**HIV/AIDS POLICY**

**Reporting Requirements:**

Your name will be reported to the Health Department if you have confirmed positive HIV Antibody test result received through confidential test, other HIV- related test results, a diagnosis of AIDS or if you have chosen to attach your name to a positive test result at an anonymous site. The Department of Health will use this information to track the epidemic and to better plan prevention, health care and other services.

**Notifying Partners:**

If you test HIV positive, your provider will talk to you about the importance and benefits of notifying your partners of their possible exposure to HIV. It is important that your partners know that they have been exposed to HIV so they can find out whether they are infected and benefit from early diagnosis and treatment. Your provider may ask you to provide the names of your partners and whether it is safe for you if they are notified. If you have been in an abusive relationship with one of these partners, it is important to share that information with your provider.

**For your information regarding services related to Domestic Violence call 1-800-942-6906**

Under state law, your provider is required to report to the Health Department the names of any of your partners (present and past sexual partners, including spouses and needle sharing partners) whom they know.

If you have additional partners whom your provider does not know, you may give their names to your provider so that they can be notified.

Several options are available to assist you and your provider in notifying partners. If you or your provider does not have a plan to notify your partners, the Health Department may notify them without revealing your identity, If this notification presents a risk of harm to you, the Heath Department may defer notification for a period of time sufficient to allow you to access domestic violence prevention services.

If you do not name any partners to your provider or if you need to confirm about your partners, the Health Department may contact you to request your coordination for this process.

**Confidentiality of HIV Test Results and Related Information**

If you feel your confidentially has been broken, or for more information about HIV confidentiality call New York State Department of Health HIV confidentiality line at 1-800-962-5065. Any health or social service provider who illegally tells anyone about your HIV information may be punished by a fine up to $5,000 and jail term of up to one year. The law also protects you from HIV related discrimination in housing, employment, health care, or other services. For information call New York State Division of Human Rights at 1-888-392-3644

**HIXNY**

Your Health information…. ALWAYS AT YOUR DOCTORS FINGERTIPS

To give you the safest care your doctor usually needs a lot of information. Your medical history, allergies, prescriptions, specialist visits, lab tests and more. The health information X- change of New York (HIXNY) is an easy way for your doctors to get this information. HIXNY has created a secure, electronic service for exchanging health information among hospitals and doctors in the capital region. This service allows your doctor to view and share information like medication history, allergies and test results. It also lets doctors write prescriptions online and send them to your pharmacy. The benefits of having accurate up to date information include fewer repeated tests, reduce risk of mistakes, easier second opinions and less chance of drug interactions.

If consent is DENIED sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT TREATMENT POLICY**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ by becoming a patient of Family Medicine of Malta request treatment from Dr. Marc D. Price D.O. and his agents.

I understand that it is my responsibly to make sure serviced provided are covered benefits under MY particular insurance policy. I shall be responsible for payment in the form of co-payment, co-insurance, deductible and for any uncovered charges related to the services provided. I further understand that if I do not present valid and sufficient information of my health insurance coverage or if Dr. Price and his agents do not participate with my insurance carrier, or if I have no insurance coverage, that I will be responsible for all incurred charges in full.

**INFORMED CONSENT TO PREFORM AIDS/HIV TESTING**

Check here that you have read the AIDS/HIV policy before signing below

**YES, I would like to speak with someone about HIV testing**

**NO, I do not wish to have HIV testing preformed at this time**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**