

## Welcome to Primary Care Associates of Sewickley

It is a pleasure to have you as a new patient in our office today. As your healthcare provider, it is our goal to provide you with excellent medical care and to ensure we meet all your medical needs.

Please keep in mind that for all routine medical questions, test results or medication refills, you may call the office between the hours of 8:00 AM and 4:00PM Monday thru Friday. PLEASE ALLOW 2 BUSINESS DAYS FOR ROUTINE MEDICATIONS TO BE CALLED IN TO YOUR PHARMACY AND 3 BUSINESS DAYS FOR CONTROLLED MEDICATIONS. Heritage Valley also offers Health Link, an online application where you are able to send medication refill requests, request appointments and view test results. You can request an account at [www.heritagevalley.org/healthlink](http://www.heritagevalley.org/healthlink). You may also email them at [healthlink@hvhs.org](mailto:healthlink@hvhs.org) and the phone is 724-773-8344. We encourage participation in Health Link so that we may communicate normal results to you in a timely fashion.

If you are having a medical emergency after hours, please call our main number (412) 749-6938 and you will be connected with our answering service who will contact the doctor on call. If this is a true life threatening medical emergency please dial 911. **PLEASE KEEP IN MIND THAT NO CONTROLLED SUBSTANCES WILL BE CALLED IN BY ANY PHYSICIANS IN THE EVENINGS OR ON THE WEEKENDS** AND AFTER HOURS MEDICATION REQUESTS WILL BE HANDLED THE NEXT BUSINESS DAY.

Occasionally you may need to see a specialist or have additional testing done outside our office. If your insurance requires a referral or authorization for these services, please allow 2 to 5 business days (depending on your insurance) to obtain.

Please know **it is your responsibility to make sure you are presenting your most current insurance card at the time of your appointment**. Also, please make sure the physician listed on your card is Dr Justine Kostrub or Dr MoNika Sauber, if your insurance requires you to select a primary care physician (PCP). If you are unsure if your insurance covers our providers please call the member services number on the back of your card to verify we are in network with your plan.

In addition, **co-pays are due at the time of the visit**. Payments may be made by cash, check, debit or credit card.

We request you please be on time for your appointments as we do our best to stay on schedule. **If you arrive 10 minutes past your scheduled appointment time, you may be asked to reschedule.**

If, for any reason you are unable to keep your appointment, please contact our office as soon as possible to reschedule. **If your appointment is not canceled outside of 24 hours or you do not show up for your scheduled appointment you will be charged a \$55 fee for a new patient visit or a \$25.00 fee for an established patient.**

Per doctor's request, **PLEASE TURN OFF YOUR CELL PHONE OR PLACE ON SILENT WHILE IN THE OFFICE.**

Once again, we appreciate the opportunity to provide you with medical care and we look forward to a productive patient/doctor relationship for all your future healthcare needs.

Sincerely,

Dr. Justine Kostrub  
Dr. MoNika Sauber

Patient Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Care Associates of Sewickley  
100 Hazel Lane Suite 200  
Sewickley PA 15143

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE STATE THE REASON FOR YOUR VISIT TODAY:**

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**CURRENT MEDICAL CONDITIONS:**

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**CURRENT MEDICATIONS**

Pharmacy Name & Phone: \_\_\_\_\_

*Please include birth control, vitamins, herbal supplements and over-the-counter medications used regularly.*

No current medications

Medication	Strength	Frequency	Reason for taking

**Past Surgical History** (please include procedures, i.e. endoscopy, colonoscopy, biopsies etc)

No surgical history

Surgery/Procedure	Date

**SOCIAL HISTORY**

Relationship Status: \_\_\_\_\_

Are You Sexually Active?:  Yes  No

Sexual Orientation: \_\_\_\_\_

Alcohol use:  Yes  No If yes, # of drinks/week: \_\_\_\_\_

Drug use (recreational, including marijuana):  Yes  No

IV drug use (past or present):  Yes  No

**Smoking Status:**

Nonsmoker Second Hand Smoke Exposure:  Yes  No

Current smoker \_\_\_\_\_ packs per day for \_\_\_\_\_ years Interested in quitting?  Yes  No

