242 MAIN STREET ~ ONEONTA, NEW YORK 13820 ~ 607-433-2343

Welcome to the Otsego County Mental Health Clinic. Before you meet with your therapist today, please fill out the paperwork enclosed in this package. When this is completed, you will meet briefly with the Financial Counselor to make payment arrangements (we accept a wide variety of insurances and have a sliding scale fee for those without insurance). You will then meet with your therapist. If medication is going to be a part of your treatment, your therapist will arrange for you to meet with one of our medical providers. If you have any further questions, please ask your therapist.

Note: In the event you need to cancel an appointment, contact the clinic 24 hours in advance.

Name: ❒ Mr. ❒ Mrs. ❒ Ms. ❒ Dr.	First	MI	Last	**Today's Date:**
Mailing Address: Street/PO Box City State Zip				**County**:
Physical Address (if different than mailing): Street City State Zip				**County**:

Phone: ❒OK to leave message ❒ Home ❒ Cell ❒ Work ❒ Message	**Phone**: ❒OK to leave message ❒ Home ❒ Cell ❒ Work ❒ Message	**Phone**: ❒OK to leave message ❒ Home ❒ Cell ❒ Work ❒ Message

Date of Birth:	**Gender**:	**Maiden or Secondary Name:**
Emergency Contact Name:	**Relationship**:	**Emergency Contact Phone**:
Relationship Status: ❒ Married ❒ Partnered ❒ Single ❒ Divorced ❒ Widowed ❒ Separated	**Primary Language**:	**Religion**:
Race: ❒ White ❒ Black/African American ❒ Asian ❒ Native Hawaiian/Other Pacific Islander ❒ American Indian/Alaska Native ❒ _____	**Ethnicity**: ❒ Hispanic/Latino ❒ Not Hispanic/Latino ❒ _____	
Who referred you to this clinic?	**Do you have any family or friends employed at this agency?** ❒ Yes ❒ No	

Statement of Confidentiality

People seeking services at Otsego County Mental Health Clinic need, and are entitled to confidence that their privacy to speak freely here is protected. The clinic has both the ethical and the legal responsibility to maintain and protect client confidentiality. We take this responsibility very seriously. There are three circumstances, however, under which confidentiality cannot be maintained:

- **If you present a danger or threat to yourself or someone else**.
  We would be obliged to contact a close relative or the police, as appropriate.
- **If we become aware of probable child abuse**.
  We would be under a legal obligation to contact the child abuse hotline in Albany. We might later be required to testify about our knowledge.
- **When the family court deals with a matter which involves the welfare of a minor, the therapist and/or the clinic record can be subpoenaed**.
  We make very vigorous efforts to avoid being subpoenaed or having our records subpoenaed and, in fact, such instances have been extremely rare. In matters of child abuse, the client-therapist privilege does not stand up. In more general matters, such as child custody or potential neglect, a family court judge may exercise the right to examine a Mental Health clinic record that has been subpoenaed to the court. The judge would then determine if
  the record contains information that should be considered when the welfare of a minor is at stake.

I am aware of and understand the above confidentiality statement.

_____ _____

Signature Witness

Describe the problem(s) that brought you here today:

Are you currently involved with or receiving services from any of the following?

- ❑ Bassett Care Coordinator/Health Navigator
- ❑ Catholic Charities
- ❑ Department of Social Services (DSS)
- ❑ Mental Health Association
- ❑ Mobile Integration Team (MIT)
- ❑ NYS Office for People with Developmental Disabilities (OPWDD)
- ❑ Opportunities for Otsego County
- ❑ Otsego County ARC
- ❑ Probation
- ❑ Parole
- ❑ PINS
- ❑ RSS
  - ❑ Supported Housing Program
  - ❑ Mountain View Social Club
  - ❑ Case Management Services
  - ❑ In-Home Stabilization Program
- ❑ Veterans' Administration (VA)

Check things for which you might need assistance:

- ❑ Housing
- ❑ Healthcare coordination
- ❑ Education
- ❑ Employment

Family History & Interpersonal Relationships

Spouse/Partner's Name:	Age:	Occupation:
List your children's names, ages, and with whom they are living:		
Name:	Age:	Living with:
Name:	Age:	Living with:
Name:	Age:	Living with:
Describe how your children get along with you:		
Describe current romantic relationship:		

