Family Services
communities without limits

Administrative Offices
29 North Hamilton Street
Poughkeepsie, NY 12601
845.452.1110

Community Programs
29 North Hamilton Street
Poughkeepsie, NY 12601
845.452.1110

100 Aaron Court
250 Aaron Court
Kingston, NY 12401
845.331.5641

110 East Main Street
Middletown, NY 10940
845.250.5270

Behavioral Health Centers
845.486.2703

20 Manchester Road
Poughkeepsie, NY
12603

223 Main Street
Beacon, NY 12508

7 Market Street
Dover Plains, NY 12522

131 County House Road
Millbrook, NY 12545

91-93 Montgomery Street
Suite 7
Rhinebeck, NY 12572

239 Golden Hill Lane
Kingston, NY 12401

7 Park Lane
Highland, NY 12528

50 Center Street
Ellenville, NY 12428

Chief Executive Officer
Leah Feldman

Welcome to Family Services' Behavioral Health Programs! We are pleased that you chose us to assist you in reaching your treatment goals and are looking forward to partnering with you on this important journey.

As part of the intake process, we have some forms for you to complete and return to us. These forms can be completed in person during check-in at your scheduled appointment or returned by mail or email (intake@familyservicesny.org).

The following forms need to be completed and returned to us:

- ⇒ Client Acknowledgements
- ⇒ Client Expectations and Responsibilities
- ⇒ Client Financial Responsibility
- ⇒ Informed Consent for Telehealth
- ⇒ Consent for HealtheConnenctions
- ⇒ Health Screening
- ⇒ HIPPA Authorization to Release Information
  (One for your PCP and others as needed)

We are also including the following important information:

- ⇒ Patient Rights
- ⇒ Notice of Privacy Practices
- ⇒ Attendance Policy

Our team of therapists, psychiatrists and nurse practitioners are available for both in-person sessions, as well as telehealth sessions through Zoom. If a session is being conducted via telehealth, a Zoom link will be sent to you via email prior to your first session. Please let us know if you need help learning how to access Zoom for your scheduled appointments. If you are unable to access services in this manner or prefer to have your services in-person, we will schedule an appointment for you in the Behavioral Health Center most convenient for you.

If you have questions about the forms or need help completing them, please feel free to call (845) 276 – 4600. You will be directed to someone who can help you.

Thank you and we look forward to working with you!

Family Services brings people together to find the support they need, improving their lives and communities, and building a stronger, safer Hudson Valley.

Programs of Family Services are funded in part by
United Way of the Dutchess-Orange Region
United Way of Ulster County

NOTICE OF PRIVACY PRACTICES

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.

If you have any questions about this Notice please contact our Corporate Compliance Officer at (844) 486 - 3424

We understand that health information about you is personal. We are committed to protecting health information about you. We need to maintain certain information about you to provide you with quality services and comply with law and regulation. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition, related health care services and payment for those services.

We are required to abide by the terms of this Notice of Privacy Practices. We are also required to notify you following a breach of unsecured health information. We may change the contents of our notice, at any time. The new notice will be effective for all protected health information that we maintain. You may obtain any revised Notice of Privacy Practices by calling us and requesting that a revised copy be sent to you or asking for one when meeting with staff. We will promptly revise and make available this Notice whenever there is a material change to the uses or disclosures, your rights related thereto, our legal duties, or other privacy practices stated in this Notice.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by Family Services, Inc. (FSI) staff to sign a financial data sheet. This document includes consent to the use and disclosure of your protected health information for treatment, payment and healthcare operations purposes, as described in this Section 1. Your protected health information may be used and disclosed by our staff and those outside of our agency that are involved in your care and treatment for the purpose of providing services to you. Your

protected health information may also be used and disclosed to bill your insurance and to support the operation of FSI.
Following are examples of the types of uses and disclosures of your protected health care information that FSI is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our Agency.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your services. This includes the coordination or management of your services with a third party that has already obtained your permission to have access to your protected health information, such as another service provider. For example, we might disclose your protected health information, as necessary, to a physician that provides care to you or to your Medicaid Service Coordinator.

Payment: Your protected health information will be used, as needed, to obtain payment for services that we provide to you, such as: making a determination of eligibility or coverage for insurance benefits, and undertaking utilization review activities. For example, obtaining services may require that your relevant protected health information be disclosed to the health plan to obtain approval for mental health services. In addition, bills may be sent to you or third party payers, such as insurance companies or health plans. The information on the bill may contain information that identifies you, your diagnosis and services provided.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of FSI. These activities include, but are not limited to, quality assessment activities, employee review activities, training of health professionals and students, licensing, and conducting or arranging for other business activities. For example, we may use your information to evaluate the performance of staff involved in your care, to assess the quality of care you receive, and to learn how to improve our services.