Former smoker \_\_\_\_\_ packs per day for \_\_\_\_\_ years, Quit date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Nicotine Substances Used:  cigarettes  cigars  chewing/pipe tobacco  e-cigarettes/vaping

Diet:  balanced  vegetarian  vegan  other (list): \_\_\_\_\_

Caffeine Use:  Yes  No If Yes, How Much? \_\_\_\_\_ Exercise: \_\_\_\_\_ times/week

Do you use a seatbelt:  Yes  No Does your home have smoke detectors:  Yes  No

Occupation: \_\_\_\_\_

Do you have an advanced directive?  Yes  No

**ALLERGIES**

No known drug allergies

Medication	Reaction	Medication	Reaction

**HEALTH MAINTENANCE**

Vaccine	Date	Vaccine	Date
Influenza		Pneumonia (Prennar, Pneumovax)	
Tetanus (Tdap/Adacel, Td)		Shingles (Zostavax, Shingrix)	

Date of last colon cancer screening (colonoscopy, FIT Test, ColoGuard): \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you ever had a stress test or cardiac catheterization?  Yes (\_\_\_\_/\_\_\_\_/\_\_\_\_)  No

Do you see a dentist every 6 months?  Yes  No

Have you had an eye exam in the last 2 years?  Yes (\_\_\_\_/\_\_\_\_/\_\_\_\_)  No

**Females:**

Have you ever been pregnant?     Yes                                     No  
 #of pregnancies: \_\_\_\_\_    # of live births: \_\_\_\_\_    # miscarriages: \_\_\_\_\_    #abortions: \_\_\_\_\_  
 Date of last pap smear:    \_\_\_\_/\_\_\_\_/\_\_\_\_    Date of last mammogram:    \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of last DEXA (bone density) scan: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Type of birth control: \_\_\_\_\_  
 If none, would you like to discuss options today?     Yes                                     No

**FAMILY HISTORY**

<b>Medical Condition</b>	<b>Mother</b>	<b>Father</b>	<b>Sibling</b>	<b>Maternal Grand-mother</b>	<b>Maternal Grand-father</b>	<b>Paternal Grand-mother</b>	<b>Paternal Grand-father</b>
Anemia (Low Blood Count)							
Asthma							
Autoimmune Disease (Lupus, Rheumatoid Arthritis)							
Bleeding Disorders							
Cancer (List Types)							
Clotting Disorder (DVT, PE)							
Congestive Heart Failure							
COPD/Emphysema							
Diabetes							
Gastrointestinal Disorders (Crohn's, Ulcerative Colitis)							
Genetic Disorders							
Heart Attack							
High Blood Pressure							
High Cholesterol							
Kidney Disease							
Liver Disease (Hepatitis, Cirrhosis)							
Mental Health Conditions (Depression, Anxiety, Suicide, Alcohol/Drug Addiction)							
Neurological Disorders (Epilepsy, MS, ALS)							
Osteoporosis							
Stroke							
Thyroid Disorder							

**Primary Care Associates of Sewickley**

**PATIENT INFORMATION**

NAME: LAST		FIRST	MIDDLE INITIAL	SEX	BIRTHDATE
				M F	
ADDRESS:	STREET	CITY	STATE	ZIP	TELEPHONE #
				( )	MARITAL STATUS
					S M W Sep Div
SOCIAL SECURITY #	E-MAIL ADDRESS	RACE (CIRCLE ONE)		ETHNICITY (CIRCLE ONE)	OCCUPATION (CIRCLE ONE)
CELL#	ALTERNATE#	American/AK Indian; Black/African American Asian/Pacific Islander; White/ Unknown/ Decline		Not of Hispanic Origin Hispanic Origin Unknown/ Decline	FT PT RET Not Employed
EMPLOYER OR NAME OF SCHOOL		ADDRESS	TELEPHONE #	ARE YOU A STUDENT?	
			( )	Yes No Parttime Fulltime	