Education

Student Status: ❑ Full-time ❑ Part-time ❑ Not a student

Highest grade completed: ❑ 5th ❑ 6th ❑ 7th ❑ 8th ❑ 9th ❑10th ❑ 11th ❑ 12th ❑ GED ❑ Business/Technical

❑ Some college, no degree ❑ Associate's degree ❑ Bachelor's degree ❑ Graduate degree ❑ Other_____

Employment

Employment Status (check all that apply): ❑ Full-time ❑ Part-time ❑ Self-employed ❑ Not employed
❑ Volunteer ❑ Retired ❑ Disabled ❑ Active Military ❑ Reserved for national assignment

Employer Name/Location:	**Occupation:**

Legal

Were you referred here by the courts?	❑ Yes	❑ No	If yes, explain:
Do you have any pending legal issues?	❑ Yes	❑ No	If yes, explain:
Do you have a court date coming up?	❑ Yes	❑ No	If yes, explain:
Have you had any legal trouble in the past?	❑ Yes	❑ No	If yes, explain:
Name(s) of attorney, probation officer, parole officer:			

Military History

Branch and dates of service:
Are you currently being seen or have you been seen at a VA? ❑ Yes ❑ No

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure – Adult

Name: _____ Age: _____ Sex: ☐ Male ☐ Female Date: _____

If this questionnaire is completed by an informant, what is your relationship with the individual? _____
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the past TWO (2) WEEKS.

	During the past TWO (2) WEEKS how much (or how often) have you been bothered by the following problems?	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly Every day	(for Clinician use) Highest Domain Score
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g. head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality overall?	0	1	2	3	4	
IX.	15. Problems with memory (e.g. learning new information) or with location (e.g. finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g. painkillers (like Vicodin), stimulants (like Ritalin or Addrall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

The Alcohol Use Disorders Identification Test: Self-Report

Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest. For each question place an X in the box that best describes your answer to that question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

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Otsego County Behavioral Health Services

Mental Health Clinic	Addiction Recovery Services	Child & Adolescent Unit	Addiction Recovery Services
Oneonta, NY 13820	Oneonta, NY 13820	Oneonta, NY 13820	Cooperstown, NY 13326
(607) 433-2343	(607) 431-1030	(607) 433-2334	(607) 547-1610

Client History ~ Health Questionnaire

Name	**Date of Birth**	**Date**
Current Physician	**Physician Address/Phone**	
Date of Last Visit	**Date of Last Physical Exam**	

Have you previously been diagnosed with a mental health illness or disorder? ☐ Yes ☐ No
If yes, explain _____

Have you ever received treatment for or had any of the following?

☐ Heartburn	☐ Pneumonia	☐ PMS	☐ Bronchitis
☐ Eye Problems	☐ Epilepsy	☐ Blood in Urine	☐ Hematuria
☐ Thyroid Problems	☐ Circulation Problems	☐ Hepatitis/Jaundice	☐ Chronic Pain
☐ Chronic Gastritis	☐ Diabetes	☐ Diarrhea	☐ Anorexia
☐ Kidney Problems	☐ Ear Problems	☐ Headaches	☐ Blood in Stool
☐ Heart Problems	☐ Head Injury	☐ Neuropathy	☐ Chest Pain
☐ Bladder Infection	☐ Pancreatitis	☐ Gout	☐ Vomiting
☐ Pregnancy	☐ Ulcers	☐ Cancer	☐ High Blood Pressure
☐ Anemia	☐ Bulimia	☐ Broken Bones	☐ Asthma
☐ Tuberculosis	☐ Cirrhosis/Liver Problems	☐ Hypoglycemia	☐ Sexually-Transmitted Diseases
☐ Sleep Problems	☐ Arthritis		

Please give details for those you have checked: _____

_____

_____

Do you have any conditions or physical disabilities not listed above? ☐ Yes ☐ No
If yes, please describe: _____

_____

_____

Have you been treated at an emergency room in the last 6 months? ☐ Yes ☐ No If yes, how many times? _____

Reason _____

_____

Have you been tested for TB (Tuberculosis) within the last year? ☐ Yes ☐ No

Have you received information on AIDS/HIV? ☐ Yes ☐ No

Please list any prescribed or over-the-counter mediations you are currently taking.

Medication	Dosage	Take how often:	Taken for:	Prescribing Doctor's Name

Please list any allergies (including those to food and medicine).