We will share your protected health information with third party "business associates" that perform various activities for FSI. Whenever an arrangement between our Agency and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose certain information about you in order to contact you for fundraising activities supported by FSI. You have the right to opt out of receiving these materials. If you or your family do not want to receive these materials, please contact our Vice President for Operations and Corporate Compliance Officer and request that these fundraising materials not be sent.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Certain uses and disclosures require your authorization. An authorization is required, with certain exceptions, for any use or disclosure of your protected health information for marketing purposes or for purposes involving the sale of your protected health information. Also, a specific authorization is required for the release of HIV/AIDS, mental health, and psychotherapy notes and information.

Except as described in this Notice, uses and disclosures will be made with your written authorization. You may revoke such authorization, at any time, in writing, except to the extent that FSI has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. In this regard, we will ask you to provide us with the names of persons to whom we may speak. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or passing. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such

information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, tract products; to enable product recalls; to make repairs or replacements, or to conduct post-marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request or other lawful process. Special rules apply for HIV/AIDS information and mental health information.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and as otherwise required by law, (2) limited information requests for identification and location purposes, (3) disclosures pertaining to victims of a crime, (4) where there is suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of FSI, and (6) medical emergency (not on FSI's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donations purposes.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorize federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or other legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 *et. seq.*

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for as long as we maintain the protected health information.

We may charge a reasonable, cost-based fee for the costs of copying, mailing or other supplies associated with your request, up to $0.75 per page for copied records. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access, you may request that the denial be reviewed by the FSI board of directors and/or the New York State Office of Mental Health. Please contact our Vice President for Operations and Corporate Compliance Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

FSI is not required to agree to a restriction that you may request, except we must agree to your request to restrict the information we provide to your health plan if the disclosure is not required by law and the information relates to health care being paid in full by someone other than the health plan. If FSI believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If FSI does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. You may request a restriction by contacting our Vice President for Operations and Corporate Compliance Officer in writing.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Vice President for Operations and Corporate Compliance Officer.

You may have the right to have FSI amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a

statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Vice President for Operations and Corporate Compliance Officer to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, pursuant to your request, or for notification purposes.

You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice electronically.

Other Uses of Health Information: Certain releases of health information may be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization.

3. Complaints

If you believe your privacy rights have been violated, you may complain to us or to:

Secretary of Health and Human Services
Office for Civil Rights
U.S. Department of Health and Human Services
Jacob Javits Federal Building, 26 Federal Plaza - Suite 3312
New York, NY 10278

Phone (800) 368-1019.

You may file a complaint with us by notifying our Vice President of Corporate Compliance of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Vice President of Corporate Compliance, **Casey Hons**, at (844) 486-3424 for further information about the complaint process.

This Notice was published and becomes effective on **12/26/13**.

PATIENT'S RIGHTS

As a patient of Family Services, Inc. you are entitled to the following rights:

1) You are entitled to an individualized plan of treatment and to participate to the fullest extent possible in the establishment and review of that plan.

2) You have the right to a full explanation of the services provided in accordance with your treatment plan.

3) You have the right to participate in outpatient treatment on a voluntary basis.

4) You have the right to object to your treatment plan or any part of it, and your objection shall not, in and of itself, result in the discontinuation of services.

5) You have the right to the confidentiality of your records. Information in your record shall be communicated to individuals outside the behavioral health center only at your written request, or in response to a valid subpoena from a court, or to make a report of possible child abuse or neglect, or in the case of a psychiatric emergency.

6) You have the right to access to your record consistent with Section 33.16 of the Mental Hygiene Law.

7) You have the right to receive clinically appropriate care and treatment that is suited to your needs and that is skillfully, safely, and humanely administered with full respect for your dignity and personal integrity.

8) You have the right to receive services in a non-discriminatory manner.

9) You have the right to be treated in a way which acknowledges and respects your cultural background and identification.

10) You have the right to the maximum amount of privacy consistent with effective treatment.

11) You have the right to freedom from abuse and mistreatment by staff.

12) You have the right to be informed of the clinic's grievance policies and procedures and to initiate any question, complaint, or objection with the clinic procedures and to initiate any question, complaint, or objection with the clinic director or any staff member.

13) You have the right to request information on completing an advanced directive.