**SPOUSE, PARENT OR GUARDIAN INFORMATION (If under 18, name of parent with whom you reside)**

NAME: LAST		FIRST	MIDDLE INITIAL	SEX	BIRTHDATE
				M F	
ADDRESS:	STREET	CITY	STATE	ZIP	TELEPHONE #
				( )	RELATIONSHIP TO PATIENT
					Spouse Parent Other
SOCIAL SECURITY #	EMPLOYER NAME AND ADDRESS			EMPLOYER TELEPHONE #	
					( )

**INSURANCE INFORMATION**

**\*\*\*\*PLEASE HAVE CARDS READY FOR STAFF TO COPY\*\*\*\***

NAME OF PRIMARY INSURANCE CO.		HOLDER'S RELATIONSHIP TO PATIENT: Circle one Parent Step Child Self Spouse Natural Child with financial responsibility Adopted Child Natural Child without financial responsibility Foster Child Significant Other Life Partner Grandchild Organ donor Other :Specify: _____
INSURED'S NAME (Subscriber of insurance)	SUBSCRIBER'S BIRTHDATE	
ID # OR AGREEMENT #	GROUP #	
EFFECTIVE DATE		

AMOUNT OF CO-PAY FOR OFFICE VISITS and SPECIALIST'S VISITS:

NAME OF SECONDARY INSURANCE CO		HOLDER'S RELATIONSHIP TO PATIENT: Circle one Parent Step Child Self Spouse Natural Child with financial responsibility Adopted Child Natural Child without financial responsibility Foster Child Significant Other Life Partner Grandchild Organ donor Other :Specify: _____
INSURED'S NAME (Subscriber of insurance)	SUBSCRIBER'S BIRTHDATE	
ID # OR AGREEMENT #	GROUP #	
EFFECTIVE DATE		

DO YOU HAVE OTHER INSURANCE THAT WILL PAY THIS ACCOUNT? You are required to complete an additional form.

- Automobile    Workmen's Comp    None    Other

Will patient be best served in a language other than spoken English? :   ° No   ° Yes If yes, please specify

**EMERGENCY CONTACT**

PLEASE NAME A PERSON WHO DOES NOT LIVE WITH YOU TO CONTACT IN CASE OF AN EMERGENCY OR IN THE EVENT WE ARE UNABLE TO REACH YOU.

NAME / RELATIONSHIP:	TELEPHONE # - HOME ( )
	TELEPHONE # - WORK ( )

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to either: **Heritage Valley Pediatric Group/ Heritage Valley OB/GYN/ Heritage Valley Medical Group/ as noted above.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_  
 PATIENT OR RESPONSIBLE PARTY

I acknowledge I have received a copy of Heritage Valley Health System's Notice of Privacy Practices for Protected Health Information.

Signed: \_\_\_\_\_ DATE: \_\_\_\_\_

Please tell us how you heard about our practice:    Friend/family    Newspaper    Internet    Website    Other \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_

ASSIGNMENT OF BENEFITS

MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related service.

We do accept Medicare assignment, however, you are responsible for your Medicare deductible. Many co-insurance plans do not cover the Medicare deductible and you will be billed. It is your responsibility to know if your co-insurance does not cover this. In addition, if the 20% after Medicare is not paid by your co-insurance, it is your responsibility to contact them regarding this. Please note: we will file your co-insurance one time only.

*I have read the above and fully understand my financial obligation.*

\_\_\_\_\_  
Date Patient Signature HIC #

MEDIGAP PATIENTS:

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by that provider of service and/or supplier. I authorize any holder of Medicare information about me to release to \_\_\_\_\_ (Name of Medigap insurer) and its agents any information needed to determine these benefits payable for related service.

