Welcome to the Otsego County Mental Health Department

WHAT TO EXPECT AT YOUR INITIAL CLINIC VISIT

- ✓ When you arrive, you will be greeted by our check-in staff who will sign you in, request a copy of your insurance card and hand you a registration form.
- ✓ You will be asked to have a seat in the waiting room and start completing the registration form.
- ✓ The completed registration form is submitted to the check-in staff person who will give you a self-assessment packet to complete.
- ✓ If at any time you need someone to help with any of the forms, please ask and our Peer Support Specialist will be happy to assist you.
- ✓ The first appointment is a two-step process: registration and the actual visit with a therapist.

REGISTRATION

- ✓ The check-in staff will meet with you briefly to go over your insurance information and our Peer Support Specialist will be notified that you are here should you require assistance with any forms.
- ✓ As required by HIPPA regulations, you will be requested to sign releases of information and you will be provided with a Privacy Policy as well as a Patients Bill of Rights.
- ✓ You will be asked to confirm your phone, addresses and insurance information. If you do not have insurance, you will be offered a sliding scale fee. Proof of income is required in order to qualify.
- ✓ Once your have registered you will be asked to complete the self-assessment packet. This information will help to streamline your visit and to ensure that your therapist is well aware of what your needs may be.

CLINIC VISIT

You will meet with a therapist for 30-45 minutes initially. In most cases your primary therapist will be the person with whom you meet. But should you feel a better fit with another therapist, please let your therapist know. He/She will discuss your reasons for coming to Otsego County Mental Health and gather some information. This will be used to develop a treatment plan you feel will provide you with the best care. Any information you provide to your therapist is protected by state and federal confidentiality law, to the extent allowed by law.

OPEN ACCESS

Under Open Access, individuals will be seen in the order in which they arrive. Wait times will vary. Should you not be able to wait, please speak with the check in staff about an arranged visit time.

For any crisis support that is needed *during business hours*, please call the
Otsego County Mental Health Clinic at
(607) 433-2343.

For any crisis support that is needed *after hours*, please call the
Mobile Crisis Assessment Team (MCAT) at
1 (800) 732-6228

MCAT:

- Provides help during a crisis to adults and children in Otsego, Delaware, Chenango, Oneida, Herkimer, and Schoharie Counties.
- Seeks to de-escalate a crisis situation, preventing possible harm, and keeping the problem outside of the legal system and avoiding hospitalization when appropriate.
- Has the ability to respond to crises where they occur. MCAT works with the individual, the family, and community agencies.

Any concern that is causing a serious problem in functioning for the person is a reason to call.

If this is *not* a crisis but you are seeking support and information, please call the
Warm Line at
(607) 433-1714
or
1 (800) 377-3281
between the hours of 4:30 pm and 10:30 pm.

The Warm Line:

- Provides confidential peer support and self help to individuals in Otsego, Delaware, Schoharie and Chenango Counties.
- Is just a phone call away where people can speak with a well-trained, non-judgmental peer support operator who has "been there".
- Can suggest referral to community services and alternative means of finding growth and health.
- Can make pre-arranged contact calls to your home by a peer support operator.

The Warm Line is NOT a crisis hotline.

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. 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

Otsego County Behavioral Health Services
Financial Disclosure and Consent to Release Information

Date____________________ Client #_________________

Name	Date of Birth	Social Security #
Address		Telephone

Insurance Information

Primary Insurance Company	Policyholder's Name & Relationship to Client
Policy #	Co-Pay $
Secondary Insurance Company	Policyholder's Name & Relationship to Client
Policy #	Co-Pay $
Tertiary Insurance Company	Policyholder's Name & Relationship to Client
Policy #	Co-Pay $

Consent

- I hereby authorize the exchange of any medical or other information necessary to obtain authorization for services and to process claims with the insurance company for services received at Otsego County Behavioral Health Services.
- I also authorize payment of medical benefits to the provider(s) of such services.

____ ________________________
Signature of Client/Legal Representative Date

Household Income (*if no insurance*)

Amount Received	Received how often? ❒ Weekly ❒ Bi-Weekly ❒ Monthly	Total Annual Income
# of Dependents	Proof of Income ❒ Paystub ❒ Other_________	Client Fee (according to schedule) $

OR

I do not wish to supply financial and/or insurance information. I understand that I am obligated to pay the full fee for each session.
Signature ____ Date ______________________

I have had the fee and billing procedure explained to me.
My responsibility for each session will be $ ___________________________________

Signature ____ Date ______________________

Staff Signature ____________________________________ Date ______________________

Otsego County Behavioral Health Services

242 Main Street ~ Oneonta, NY 13820

	Mental Health-Adult	Children's Services	Addiction Recovery Services
☎	Mental Health-Adult (607) 433-2343	Children's Services (607) 433-2334	Addiction Recovery Services (607) 431-1030
Fax	Mental Health-Adult (607) 433-6229	Children's Services (607) 433-1364	Addiction Recovery Services (607) 431-1033

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name ______________________ Date of Birth ______________________

Patient Address ______________________

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45CFR, Pts.160 &164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that:

1. This authorization may include disclosure of all of my health information, including where applicable, any and all information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV*/AIDS-RELATED information.
2. If I am authorizing the release of HIV*-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing 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 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I understand that I can revoke this authorization in writing at any time, except to the extent that action was already taken based upon this original authorization. This authorization expires as noted below in #8.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE PROVIDER OR ENTITY SPECIFIED IN ITEM 5.

