Role Play Example:
Paperwork at the Sign In Desk

1. Sample "HIPAA" and the "Consent to Treat" forms are placed on a clipboard and given to the individual who plays the role of the office receptionist. The sample insurance card is given to the individual who plays the role of the patient.
2. Using the following script, practice the back and forth exchange that occurs when signing in for a medical appointment. Practice signing and dating the forms. Reverse roles and repeat.

You Will Need:

- ❑ Clip board
- ❑ "HIPAA" form
- ❑ "Consent to Treat" form
- ❑ Insurance card
- ❑ Pen or pencil

YOU

Hello, my name is: (say your name)
I have an appointment at (say time of your appointment)
I am here to see (say name of your doctor)

Office Receptionist

Ok, let's take care of some paperwork:
Signing the "Consent to Treat" form gives us permission to provide medical care. The "HIPAA" form gives us permission to share your health information with the insurance company and with any other people that you list on the form.

YOU

(Give receptionist your insurance card)
I would like to list someone on my HIPAA form.
Where do I add that information?

Office Receptionist

You can list people in this section.
(Receptionist indicates section on the HIPAA form)
Signing the form gives us permission to share your health information with anyone who is listed in this section.
(Receptionist copies insurance card for office records)

YOU

Thank you!
(Remember to sign and date the forms. Be sure the receptionist remembers to return your insurance card!)

How to use the Role-Play Template: Use this template as a script with 2 or more individuals, or use the blank template to customize scenarios. The insurance card and a clip board with the "HIPAA" and "Consent to Treat" forms are used as props. Have individuals practice signing the forms. Reverse roles and repeat. Use the "confidence meter" before and after each role-play session to track progress.

Benefit Card

ID Number
Last Name
First Name

NEW YORK STATE
BENEFIT
IDENTIFICATION CARD
ID NUMBER
AB12345C
CARD NUMBER
123456 1234 5678 111 01
SEX
F
DOB
11/11/1992
LAST NAME
SARAH
FIRST NAME
JONES
Sarah Jones
ISO#100123
ACCESS NUMBER
1234 1234 123
SEQ#
01

Card Number
ISO Number
Access Number
SEQ Number

How to use the Benefit Card Use this sample New York State Benefit card to become familiar with the information that is included on an Insurance card. You can also use it as a prop during role play when you practice signing in at the doctor's office. There is an unlabeled card at the end of the chapter. Circle the ID number and the card number. Try to find this information on your own insurance card.

HIPAA Form

New York State Department of Health
HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information

Patient Name: ____________________
DOB: ____________________
Telephone Number: ____________________

(This form has been approved by the New York State Department of Health)

Patient Address: ____________________

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV*RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 7.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditions upon my authorization of this disclosure.
5. Information disclosed under this authorization might be disclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6. Name and address of health provider or entity to release this information:

7. Name and address of person(s) to whom this information will be disclosed:
a) ____________________
b) ____________________
c) ____________________

8. Specific information to be disclosed:
☐ Oral disclosure of medical information from (insert date) __________ to (insert date) __________.
☐ Complete copy of Medical Record **OR** check all that apply:
☐ discharge summaries ☐ office notes (except psychotherapy notes) ☐ test results ☐ radiology reports ☐ x-ray films
☐ billing records ☐ Other: ____________________
Copies of Medical Record for Dates of Service From: (insert date) __________ to (insert date) __________
Include: *(Indicate by Initialing)* ______ **Alcohol/Drug Treatment** ______ **HIV-Related Information**
______ **Mental Health Information**

9. Reason for release of information:
☐ At request of individual
☐ Other: ____________________

10. This authorization will expire upon:
☐ Revocation
☐ Date/Event: ____________________
☐ One Time Release

11. If not the patient, name of person signing form:

12. Authority to sign on behalf of patient:

All items on this form have been completed, and my questions about this form have been answered. In addition, I have been provided a copy of the form.

______________________________ Date: __________
Signature of patient or representative authorized by law

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

Your name

Your date of birth

Your phone #

Your address

Who will give out your information

Who will get your information

Decide how your health information can be shared. The providers can talk with each other OR they can share copies of your entire medical record, or parts of your record (you decide)

Initial here if it is OK with you to share information about alcohol/drug treatment, mental health care and/or HIV related information

Give reason for sharing information, decide and indicate here how long information can be shared

If you have a health guardian he/she signs here

Today's date

Sign your name here!

Consent to Treat Form

Consent to Diagnostic and Medical Treatment

CONSENT TO DIAGNOSTIC AND MEDICAL TREATMENT

I know that I or my child_________________________ may have a condition that requires medical care, and willingly give permission to such care in The Hospital. I also understand that this care may include routine diagnostic procedures and medical treatment.

As part of this care, I give permission for any blood, urine, tissue or other body samples to be used for diagnosis or treatment. I also agree that these samples may be used for scientific purposes after all necessary diagnostic tests have been completed and after The Hospital removes all my personal information.

No promises have been made to me about the result of treatments or examinations that I will have while I am in the hospital.

I understand that if I decide to leave the hospital without being formally discharged, that this means I am withdrawing my request for treatment.

FINANCIAL AGREEMENT

I agree to assume full, primary responsibility for payment of all charges for services I receive from The Hospital and any physician or physician organization performing services at The Hospital and are not paid by my insurance company or other party.

I give permission to The Hospital and any physician or physician organization performing services at The Hospital and its agents to disclose my protected health information to my insurance company or others as necessary to obtain payment for services, including confidential HIV-related information.

I agree to pay any amount of money I owe for the services within 30 days after I receive a bill.

I give permission to The Hospital and any physician or physician organization performing services at The Hospital to review my credit reports if a balance of the bill remains unpaid after 30 days.

ASSIGNMENT OF BENEFITS

I assign to The Hospital and any physician or physician organization performing services any monies and benefits payable to me under any health insurance or other insurance policy, governmental program, or other party providing benefits for all or a part of the services provided.

I agree that any credit balance after payment from such sources may be applied on any account at The Hospital and any physician or physician organization performing services at The Hospital.

I certify that the information given regarding my insurance is correct and current.

I agree to pay The Hospital and any physician or physician organization performing services at The Hospital within 30 days of receiving any payment made directly to me by my insurance company or other party that is connected to charges for Hospital services.

I agree to complete any forms necessary to obtain payment or assignment of such monies or benefits.

I give permission to The Hospital and any physician or physician organization performing services at The Hospital to request payment for services for no-fault benefits, workers compensation benefits, or any other benefits available to me under any governmental programs for any unpaid balance of my hospital bill. This will be done for me if I am eligible for benefits and do not submit a request for payment of services from these governmental programs.

Patient Name:_________________________ MR#:_______________

Sign Here:_________________________ Date:_______________

Print patient name

Sign here!

Today's date

How to use the forms

Practice signing and dating the HIPAA and Consent to Treat forms.