325 Columbia Street · Suite 300 · Hudson, New York 12534 · (518) 828-9446 · Clinic Fax (518) 828-9450
Daniel S. Almasi, LCSW-R, Department Head/Director of Community Services
Kathleen Sprague, LCSW, Deputy Director / Director of Clinical Services

Welcome to Columbia County Mental Health Center

Congratulations on taking this first step toward better mental health. We thank you for choosing Columbia County Mental Health Center as your mental health provider. We understand that asking for help can be a difficult choice and many people are hesitant to seek counseling. We commend you for making the choice to pursue a path of wellness and recovery intended to improve your health and emotional well being.

The staff members of Columbia County Mental Health Center are New York State licensed behavior health professionals who are committed to working with you to create a customized care plan to address your needs. Our purpose is to create a warm and compassionate environment where you will feel accepted, cared for, and comfortable expressing yourself. You can expect to be treated with respect and dignity by all staff, both administrative and clinical. We strive to provide the highest quality care possible and encourage you to let us know if you are not satisfied with your services or have any concerns or suggestions about your treatment.

Please review the attached information and return completed forms to the reception desk. If you have any questions when completing these forms, please feel free to ask for assistance. During your visit with us today you can expect to be seen by a Clinician as well as a Nurse, and that this process can take anywhere from one to two hours. We appreciate your patience as we work to attend to everyone visiting the Clinic today.

Remember, the most important factor in achieving success with your mental health is persisting until you have met your goals. Once again, thank you for allowing us to be part of your recovery.

Warmly,

Kathleen Sprague LCSW

Kathleen Sprague, LCSW
Deputy Director / Director of Clinical Services

Helping Columbia County Residents Find Hope & Healing For Over 50 Years

columbiacountymhc.com

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Daniel S. Almasi, LCSW-R, Department Head/Director of Community Services
Kathleen Sprague, LCSW, Deputy Director / Director of Clinical Services

Dear Client:

New York State Public Health Law requires most prescribers of controlled substances to consult New York State's online Prescription Monitoring Program (PMP) Registry through the Health Commerce System (HCS) when writing prescriptions for certain controlled substances. The PMP Registry provides practitioners with direct, secure access to view dispensed controlled substance prescription histories for their patients. Please note other states have similar databases which may also be accessed if necessary.

Columbia County Mental Health Center prescribers are required to access the PMP Registry prior to writing any prescription for a controlled substance for their clients.
This is part of the assessment process and will allow the prescriber to better evaluate an individual's medication treatment plan. The PMP Registry may also be accessed periodically throughout the client's treatment process.

We appreciate your understanding and cooperation with this initiative. If you have any questions about the PMP and this policy, please ask a member of the clinic's nursing staff.

Sincerely,

Kathleen Sprague LCSW

Kathleen Sprague, LCSW
Deputy Director / Director of Clinical Services

Columbia County Mental Health Center

Wellness Questionnaire

Today's Date:_________________

Client's First & Last Name: ____

Date of Birth:___________ Age: ________

Referred here by: ____

Why are you seeking treatment? ____

____

____

What are your symptoms *(please check all that applies)*?

______	anxiety	_______	depressed/sad	______	appetite/weight changes
______	panic attacks	_______	crying frequently	______	sleep disturbance
______	hearing voices	_______	hopelessness	______	repetitive behaviors
______	fear/phobia	_______	racing thoughts	______	irritable/moody
______	mania	_______	feel "on edge"	______	low energy/fatigue
______	low self-esteem	_______	poor concentration	______	difficulty making decisions
______	lack of enjoyment	Other:	____________________________		

When did these symptoms begin?____

____

____

What do you think would help you? ____

____

____

Client Demographic Information

Client's Name (First-Middle-Last): ______________________________

Nickname or Preferred Name: ______________________________

If client is a minor, please list parent/legal guardian name: ______________________________

Date of Birth ____________ **Age** ______ **Social Security No.**______________

Legal Gender at birth ______________________________

Physical Address ______________________________

City ______________ State ______ Zip ________ Town ______________

Mailing Address (if different than Physical) ______________________________

City ______________ State ______ Zip ________ Town ______________

Resident of Columbia County? Yes ____ No ____

Home # ______________________ Cell # ______________________

Email: ______________________________

Insurance Information

Primary Insurance Company Name ______________________ ( ) HMO ( ) PPO ( ) Other

Policy ID Number ______________ Group Number ______________________

Name of Insured ______________________ Insured Date of Birth ____________

Secondary Insurance Company Name ______________________ ( ) HMO ( ) PPO ( ) Other