5.

☐ Otsego County Mental Health – Adult	☐ Receive records	☐ Send records
☐ Otsego County Children & Youth Services	☐ Receive records	☐ Send records
☐ Otsego County Addiction Recovery Services	☐ Receive records	☐ Send records
Name/Address/Phone of other person/entity: ______________________	☐ Receive records	☐ Send records

6. Purpose of disclosure: **Emergency Contact, appointment cancellations**

7. The specific information to be obtained or released:
   ☐ Intake notes ☐ Treatment plans ☐ Progress notes ☐ UDS/Lab results ☐ Billing records
   ☐ Attendance in treatment ☐ Psychiatric evaluations ☐ Discharge notes
   ☐ Other (please be specific)______________________

8. Expiration of authorization to release:
   ☐ One year following discharge date ☐ One year from date signed ☐ One-time disclosure ______________ Expires
   ☐ Other ______________________

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

______________________ Signature of Patient or Representative Authorized by Law ______________ Date

______________________ Signature of Parent or Guardian ______________ Date

______________________ Signature of Witness ______________ Date

*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

Otsego County Behavioral Health Services

242 Main Street ~ Oneonta, NY 13820

☎ Mental Health-Adult (607) 433-2343 | Children's Services (607) 433-2334 | Addiction Recovery Services (607) 431-1030
Fax Mental Health-Adult (607) 433-6229 | Children's Services (607) 433-1364 | Addiction Recovery Services (607) 431-1033

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name ______________________ Date of Birth ______________________

Patient Address ______________________

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45CFR, Pts.160 &164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that:

1. This authorization may include disclosure of all of my health information, including where applicable, any and all information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV*/AIDS-RELATED information.
2. If I am authorizing the release of HIV*-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing 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 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I understand that I can revoke this authorization in writing at any time, except to the extent that action was already taken based upon this original authorization. This authorization expires as noted below in #8.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE PROVIDER OR ENTITY SPECIFIED IN ITEM 5.

5.

☐ Otsego County Mental Health – Adult	☐ Receive records	☐ Send records
☐ Otsego County Children & Youth Services	☐ Receive records	☐ Send records
☐ Otsego County Addiction Recovery Services	☐ Receive records	☐ Send records
Name/Address/Phone of other person/entity: ______________________ ______________________ ______________________ ______________________	☐ Receive records	☐ Send records

6. Purpose of disclosure: **Primary Care Physician**

7. The specific information to be obtained or released:
   ☐ Intake notes ☐ Treatment plans ☐ Progress notes ☐ UDS/Lab results ☐ Billing records
   ☐ Attendance in treatment ☐ Psychiatric evaluations ☐ Discharge notes
   ☐ Other (please be specific)______________________

8. Expiration of authorization to release:
   ☐ One year following discharge date ☐ One year from date signed ☐ One-time disclosure ______________ Expires
   ☐ Other ______________________

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

______________________ ______________________
Signature of Patient or Representative Authorized by Law Date

______________________ ______________________
Signature of Parent or Guardian Date

______________________ ______________________
Signature of Witness Date

*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

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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 or co-insurance, you will be charged the fee set by your health plan. If your insurance does not cover our services, you will be charged according to the sliding scale.
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

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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 (Health 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 | City | State | Zip Code

____
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

15) 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.
16) A person has the right to a full explanation of services rendered in accordance with his treatment plan.
17) 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.
18) 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.
19) The patient's clinical record shall be a confidential document maintained in accordance with Section 33.13 of the Mental Hygiene Law.
20) The patient shall be assured access to his clinical records in accordance with Section 33.13 of the Mental Hygiene Law.
21) 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.
22) A patient has a right to receive treatment in a manner that is non-discriminatory.
23) A patient has the right to be treated in a way which acknowledges and respects his/her cultural environment.
24) A patient has the right to privacy consistent with the effective delivery of treatment.
25) A patient has the right to freedom from abuse and mistreatment by an employee.
26) A patient has the right to request a change of therapist.
27) A patient has the right to terminate treatment, unless determined to be a danger to him/herself or others.
28) 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 or co-insurance, you will be charged the fee set by your health plan. If your insurance does not cover our services, you will be charged according to the sliding scale.
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