Please list any surgeries or medical hospitalizations.

Surgery/Hospitalization	Dates	Reason

Client History ~ Health Questionnaire (cont')

Have you had any changes in:	No	Yes	If yes, in what way has it changed?
Appetite			
Weight			
Sleeping Habits			
Energy Level			

Do you:	No	Yes	If yes, how often?
Drink Coffee or Tea			
Exercise			
Use Tobacco			**How soon after you wake do you use tobacco?** ☐ After 60 min. ☐ 31-60 min. ☐ 6-30 min. ☐ Within 5 min
			How much do you use in a day?

Drinking/Drug Use (When thinking about drug use, include illegal drug use and the use of prescription drugs other than as prescribed.)	No	Yes
Have you ever felt that you ought to cut down on your drinking or drug use?		
Have people annoyed you by criticizing you for drinking or drug use?		
Have you ever felt bad or guilty about your drinking or drug use?		
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?		

Do you have any current health concerns? ☐ Yes ☐ No

If yes, please explain: _____

_____

To be completed and reviewed by medical staff:		
Height	Weight	BMI
Pulse	Blood Pressure	Drug Screen
Physical exam recommended: ☐ Yes ☐ No		
Releases for medical records		
Lab work indicated		
Clinical impression		
Follow-up		
Reviewed by:		

MD/NPP/RN Signature Date

PATIENTS' BILL OF RIGHTS

1) A person has a right to continuous, ongoing treatment with an individualized treatment plan and the right to participate to the fullest extent consistent with the patient's capacity, in his/her own treatment planning.
2) A person has the right to a full explanation of services rendered in accordance with his treatment plan.
3) Participation in an outpatient treatment program is voluntary and a person has a right to refuse treatment unless he/she is found to be legally incompetent and/or a danger to him/herself or others.
4) While a patient's full participation in his treatment is the central goal, objection to his/her treatment plan or disagreement with any portion of the plan shall not result in the patient's termination from treatment unless such objection renders the patient's continued participation in the treatment clinically inappropriate or would endanger the safety of him/herself or others.
5) The patient's clinical record shall be a confidential document maintained in accordance with Section 33.13 of the Mental Hygiene Law.
6) The patient shall be assured access to his clinical records in accordance with Section 33.13 of the Mental Hygiene Law.
7) The patient has the right to receive clinical care and treatment which is appropriately suited to his/her needs, skillfully, safely and humanely administered and with full respect for dignity and personal integrity.
8) A patient has a right to receive treatment in a manner that is non-discriminatory.
9) A patient has the right to be treated in a way which acknowledges and respects his/her cultural environment.
10) A patient has the right to privacy consistent with the effective delivery of treatment.
11) A patient has the right to freedom from abuse and mistreatment by an employee.
12) A patient has the right to request a change of therapist.
13) A patient has the right to terminate treatment, unless determined to be a danger to him/herself or others.
14) A patient has the right to be informed of the provider's grievance policy and procedure and to initiate any question, complaint or objection, in accordance to the policy.

STATE AGENCIES THAT PROTECT PATIENT RIGHTS

State of New York Commission on Quality Of Care for the Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, New York 12210-2895
(518) 473-4090

Legal Services of Central New York, Inc.
Protection & Advocacy Unit
472 South Salina Street, Suite 300
Syracuse, New York 13202
(315) 475-3127

NYS Office of Mental Health
Customer Relations Bureau
44 Holland Avenue
Albany, New York 12229
(800) 597-8481 – voice (800) 210-6456 – Spanish
(800) 597-9810 – hearing impaired

New York State Office of Mental Health
Central New York Field Office
545 Cedar Street
Syracuse, New York 13210
(315) 426-3930

Alliance for the Mentally Ill of New York
260 Washington Avenue
Albany, New York 12210
(518) 462-2000

Families First
29 North Hamilton
Poughkeepsie, NY 12601
(845) 452-1114

OUR FEE POLICY

We must bill for all visits to the clinic at the agreed-upon fee for each person.
Insurance: If you are covered by insurance that charges a co-pay, you will be charged the fee set by your health plan. If you are covered by insurance that pays only part of our fee, you will be charged for the remainder.
Medicare: If you are covered by Medicare, you will be charged the Medicare allowable fee for the amount not covered by the Medicare plan.
Medicaid: Medicaid will be billed in full.
Sliding Scale Fee: If you are not covered by any insurance, you will be charge according to the sliding scale fee guidelines. We will need proof of income.
Please note: If you have an insurance plan, but choose not to use it, you will be charge d the full rate of $90.00 for each visit.