Policy ID Number ______________ Group Number ______________________

Name of Insured ______________________ Insured Date of Birth ____________

YOU MUST PROVIDE INSURANCE INFORMATION TO ESTABLISH YOUR CO-PAY. IF YOU DO NOT HAVE INSURANCE, YOU MUST PROVIDE DOCUMENTATION OF INCOME TO DETERMINE YOUR FEE. IF YOU DO NOT PROVIDE INSURANCE OR INCOME INFORMATION, YOU WILL BE CHARGED THE FULL COST OF SERVICE. FAILURE TO PAY MAY RESULT IN A REDUCTION OF SERVICES.

I request that payment of authorized benefits be made on my behalf to Columbia County Mental Health Center for services furnished to me by the provider. I authorize Columbia County Mental Health Center to release to the above insurance carriers, Medicaid or Medicare any medical or other information necessary to process my insurance claims.

____

Signature of Client ***(or legal representative if client is a minor)*** Date

Client Demographic Information

Sexual Orientation
- ☐ Heterosexual
- ☐ Homosexual
- ☐ Bisexual
- ☐ Decline to identify
- ☐ Other (please write below)

____

Gender Identity
- ☐ Male
- ☐ Female
- ☐ Decline to identify
- ☐ Non-binary
- ☐ Other (please write below)

____

Preferred Pronouns
- ☐ He/Him
- ☐ She/Her
- ☐ They/Them
- ☐ Other (please write below)

____

Race
- ☐ African American
- ☐ American Indian
- ☐ Alaska Native
- ☐ Asian
- ☐ Caucasian/White
- ☐ Decline to identify
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ Other (please write below)

____

Relationship Status
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Other (please write below)

____

Highest Level of Education
- ☐ Grade School
- ☐ High School
- ☐ Vocational School
- ☐ Associate's Degree
- ☐ Bachelor's Degree
- ☐ Some College
- ☐ Master's Degree
- ☐ Other (Please write below)

____

Employment Status
- ☐ Full-time
- ☐ Part-time
- ☐ Self-employed
- ☐ Retired
- ☐ Unemployed
- ☐ Disabled/Disability
- ☐ Student
- ☐ Homemaker

If employed, name of Employer:

____

Preferred Language
- ☐ English
- ☐ Spanish
- ☐ Bangladesh
- ☐ French
- ☐ German
- ☐ Hebrew
- ☐ Hindu
- ☐ Italian
- ☐ Other (Please write below

____

If minor, Parent or Guardian
- ☐ Mother
- ☐ Father
- ☐ Guardian
- ☐ Grandmother
- ☐ Grandfather

Guardianship paperwork? Yes / No

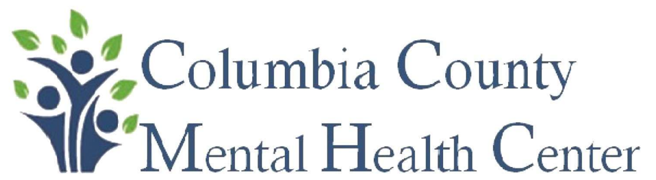
- ☐ Other (Please write below)

____

Have you ever served, or are you currently serving, in the Military?
- ☐ Currently serving
- ☐ Prior service
- ☐ Veteran
- ☐ N/A

If client is a student, what school do they attend? ______________________

In what grade is your student? ______________________



Notice of Privacy Practices

This notice describes the privacy practices of the Columbia County Department of Human Services/Mental Health Center (hereafter referred to as CCDHS/MHC) and the privacy rights of the people we serve. It will describe how information about you may be used and disclosed and how you can get access to this information.
The Health Insurance Portability and Accountability Act (HIPAA) Privacy rule DOES NOT CHANGE the way you get services from CCDHS/MHC, or the privacy rights you have always had under federal and state laws. The Privacy rule adds some details about how you can exercise your rights.

PLEASE REVIEW THIS NOTICE CAREFULLY.