*I have read the above and fully understand my financial obligation.*

\_\_\_\_\_  
Date Patient Signature HIC #

o **BLUE SHIELD PATIENTS**

We participate in a variety of Pennsylvania Blue Shield plans in addition to Blue Shield plans of other states. You will be billed for any applicable co-payments and deductibles. I understand that payment for office visits is due in full at the time of the visit.

o **COMMERCIAL HEALTH INSURANCE PATIENTS**

As a courtesy to our patients, when we have your complete insurance information, a claim is automatically submitted to your insurance carrier unless we are instructed otherwise. In some cases, you will receive payment. You are personally responsible for payment of the entire account. We will assist you; however, any questions related to delayed payment or denial should be directed to your insurance company and not to our office.

o **HMO AND PPO PATIENTS**

We participate in numerous HMO and PPO programs. Due to the varied guidelines defined by each plan, it is your responsibility to know your specific plan. Additionally, in certain programs, you will be responsible for any co-payments that apply.

o **SELF PAY PATIENTS**

Payment for services rendered is due at the time of service unless other arrangements have been made prior to your appointment. Your prompt payment is appreciated. We do not want your health care to be a financial hardship to you. If you have any difficulties, our billing department will help to establish a payment program to accommodate your needs.

*I have read the item checked above and fully understand my financial obligation.*

\_\_\_\_\_  
Date Patient Signature

Primary Care Associates of Sewickley  
Dr Justine Kostrub  
Dr. MoNika Sauber  
100 Hazel Lane Suite 200  
Sewickley PA 15143

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

By my signature below, I hereby authorize the practice to disclose my Protected Health Information (PHI) (including my HIV/Aids related information, if any) to the person(s) listed below.

NAME \_\_\_\_\_

Relationship \_\_\_\_\_

NAME \_\_\_\_\_

Relationship \_\_\_\_\_

NAME \_\_\_\_\_

Relationship \_\_\_\_\_

NAME \_\_\_\_\_

Relationship \_\_\_\_\_

*Patient's Signature* \_\_\_\_\_ *Date* \_\_\_\_\_

By signing below, I hereby authorize the practice to leave my Protected Health Information (including test results, prescriptions and appointment reminders) on the following:

\_\_\_\_\_ Answering Machine/Voice Mail (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_ E-mail \_\_\_\_\_

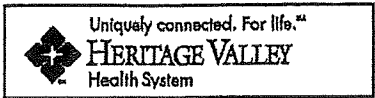
\_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

*Patient's Signature* \_\_\_\_\_ *Date* \_\_\_\_\_

(In effect until further notice from patient)

NOTE: As your primary physician, we will forward any patient information to other medical professionals/hospitals when needed in order to aid in the continuity of your care.

**PLEASE LEAVE COMPLETED FORM AT FRONT DESK BEFORE LEAVING**



**AUTHORIZATION FOR  
RELEASE OF INFORMATION  
TO BE SENT TO OUR PRACTICE**  
(Please print clearly)

**PATIENT INFORMATION:**

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Social security number \_\_\_\_\_ Date of birth \_\_\_\_\_

**I THE UNDERSIGNED, HEREBY AUTHORIZE:**

Practice or Doctor's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**TO PROVIDE:**

**Primary Care Associates of Sewickley  
Dr Justine Kostrub and Dr MoNika Sauber  
100 Hazel Lane, Suite 200  
Sewickley PA 15143  
Phone: 412-749-6938  
Fax: 412-749-6940**

**WITH THE FOLLOWING INFORMATION:**

**Medical Records Summary** (includes doctors' notes, hospital records, laboratory and diagnostic tests within past two years, medication list, problem list, most recent EKG, immunization record, and living will/advance directives). If records are being sent for a specialist consultation, the most pertinent records will be sent.