~ We recognize that there are extenuating circumstances which affect people's ability to pay. We will work with you to develop a payment plan that meets your budget needs. We are committed to providing high quality services at a reasonable price. No one will be denied services at the clinic because of documented inability to pay.

I have read this document and understand my rights as a patient.

_____	_____	_____	_____
Client Signature	Date	Witness Signature	Date

242 MAIN STREET ~ ONEONTA, NEW YORK 13820 ~ 607-433-2343

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and certifications.

I have read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations.

Patient Name _____
Please Print

Relationship to Patient _____

Signature _____

Date _____

Office Use Only

I attempted to obtain the patient's signature and acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Office Staff Name/Signature	Reason

HIXNY ELECTRONIC DATA ACCESS CONSENT FORM
Otsego County Community Services

In this Consent Form you can choose whether to allow Otsego County Community Services to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York, Inc. (doing business as Hixny), which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Otsego County Community Services to see and obtain access to your electronic health records in this way. You can give consent or deny consent and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services**.

If you check the **I GIVE CONSENT** box below, you are saying, "Yes, Otsego County Community Services staff involved in my care may see and get access to all of my medical records through Hixny."

If you check the **I DENY CONSENT** box below, you are saying, "No, Otsego County Community Services may not be given access to my medical records through Hixny for any purpose."

Hixny is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (Heatlh IT). To learn more about Hixny and ehealth in New York State, read the brochure "Your Health Information – Always at Your Doctor's Fingertips." You can ask Otsego County Community Services for it or go to the website www.hixny.org.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices: (You can fill out this form now or in the future.)

- ❑ **I GIVE CONSENT** for Otsego County Community Services Board to access ALL of my electronic health information through Hixny in connection with providing me any health care services, including emergency care.

- ❑ **I DENY CONSENT** for Otsego County Community Services to access my electronic health information through Hixny for any purpose, even in a medical emergency.
  NOTE: Unless you check this box, New York State law allows the people treating you **in an emergency** to get access to your medical records, including records that are available through Hixny.

Print Name of Patient	Date of Birth	Client #

Address	Phone #

Signature of Patient or Patient's Legal Representative	Date Signed

Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about patient information in Hixny and the consent process:

1. **How your information will be used**: Your electronic health information will be used by Otsego County Community Services **only** to:

    - Provide you with medical treatment and related services.
    - Check whether you have health insurance and what it covers.
    - Evaluate and improve the quality of medical care provided to all patients.

    NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What types of information about you are included**: If you give consent, Otsego County Community Services may access ALL of your electronic health information available through Hixny. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like x-rays or blood tests), and lists of medications you have taken. This information may relate to sensitive health conditions, including, but not limited to:

    - Alcohol or drug use problems
    - Birth control and abortion (family planning)
    - Genetic or inherited diseases or tests
    - HIV/AIDS
    - Mental health conditions
    - Sexually transmitted diseases

3. **Where health information about you comes from**: Information about you comes from places that have provided you with medical care or health insurance (Information Sources). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Otsego County Community Services. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

4. **Who may access information about you if you give consent:** Only these people may access information about you: doctors and other health care providers who serve on Otsego County Community Services medical staff who are involved in your medical care; health care providers who are covering or on call for Otsego county Community Services doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **Penalties for improper access to or use of your information:** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Otsego County Community Services at (607) 433-2343, Hixny at (518) 783-0518, or the NYS Department of Health at (877) 690-2211.

6. **Redisclosure of information:** Any electronic health information about you may be redisclosed by Otsego County Community Services to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Hixny and persons who access this information through the Hixny must comply with these requirements.

7. **Effective period:** This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

8. **Withdrawing your consent:** You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Otsego County Community Services. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 783-0518**. Note: Organizations that access your health information through Hixny while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records**.

9. **Copy of form:** You are entitled to get a copy of this Consent Form after you sign it.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. 164.520 (B) (1) (I)

Otsego County Mental Health Clinic is required by law to maintain the privacy of your medical information and to give you this notice of legal duties and privacy practices with respect to medical information about you. This notice may be revised at any time. Any revisions will be effective for past, present or future medical information we have about you. The Otsego County Mental Health Clinic is required to follow the terms of the most current notice and will post it in all sites where physical services are delivered. In addition, each time you receive services or are admitted to the Otsego county Mental Health Clinic, you will receive a copy of the notice. 164.520 (b) (1) (v) (A-C)

All employed and contracted staff will follow this notice.

