

*VERY FEW PHYSICIANS SPEAK LANGUAGES OTHER THAN ENGLISH. IF THE PATIENT REQUIRES THAT A FOREIGN LANGUAGE BE SPOKEN, AND A DOCTOR WHO SPEAKS THAT LANGUAGE IS NOT AVAILABLE THEY SHOULD BE TOLD TO BRING AN INTERPRETER TO THE APPOINTMENTS. THE INTERPRETER SHOULD BE OVER 16 YEARS OLD AND OF THE SAME SEX AS APPLICANT.

Union Health Steward's Signature _____

USE THIS FORM IF YOU WOULD LIKE THE HEALTH CENTER TO PROVIDE YOUR CONFIDENTIAL MEDICAL INFORMATION TO A FAMILY MEMBER OR OTHER REPRESENTATIVE

**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

By signing this authorization, I authorize the Sidney Hillman Health Center to use and/or disclose certain protected health information (PHI) about me

to _____, _____. This authorization permits the Sidney Hillman Health
(Name of person we can share this information with) (Relationship)

Center to use and/or the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.): ALL TYPES OF SERVICES.

The information will be used or disclosed for the following purpose: AT THE REQUEST OF PATIENT .

If requested by the member, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.
(Expiration Date or Defined event).

The Sidney Hillman Health Center will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from the Sidney Hillman Health Center. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may not longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the Sidney Hillman Health Center has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

The Sidney Hillman Health Center
750 East Avenue
Rochester, NY 14607

Signed By:

_____ _____
Signature of Member , Legal Guardian or Power of Attorney — Relationship to Member if Legal Guardian or Power of Attorney

_____ _____
Print Name of Member — Date

***MEMBER/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION.***

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**HCN** _____

**SHHC REPRESENTATIVE** _____

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