Other \_\_\_\_\_ For dates of service: from \_\_\_\_\_ to \_\_\_\_\_

PURPOSE OF DISCLOSURE:  I am transferring to this practice  Other \_\_\_\_\_

**Expressed Authorization: \*\*\*Signature Required\*\*\***

*I understand that my medical record may contain information related to:*

- *Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV*
- *Psychiatric Care*
- *Treatment for alcohol and/or drug abuse.*

I give my consent for release of this information: \_\_\_\_\_  
Signature Date

I DO NOT give consent for release of this information: \_\_\_\_\_  
Signature Date

This authorization for release of information is valid for 90 days from the date of signature, unless revoked by written notice to the providing institution, provided the notice is received prior to the release of information. I understand that signing this authorization is voluntary, and Heritage Valley Health System cannot deny me treatment for not agreeing to sign this authorization. I understand that I may see a copy of the information described on this form and that there may be a fee associated with copying. I understand that once the above information is disclosed, it may not be under control of Heritage Valley Health System and may not be protected by federal privacy regulations, therefore there is a potential for unauthorized re-disclosure. I understand that this authorization may be revoked at anytime. I understand that if I do revoke the authorization, I must do so in writing and present my written revocation to be filed in my medical record, which will not apply to information that has already been disclosed in response to this authorization. *If I have questions about the disclosure of my health information, I may contact the Office Manager or the Privacy Officer of Heritage Valley Health System.* I hereby certify that I have read this authorization and agree to its terms.

Required: Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

\*Signature if other than patient (use P.O.A. documentation) \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

Signature of witness \_\_\_\_\_ Date \_\_\_\_\_





Uniquely Connected. For life<sup>SM</sup>

## HERITAGE VALLEY HEALTH SYSTEM

### Heritage Valley Health System

#### Notice of Privacy Practices for Protected Health Information

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.**

Heritage Valley Health System (HVHS) CONTINUES TO BE COMMITTED TO PROTECTING THE PRIVACY OF YOUR MEDICAL AND BUSINESS INFORMATION. It has been our practice not to disclose your medical information for any purpose without your written authorization. We are now required by law to provide you with this statement to inform you in writing how your medical information will be used and disclosed.

Protected Health Information, or PHI, is defined by the federal government as, individually identifiable health information that is or has been electronically maintained, electronically transmitted by a covered entity, or information when it takes any other form. PHI is a part of health information, including demographic information, collected from the individual and is created or received by a healthcare provider, relates to past, present, or future health or condition of the individual or payment for the provision of care. PHI identifies the individual directly or affords that the individual can reasonably be identified. Covered entity is defined as a healthcare provider who transmits any health information in electronic form.

We are required by law to maintain the privacy of your protected health information and to provide you with this Notice of our legal duties and privacy practices. HVHS is required by law to follow the terms of this Notice. HVHS reserves the right to change the terms of the Notice and to make any revision necessary to the protected health information we maintain. Once given, you may revoke your authorization in writing at any time. Other uses and disclosures not described in the Notice will not be made without your authorization.

Following any revisions made to this Notice, HVHS will make these changes available through distribution of the revised Notice by posting the revised Notice in HVHS facilities and on the HVHS website.

#### **How your Medical Information May Be Used and Disclosed:**

- HVHS will use your medical information as part of providing patient care. For example, your medical information will be used by the healthcare professionals providing your care, by the business office to bill for the services provided, and by selected care and quality employees who review medical information to assure quality and medical necessity of services provided.
- HVHS may contact you to provide appointment reminders or information about treatments, alternatives, or other health-related benefits and services that may be of interest to you.
- During inpatient treatment at a HVHS facility, the hospitals and consulting physicians are considered an Organized Health Care Arrangement (OHCA). This means related health information can be shared for purposes of treatment, payment, or healthcare operations.
- Unless you object, while an inpatient or outpatient of HVHS, and with the exception of behavioral health patients, HVHS:
  - will include general information, including your name, location in the hospital, your condition described in general terms, and your religious affiliation in a list or directory of individuals located in the facility where you are hospitalized. This information, except for the religious affiliation, will be released to people who ask for you by name. Your religious affiliation may be given to members of the clergy, even if they do not ask for you by name.
  - disclose to family members, other relatives or close personal friends who are responsible for your care the medical information directly relevant to that person's involvement with your care.
  - use or disclose your medical information to notify a family member or personal representative of your location, general condition, or death.
- HVHS may also:
  - disclose your medical information to a public or private entity for the purpose of coordinating with that entity to assist in disaster relief efforts.