Uses and Disclosures of Health Information: 164.520(b) (1) (ii) (A,D)

For Treatment: To your doctor and for referrals, appointment reminders and coordination with programs that may be involved in your care, such as a friend or family member, labs, pharmacy, medical equipment provider or meals on wheels. This also includes disclosure to our contracted Mobile Crisis Assessment Team (MCAT) in order to provide safe, responsive, and effective crisis services for our clients. Efforts will be made to ensure that informed consent is obtained from clients whenever possible.
For Payment: To the insurance company. Copies of notes related to treatment and services you received may be required to accompany the bill.
For Health Care Operations: To run the agency and to assess patient care such as reviewing our treatment and services and to evaluate the performance of staff in caring for you.
If Applicable: May contact the individual for appointment reminders or to give information regarding treatment alternatives, may contact individual to raise funds for the covered entity, and if group health plan, may disclose protected health information to the sponsor of the plan. 164.520 (b) (1) (iii) (A-C)

Special Situations – PHI may be released without your consent or authorization: 164.520 (b) (1) (ii) (B,D)

As required by law and to avert serious threat to health and safety: in response to court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness or missing person; in emergency circumstances to report details of a crime, suspected crime or about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; national security, intelligence activities and protective services for the president or other officials, etc. 164.512 (a) (1-2) (c) (e) (f) (j)
Public Health Risks: to prevent or control disease, injury or disability, to report births and deaths, to report child abuse or neglect or domestic violence when required or authorized by law, in the event of a disaster, etc. 164.512 (b) (1) (i-v), 164.512 (c)
Health Oversight Activities: including audits, investigations, inspections and licensure activities as required by state or federal mandate. 164.512 (d)
Coroners, Medical Examiners and Funeral Directors: for identification purposes, to determine cause of death or as necessary to carry out their duties. 164.512 (g) (1-2)
Organ and Tissue Donation: if a donor, to an organization that handles organ procurement. 164.512 (b)
Research: if viewed by an independent review board. 164.512 (i)
Military and Veterans: as required by military command authorities. 164.512 (k)
Workers Compensation: as required to comply with laws relating to workers compensation. 164.512 (1)

(Exceptions to release without consent: We will follow the provision of 42 CFR Part 2, which severely restricts the release of protected health information without your permission if the records are from substance abuse treatment.)

Other Uses of Medical Information not covered by this notice or applicable law will be made only with your written permission. Permission may be revoked by you in writing, at any time. Please understand that we are unable to take back any disclosure we have already made with your permission. 164.520 (b) (1) (ii) (E)

You have the right to:

- **Request a restriction** on the medical information we use or disclose about you. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. A request for restrictions must be made in writing to the Director and must specify the information to be restricted, if restriction is for use and/or disclosure, and to whom the restriction applies. 164.520 (b) (1) (iv) (A)
- **Request confidential communications**: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Written request must be submitted to the Privacy Officer/designee. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. 164.520 (b) (1) (iv) (B)
- **Inspect and copy** medical information (usually medical and billing records) that may be used to make decisions about your care. Request must be in writing to the attention of the Privacy Officer. A fee of 75 cents per page may be charged for the cost of copying, mailing or other supplies associated with your request. We may deny your request to inspect and coy in certain limited circumstances. A denial will be issued in writing with instructions on how to request a review of the denial. 164.520 (b) (1) (iv) (C)
- **Request an amendment** if you feel that medical information we have about you is incorrect or incomplete. You have the right to request an amendment for as long as the information is kept by the Agency. The written request must be submitted to the Privacy Officer/designee with a reason that supports your request. Your request for an amendment may be denied. You will receive the denial in writing with an explanation and instructions on how to appeal the denial decision. 164.520 (b) (1) (iv) (D)
- **Receive an account of disclosures** for reasons other than treatment, payment or health care operations. Requests must be in writing to the Privacy Office/designee and state a time period which may not be longer than six years or include dates prior to April 14, 2003. The list will be a paper copy and the first list you request within a 12 month period will be free. Additional lists may incur a cost. You will be notified of the amount involved to give you the opportunity to withdraw or modify your request before any costs are incurred. 164.520 (b) (1) (iv) (E)
- **Receive a paper copy of this notice upon request.** 164.520 (b) (1) (iv) (F), 164.520 (c) (1-4)