14) You have the right to contact the Vice President for Behavioral Health at (845) 486-2703, ext. 1327 if you feel any of these rights have been violated.

15) You have a right to request a change in therapist.

3.9.2023
CH

Family Services
communities without limits

Jean-Marie Niebuhr, LCSW-R
Deputy Commissioner
Dutchess County Department of
Behavioral and Community Health
230 North Road
Poughkeepsie, NY 12601
(845) 486-3791

Katrina Williams, LCSW-R, CASAC
Deputy Commissioner
Ulster County Department of Mental Health
239 Golden Hill Lane
Kingston, NY 12401
(845) 340-4143

New York State Office of Mental
Health Customer Relations
44 Holland Ave.
Albany, NY 12229
(800) 597-8481

National Alliance for the Mentally Ill Of NYS
Mid-Hudson Affiliate
260 Washington Ave
Albany, NY 12210
(845) 297-6440

New York State Justice Center
for the Protection of People
with Special Needs
161 Delaware Ave
Delmar, NY 12054
(518) 549-0200

NYS Commission on Quality of
Care for the Mentally Disabled
99 Washington Ave., Suite 1002
Albany, NY 12210
(800) 624-4143

Family Services
communities without limits

CLIENT ACKNOWLEDGEMENTS

Client Name (Printed):	Center:	DOB:	Netsmart #:

HIPAA
I acknowledge that I have received a copy of the Notice of Privacy Practices (which includes my rights as outlined in HIPAA regulations). I understand if I have any questions about the Notice of Privacy Practices, I can speak with my provider or contact the Privacy Officer whose information is listed in the packet.

Treatment
I consent and authorize Family Services to provide all treatment and services as necessary or desirable for the care of the person named on this record, including, but not restricted to, an assessment of the person and services as are developed under the service plan for this person. It is my understanding that all services will be reviewed with me and explained.

Patient Rights
I acknowledge that I have received a copy of my Patient Rights.

Client Rights & Responsibilities
I acknowledge that I have received a copy of the Clients Rights and Responsibilities appropriate to program(s) where I am receiving treatment/services.

Attendance Policy
I acknowledge that I have received a copy of the Attendance Policy.

3rd Party Payments
I request that payment of authorized benefits from Medicare, Medicaid, Medigap and any other insurance I may have be made on behalf of the person named on this record to Family Services for any service provided to the person named on this record. I authorize Family Services to release any information necessary to determine these benefits or the benefits payable for related services. I agree to pay any additional charges including deductibles, copays, or coinsurance, if appropriate, that my insurance company does not pay for the services.

X _____
Printed Name of Client / Guardian

X _____
Relationship to Client (If other than self)

X _____
Signature of Client / Guardian

X _____
Date

Family Services
communities without limits

CLIENT FINANCIAL RESPONSIBILITY AGREEMENT

Welcome to Family Services, Inc. [FSI]. We are committed to providing excellent outpatient behavioral health services to you and our community. We are glad you are here. Family Services is a public behavioral health clinic supported through multiple funding sources including County funding. Therefore, we charge a fee for our services. As a public clinic, however, we do not refuse services based on an inability to pay. We use options such as a sliding fee scale to assist our clients who have difficulty paying.

PAYMENT FOR SERVICES

It is the expectation of FSI that clients will pay their fee at the time of services. Payment for services is expected each time you receive a service from a therapist or prescriber at Family Services. This means that if you have an established sliding scale fee or co-pay determined by your insurance company you are responsible to pay that amount at the time of your visit.

> ***Note**: Copay's are determined by your insurance company and cannot be changed or reduced. As the provider of this service we are required to charge you the copay. As the recipient of services you are required to pay your co-payment at time of service.*

MONTHLY BILLING AND PAST DUE BALANCES

If payment is not made at the time of services, a bill will be generated. It is the clinic's expectation that payment will be made upon receipt. A past due balance is a balance owed to the clinic for at least 30 days but less than one year. In an effort to resolve past due balances you can contact the Billing Liaison to discuss your payment agreement and identify ways to bring your balance current. If you have a problem paying your established fee please speak to a staff member so that an appointment can be scheduled with our Billing Liaison. The Billing Liaison can discuss your situation and possible payment options available to you.

