



Patient Discharge Reconsideration Request Form

Health Center Name: Upstate Family Health Center, Inc.

Patient Full Name: _____

Patient Date of Birth: _____

Patient Current Phone Number: _____

Patient Email Address (If applicable): _____

Date of Original Discharge: _____

Patient Reason for Request for Reconsideration:

Patient Signature: _____

Date: _____

Employee Use Only

Employee Name Accepting Form: _____

Date: _____

Patient Original EMR MRN: _____

Main Office
1001 Noyes Street
Utica, NY 13502
Phone: (315) 624-9470
Fax: (315) 624-9481



Behavioral Reinstatement Agreement

Conditions of Reinstatement (Check all that apply):

- Respectful communication required at all times
- Compliance with appointment attendance policy
- Compliance with treatment plan
- Adherence to financial and sliding fee policy
- No disruptive, threatening, or aggressive behavior

Monitoring Period:

- 90 Days
- 6 Months
- 12 Months

Patient Signature: _____

Health Center Representative Signature: _____

Date: _____

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