- use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation, and intervention.
- disclose medical information when requested by a licensed state or federal agency for accreditation purposes.
- disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and /or legal proceedings.
- disclose your medical information in the course of certain judicial or administrative proceedings.
- disclose your medical information for law enforcement purposes or other specialized government functions.
- disclose your medical information to a coroner, medical examiner, or a funeral director.
- if you are an organ donor, disclose your medical information to an organ donation and procurement organization.
- use or disclose your medical information for certain research purposes.
- use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or the public.
- disclose your medical information as authorized by laws relating to worker's compensation or similar programs.
- may contact you to raise funds for the hospital.

#### **Your Rights Regarding Your Medical Information:**

Your rights related to your medical information are as follows:

- You have the right to request restrictions on certain uses and disclosure of your medical information. HVHS is not required by law to agree to your requested restrictions except when disclosure is to a health plan for services paid exclusively by the patient.
- You have the right to receive communications from HVHS in a confidential manner.
- You have the right to inspect and obtain a copy of your medical information. This right is subject to certain specific exceptions. You will be charged a fee for any copies of your medical information.
- You have the right to request an amendment to your medical information. HVHS may deny your request for certain specific reasons. If HVHS denies your request a written explanation for the denial and information on further rights will be provided to you.
- You have the right to receive an accounting of the disclosures of your medical information made by HVHS for six years prior to your request, effective after April 14, 2003. By law, disclosures for treatment, payment, health care operations, and certain other specific disclosures are not included in the accounting.
- If you do not wish to be contacted for fundraising efforts, you may notify us in one of three ways.  
In writing: Heritage Valley Health Systems Foundations, 420 Rouser Road, Suite 102, Moon Township, PA., 15108  
By calling: 412-749-7121  
Or e-mailing: [foundation@hvhs.org](mailto:foundation@hvhs.org)
- You have the right to receive a paper copy of HVHS' Notice of Privacy Practices for Protected Health Information. You have a right to submit a complaint to HVHS and/or to the United States Department of Health and Human Services if you believe HVHS has violated your privacy rights. To complain to HVHS or to request additional information on your privacy rights, please contact HVHS' Privacy Officer by calling (724) 773-3434 or by writing to HVHS Privacy Officer, The Medical Center, Beaver, 1000 Dutch Ridge Road, Beaver, PA, 15009. If you choose to file a complaint you will not be retaliated against in any way.
- Per the federal Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification final rule published January 25, 2013, unless a specific exception as identified in 45 CFR 160 or 164 exists, you have a right to be notified of any unauthorized access, use or disclosure of your medical or business information which compromises the security or privacy of such information.

#### **Your Medical Information and Health Information Exchanges (HIE):**

HVHS participates in Health Information Exchanges (HIE). Generally, a HIE is an organization that regional hospitals, physicians, and other healthcare providers participate in to exchange patient information in order to facilitate health care, avoid duplication of services (such as tests)

and to reduce the likelihood that medical error will occur. By participating in the HIE, Provider may share certain of your health information with other providers that participate in the HIE (each a "Participating Providers") or participants of other health information exchanges. This health information could include, but is not limited to:

- General laboratory results including microbiology
- Pathology test results including biopsies, Pap smears, etc.
- Radiology results including x-rays, MRIs, CT scans etc.
- Results of outpatient diagnostic testing including GI testing, cardiac testing, neurological testing, etc.
- Health Maintenance documentation
- Problem list documentation
- Allergy list documentation
- Immunization profiles
- Medication lists
- Progress notes
- Consultation notes
- Discharge instructions
- Inpatient operative reports
- Emergency Room visit discharge summary notes
- Urgent Care visit progress notes