ACTIVE COVERAGE REQUIRED

Medical insurances such as Medicaid, Medicare, and Private insurance will only pay for the services you receive when your coverage is ACTIVE. Active coverage means that you have paid your periodic premium or spend down and that your coverage has been properly recertified. Verification of your coverage and copayment is very important. If your coverage is not active it is *your responsibility* to notify the office and be prepared to pay a fee at the time of services. *The only exception to this is if you have written proof that you have re-applied for your insurance and it is actively pending.*

INSURANCE AND TYPE OF SERVICE PROVIDER

The coverage you have may impact which provider you can see for individual therapy or medication management. This is an additional reason you need to be proactive in letting us know about your active coverage and any changes that may occur with your insurance. If our providers are not in your network we will help you connect with another provider in your network. Self-Pay

WORKER'S COMPENSATION CLIENTS

Worker's compensation does not pay for therapy services. A fee schedule will need to be developed to cover worker's compensation cases.

Billing Liaison - (845) 486-2703
Ext. 1702 or 1705

Family Services
communities without limits

Informed Consent for Telehealth Services

Client Name (Printed):	Center:	DOB:	Netsmart #:

- I understand that Telehealth is the secure use of two-way real-time interactive audio and video equipment to provide and support mental health services at a distance. Such services do not include a non-clinical telephone conversation, electronic mail message or facsimile transmission between a provider and a recipient, or a consultation between two professional or clinical staff.
- Telehealth can be beneficial to my care, particularly when on-site services are not available or would be delayed because of distance, location, time of day, or availability of resources. The benefits of Telehealth can include improved access to care, provision of care locally in a timelier fashion, improved continuity of care and coordination of care.
- I understand that my Telehealth sessions will not be audio or video recorded at any time.
- I understand that Family Services utilizes encrypted and secure software which complies with all laws including the Health Information Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH).
- I understand that I have the right to refuse to participate in Telehealth services.
- Services will then be provided to me by an appropriate provider at Family Services based on scheduling availability.
- I understand that I have the right to withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- I understand that the laws that protect the confidentiality of my health information also apply to Telehealth.

I have read and understand the information provided above. I have been given information on Telehealth services at Family Services and request to utilize this service as part of my treatment. I understand that the alternative to Telemental Health is an in person appointment with an appropriate provider based on schedule availability. This informed consent will expire upon my revocation or six months following termination of treatment at Family Services.

_____ _____
Signature of Client/Guardian Date

_____ _____
Printed Name of Client/Guardian Relationship to Client
(If other than self)

OR

Obtained verbal consent: ☐

_____ _____
Staff Signature Date:

Revoked: ☐ Created: _____
Date: _____ Modified: _____
Client Signature: _____ Client Verbal Notification: ☐
Staff Name: _____ Staff Signature: _____

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/.

The choice I make on this form will NOT affect my ability to get medical care. The choice I make on this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through HealtheConnections and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through HealtheConnections. This includes information created before and after the date this form is signed. 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 medicines you have taken. This information may include sensitive health conditions, including but not limited to:

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

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from HealtheConnections. You can obtain an updated list at any time by checking HealtheConnections website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access, who carry out activities permitted by this form, as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through HealtheConnections for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **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 the Provider Organization directly by accessing their contact information on the HealtheConnections website at http://healtheconnections.org/; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as HealtheConnections ceases operation (or until 50 years after your death, whichever occurs first). If HealtheConnections merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through HealtheConnections while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form**.**

Family Services
communities without limits

HEALTH SCREENING SELF-REPORT

Client Name (Printed):	Center:	DOB:	Netsmart #:
Gender:			

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (*PLEASE CHECK YES OR NO*)

1. MEDICAL SCREEN	NO	YES	PLEASE DESCRIBE OR EXPLAIN
Allergies			
Auto-immune Disorder			
Blood Disorder (e.g. Anemia)			
Bone or Joint Problems			
Cancer			
Diabetes			
Endocrine Disorders (e.g. Thyroid)			
D.T.'s (Delirium Tremens)			
Ear, Nose, & Throat Disorders			
Epilepsy (Convulsions, Seizures)			
Eye Problems (e.g. Glaucoma)			
Gastro-Intestinal Disorder (stomach)			
Gynecological Problems			
Heart Disease/Circulatory Problems			
Head Injury			
Hypertension (High Blood Pressure)			
Hypoglycemia (Low Blood Sugar)			
Hypotension (Low Blood Pressure)			
Liver Disease (e.g. Hepatitis)			
Lung Disease (e.g. Asthma, Emphysema, T.B.)			
Lyme Disease			
Physical Limitations			
Pregnancy			
Sexual Problems			
Sexually Transmitted Disease (e.g. Gonorrhea, Herpes, Syphilis)			
Skin Problems			
Sleep Disturbances			
Urinary Problems			
Other Medical Problems			

