Mount Sinai

Name: _____

DOB: _____

MRN: _____

Front Door Acknowledgment

Treatment:
I hereby agree and authorize Mount Sinai Health System (MSHS), the physicians, nurses, and other clinical staff to provide me with care. This may include treatments, tests, and procedures that are necessary for my care and well-being. I am aware that I may be taken care of by students and trainees under supervision including for sensitive exams (e.g. breast, pelvic, rectal, prostate), unless I request otherwise and my primary physician determines that it is safe to proceed without these team members.

Observers and Vendors:
I am aware that technical or vendor support individuals may be part of my medical care.

Blood Testing During an Exposure:
I understand that if an individual involved in my care and treatment becomes exposed to certain bodily fluids resulting in the possibility of transmission of a blood borne disease, my blood will be tested for HIV, Hepatitis B and Hepatitis C to determine risk of exposure.

HIV Testing for Patients:

General HIV information:

- HIV, the virus that causes AIDS, can be spread through unprotected sex, sharing needles, childbirth or breastfeeding.
- If I test positive, I can get treatment for HIV/AIDS to help me stay healthy and live longer.
- People living with HIV/AIDS can use safe practices to protect others from becoming infected.
- It is illegal to discriminate against anyone because of their HIV status.

According to NYS Public Health Law, Article 27F, patients are required to receive information about HIV testing as follows:

- Health care providers must offer an HIV test to all patients 13 years old and above.
- Testing is voluntary and all HIV test results are confidential (private).
- Anonymous HIV testing (without giving your name) is available at certain public testing sites.
- I may withdraw my consent at any time-either verbally or in writing.

Vaccinations:
I am aware that MSHS may share my vaccination information with New York City State Department of Health in the New York State Immunization Information System (NYSIIS). The purpose of this is to ensure that my health care provider is aware of my relevant medical information so they can work with me to receive needed immunizations.

Additional Treatment Information:
If I am delivering a baby, I understand the care team will administer vitamin K and erythromycin eye ointment to my baby as part of standard newborn treatment.

Images and Sound Recordings:
I am aware that images and sound recordings (Recordings) may be taken for clinical or quality improvement purposes as part of my care. Camera surveillance in clinical and public areas may be utilized for safety purposes.

Recordings may be used for educational purposes (for example a presentation, conference, or publication) as long as my identity is not revealed by the pictures or by the descriptions accompanying them. If identifiable information is present in Recordings to be used for educational purposes, I will be specifically asked for permission before use.

I understand that I have the right to revoke my consent to the use of my Recordings for education or research purposes at any time and that such refusal will not compromise my access to or the quality of care I receive.

Artificial Intelligence Use
I understand that MSHS may use artificial intelligence (AI) tools to assist my care team in making their professional assessments and decisions about my care.

I have read the above and if I have any questions or would like additional information, I will notify my care provider.

Patient* or Legally Authorized Representative**

Print Name	Signature	Date	Time	Relationship

* The signature of the patient must be obtained unless the patient is under the age of 18 years old or lacks capacity.
** Court appointed guardian, Health Care Proxy, or Surrogate under the Family Health Care Decisions Act