All Participating Providers have agreed to a set of standards relating to its access, sharing, use and disclosure of health information available through the HIE. These standards are intended to comply with all applicable state and federal laws. As a result, you understand and agree that unless you notify your healthcare Provider that you do not wish for your health information to be available through the HIE ("Opt-Out"):

- Health information that results from any Participating Provider providing services to you will be made available through the HIE. For clarity, if you Opt-Out, your health information will no longer be accessible through the HIE. However, your opt-out does not affect health information that was disclosed through the HIE prior to the time that you opted out;
- Regardless of whether you choose to opt-out of the HIE, your health information will still be provided to the HIE. However, if you choose to Opt-Out, the HIE will not exchange your health information with other providers. Additionally, you cannot choose to have only certain providers access your health information;
- All Participating Providers who provide services to you will have the ability to access to your information. However, Participating Providers that do not provide services to you will not have access to your information;
- Information available through the HIE may be provided to others as necessary for referral, consultation, treatment and/or the provision of other treatment-related healthcare services to you. This includes providers, pharmacies, laboratories, etc.
- Your information may be disclosed for payment related activities associated with your treatment by a Participating Provider; and your information may be used for healthcare operations related activities by Participating Providers.
- You may Opt-Out at any time by requesting an Opt-Out form from the registration staff at your point of service or in one of two ways.
  - In writing: Heritage Valley Health System, Medical Records – Release of Information, 1000 Dutch Ridge Road, Beaver, PA 15009
  - By emailing: [roi@hvhs.org](mailto:roi@hvhs.org)
  - Please allow (2) business days for the processing of your Opt-Out request.

A list of HIE Participating Providers may be found at: [www.heritagevalley.org/hie](http://www.heritagevalley.org/hie)



# HERITAGE VALLEY HEALTH LINK

**How do I become a member of Health Link?**  
Thank you for wanting to become a member of Health Link. There are three ways to create an account:

1. Receive an invitation at one of our Primary Care Physician Offices.
  - Select the "Request an Invitation" option on a kiosk located in your Primary Care Physician's office during check in.
  - Request an invitation to Health Link from your Primary Care Physician's office staff during your next visit.
2. Receive an "Opt-In" letter upon discharge from Heritage Valley Beaver, Heritage Valley Sewickley, or at one of our outpatient service locations.
  - The letter will contain your Full Name, Heritage Valley Health System Care Card Number, and a unique 12 digit "Opt-In" Code.
  - Create an Account Online at [www.heritagevalley.org/healthlink](http://www.heritagevalley.org/healthlink) by selecting the "Start Account Creation" button and completing the brief Information Form. Please use your Heritage Valley Health System Care Card Number and "Opt-In" Code from your letter.
3. Create an Account Online at [www.heritagevalley.org/healthlink](http://www.heritagevalley.org/healthlink) by selecting the "Start Account Creation" button and completing the brief Information Form.

**Are there any features that will be added?**

A number of features and enhancements will be added in the coming months which will enable Health Link users to:

- Send secure messages to their healthcare provider
- Request prescription renewals
- Make payments for Heritage Valley bills online using a credit card or electronic check.
- Fill out and submit forms prior to appointments

*If you have additional questions regarding Health Link, please email us at [healthlink@hvhs.org](mailto:healthlink@hvhs.org).*



**What is Health Link (powered by FollowMyHealth)?**

Heritage Valley's Health Link is a secure online patient portal that enables patients to:

- Conveniently and securely review their health information online
- View lab results, radiology reports, and read summaries from physician office and ConvenientCare visits
- View discharge summaries from hospital admissions
- Review health information (allergies, medications, conditions, etc.)
- Schedule Physician Office appointments (with participating physicians)
- Link to their child's information for easy access to health information  
...and more!

**What is FollowMyHealth?**

Hundreds of healthcare organizations and thousands of physicians across the country use FollowMyHealth as the power behind their hospital or clinic's specific patient portal. The FollowMyHealth platform combined with Health Link ensures that you and Heritage Valley will remain "Uniquely Connected... For Life"