2. NUTRITIONAL SCREEN	NO	YES	PLEASE DESCRIBE OR EXPLAIN
Changes in Bowel Habits			
Changes in Eating Habits			
Food Allergies or Intolerances			
Inadequate Food Supply			
Recent Weight Loss or Gain			

3. MEDICAL HOSPITALIZATIONS AND/OR SIGNIFICANT MEDICAL PROCEDURES

Date: _____

Reason: _____

4. PHYSICAL PAIN SCREEN

Are you experiencing pain? ☐NO ☐YES

If "YES", is the pain: ☐ACUTE (recent onset) ☐CHRONIC (long term)

Where is the pain?_____

On a scale of 1-10 (10 being the most intense) rate your pain. _____

Are you receiving treatment/medication for your pain? ☐NO ☐ YES

If "YES" what is treatment/medication and who is prescribing it?_____

5. SUBSTANCE USE

SUBSTANCE:			How Often:	Dates of Last Used:
Alcohol	☐NO	☐YES	_____	_____
Tobacco	☐NO	☐YES	_____	_____
Other Drugs (List below)	☐NO	☐YES	_____	_____

_____

6. CURRENT MEDICATIONS (include prescription and non-prescription drugs; amount and frequency)

Medication:	Dose/Amount:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. HAVE YOU HAD ANY PHYSICAL EXAMINATIONS, SPECIAL TESTS, E.G. EKG, BLOOD TESTS, X-RAYS WITHIN THE PAST YEAR?

☐No ☐Yes

Exam/Test Performed:	Date:	Physician/Clinic:
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. CURRENT PROVIDER OF MEDICAL CARE

Name: _____

Address: _____

Phone:_____

Date of last visit: _____

Reason: _____

_____ _____

Printed Name of Client / Guardian (*Circle one*) **Relationship to Patient (If other than self)**

_____ _____

Signature of Client / Guardian (*Circle one*) **Date**

REVIEWED BY: _____ _____

Intake Clinician **Date**

ASSESSMENT BY MEDICAL STAFF BASED ON REVIEW OF THE HEALTH SCREENING SELF - REPORT

☐ No apparent medical problem(s).
☐ Physical assessment recommended on as needed basis.
☐ Currently receiving medical care and follow-up.
☐ Referral needed? ☐ No ☐ Yes

Reason: _____
_____
_____

Comments: _____
_____
_____

_____ _____
Signature of Medical Staff [RN, NPP, or MD] **Date**

Family Services
communities without limits

GENERAL
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

PATIENT'S NAME: _____ **LOCATION**: _____ **DOB:** ___ /___ /___

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, as well as MENTAL HEALTH TREATMENT**. Disclosure of **CONFIDENTIAL HIV RELATED INFORMATION** requires an additional authorization.
2. By authorizing the release of 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. If I experience discrimination because of the release or disclosure of 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 conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE FSI, INC. TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE INDIVIDUAL OR ENTITY IDENTIFIED BELOW.**
7. **PLEASE INIITAL NEXT TO THE INDIVIDUAL OR ENTITY YOU WISH FSI, INC. TO SHARE AND DISCUSS YOUR HEALTH INFORMATION WITH.**

AGENCY/PERSON(S) NAME:_____ **Fax/Email:** _____

Address: _____ **Phone:** _____

8. Specific information to be released:

☐ Psychiatric Assessment ☐ Psychosocial Assessment ☐ Progress Notes ☐ Medication History ☐ Treatment Plans
☐ Attendance ☐ Medical Record from (insert date) _____ to (insert date) _____
☐ Entire Medical Record including progress notes, assessments, treatment plans, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
☐ Other: Most recent labs/ bloodwork, current medications, problem list, annual physical examination result, EKG results (if applicable)

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

10. My authorization is subject to revocation at any time (except to the extent that action has already been taken) and EXPIRES:

☐ UPON MY REVOCATION OR SIX MONTHS FOLLOWING TERMINATION OF TREATMENT, OR

☐ ON THIS EVENT OR DATE: _____

Unless an expiration date or event is specified, this authorization is valid for 1 year from the date which it was signed.

Date: _____ **Patient Signature**: _____

OR

Patient's representative who is empowered to act on his/her behalf by reason of _____

Date: _____ Print Name: _____ Signature: _____

I have been offered/received a copy of this authorization: _____ (Please Initial)

☐ **REVOKED** **Effective Date:** _____ **Signature:** _____

CH REVISED 04/01/2019
CH REVISED 10/30/2019
BM REVISED 04/08/2026