Complaints:

If you believe that your privacy rights have been violated, you have the right to complain without fear of reprisal or retaliation. Complaints can be made to the Complaints Officer/designee (see below). Complaints can also be made to the Department of Health and Human Services Secretary. The Complaints Officer/designee will provide you with the appropriate address upon request. 164.520 (b) (1) (vi)

Privacy Officer – (607) 433-2343
Complaint Officer – (607) 433-2343
242 Main Street
Oneonta, NY 13820

242 MAIN STREET ~ ONEONTA, NEW YORK 13820 ~ 607-433-2343

PATIENTS' BILL OF RIGHTS

1) A person has a right to continuous, ongoing treatment with an individualized treatment plan and the right to participate to the fullest extent consistent with the patient's capacity, in his/her own treatment planning.
2) A person has the right to a full explanation of services rendered in accordance with his treatment plan.
3) Participation in an outpatient treatment program is voluntary and a person has a right to refuse treatment unless he/she is found to be legally incompetent and/or a danger to him/herself or others.
4) While a patient's full participation in his treatment is the central goal, objection to his/her treatment plan or disagreement with any portion of the plan shall not result in the patient's termination from treatment unless such objection renders the patient's continued participation in the treatment clinically inappropriate or would endanger the safety of him/herself or others.
5) The patient's clinical record shall be a confidential document maintained in accordance with Section 33.13 of the Mental Hygiene Law.
6) The patient shall be assured access to his clinical records in accordance with Section 33.13 of the Mental Hygiene Law.
7) The patient has the right to receive clinical care and treatment which is appropriately suited to his/her needs, skillfully, safely and humanely administered and with full respect for dignity and personal integrity.
8) A patient has a right to receive treatment in a manner that is non-discriminatory.
9) A patient has the right to be treated in a way which acknowledges and respects his/her cultural environment.
10) A patient has the right to privacy consistent with the effective delivery of treatment.
11) A patient has the right to freedom from abuse and mistreatment by an employee.
12) A patient has the right to request a change of therapist.
13) A patient has the right to terminate treatment, unless determined to be a danger to him/herself or others.
14) A patient has the right to be informed of the provider's grievance policy and procedure and to initiate any question, complaint or objection, in accordance to the policy.

STATE AGENCIES THAT PROTECT PATIENT RIGHTS

State of New York Commission on Quality Of Care for the Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, New York 12210-2895
(518) 473-4090

Legal Services of Central New York, Inc.
Protection & Advocacy Unit
472 South Salina Street, Suite 300
Syracuse, New York 13202
(315) 475-3127

NYS Office of Mental Health
Customer Relations Bureau
44 Holland Avenue
Albany, New York 12229
(800) 597-8481 – voice (800) 210-6456 – Spanish
(800) 597-9810 – hearing impaired

New York State Office of Mental Health
Central New York Field Office
545 Cedar Street
Syracuse, New York 13210
(315) 426-3930

Alliance for the Mentally Ill of New York
260 Washington Avenue
Albany, New York 12210
(518) 462-2000

Families First
29 North Hamilton
Poughkeepsie, NY 12601
(845) 452-1114

OUR FEE POLICY

We must bill for all visits to the clinic at the agreed-upon fee for each person.
Insurance: If you are covered by insurance that charges a co-pay, you will be charged at the fee set by your health plan. If you are covered by insurance that pays only part of our fee, you will be charged for the remainder.
Medicare: If you are covered by Medicare, you will be charged the Medicare allowable fee for the amount not covered by the Medicare plan.
Medicaid: Medicaid will be billed in full.
Sliding Scale Fee: If you are not covered by any insurance, you will be charge according to the sliding scale fee guidelines. We will need proof of income.
Please note: If you have an insurance plan, but choose not to use it, you will be charge d the full rate for each visit.

~ We recognize that there are extenuating circumstances which affect people's ability to pay. We will work with you to develop a payment plan that meets your budget needs. We are committed to providing high quality services at a reasonable price. No one will be denied services at the clinic because of documented inability to pay.

I have read this document and understand my rights as a patient.

_____	_____	_____	_____
Client Signature	Date	Witness Signature	Date