CCCCDHS/MHC privacy commitment to you: CCCCDHS/MHC provides many different services to you. We understand that information about you and your family is personal. We are committed to protecting your privacy and sharing information only with those who need to know and are allowed to see the information to assure quality services for you. CCCCDHS/MHC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. This notice tells you how CCDHS/MHC uses and discloses information about you. It describes your rights and what CCDHS/MHC responsibilities are concerning information about you. When we use the word "you" in this Notice, we also mean your personal representative. Depending on your circumstances and in accordance with state law, this may mean your guardian, your health care proxy, or your involved parent, spouse, or involved adult family member. If you have questions about any part of this Notice of Privacy Practices (hereafter referred to as the Notice) or if you want more information about the privacy practices at DHS/MHC, please contact: *Jim Breig, Corporate Compliance Officer/Privacy Officer, 401 State St., Hudson, New York 12534, (518) 828-8561.*

Who will comply with this Notice: All people who work for CCDHS/MHC will comply with this Notice. This includes employees, persons CCDHS/MHC contracts with who are authorized to enter information in your record or need to review your record to provide services to you, and volunteers who CCDHS/MHC allows to assist you.

What information is protected: All information that we create or keep that relates to your health or care and treatment, including but not limited to: your name, address, birth date, social security number, your medical information, your service or treatment plan, and other information about your care in our programs (including photographs or other images) is considered protected information. In this Notice, we refer to protected information as protected health information or "PHI". We create and collect information about you and we keep a record of the care and services you receive though this agency. The information about you is kept in a record; it may be in the form of paper documents in a chart or on a computer. We refer to the information that we create, collect, and keep as a "record" in this Notice.

Your health information rights: Unless otherwise required by law, your record is the physical property of CCDHS/MHC, but the information in it belongs to you and you have the right to have your information kept confidential. You have the following rights concerning your PHI:

- You have a right to see or inspect your PHI and obtain a copy of the information. Some exceptions apply, such as information compiled for use in court or administration proceedings. NOTE: CCDHS/MHC requires you to make your request for records in writing to the Privacy Officer. You may request copies in paper format or in an electronic form such as a CD, portable device, or memory stick. In some instances, we may charge you for copies.
- If we deny your request to see your information, you have the right to request a review of that denial. The Director/designee will appoint a licensed health care professional to review the record and decide if you may have access to the record.
- You have the right to ask CCDHS/MHC to change or amend information that you believe is incorrect or incomplete. We may deny your request in some cases, for example, if the record was not created by CCDHS/MHC or if after reviewing your request, we believe the record is accurate and complete.

- You have the right to request a list of the disclosures that CCDHS/MHC has made of your PHI. The list, however, does not include certain disclosures, such as those made for treatment, payment, and health care operations, or disclosures made to you or made to others with your permission.
- You have the right to request a restriction on uses or disclosures of your health information related to treatment, payment, health care operations, and disclosures to involved family. CCDHS/MHC, however, is not required to agree to your request.
- You have the right to request that CCDHS/MHC communicates with you in a way that will help keep your information confidential. You may request alternate ways of communication with you or request that communications are forwarded to alternative locations.
- You have the right to limit disclosures to insurers if you have paid for the service completely out of pocket.
- You will be notified if there is a breach of unsecured PHI containing your information; we are required by federal law to provide notification to you.
- We will require you to submit your requests in writing to the Privacy Officer. To request access to your clinical information or to request any of the rights listed here, you may contact *Jim Breig, Corporate Compliance Officer/Privacy Officer, 401 State St., Hudson, New York 12534, (518) 828-8561.*

NOTE: Other regulations may restrict access to HIV/AIDS information, federally protected education records, and federally protected drug and alcohol information. See any special authorizations or consent forms that will specify what information may be released and when, or contact the Privacy Officer listed above.

Our responsibilities to you: We are required to:

- Maintain the privacy of your information in accordance with federal and state laws.
- Give you this Notice that tells you how we will keep your information private.
- Tell you if we are unable to agree to a limit on the use or disclosure that you request.
- Carry out reasonable requests to communicate information to you by special means or at other locations.
- Get your written permission to use or disclose your information except for the reasons explained in this Notice.
- We have the right to change our practices regarding the information we keep. If practices are changed, we will tell you by giving you a new Notice.

How CCDHS/MHC uses and discloses your health information: CCDHS/MHC may use and disclose information without your permission for the purposes described below. For each of the categories of uses and disclosures, we explain what we mean and offer an example. Not every use or disclosure is described, but all of the ways we will use or disclose information will fall within these categories.

- **Treatment:** CCDHS/MHC will use your information to provide you with treatment and services. We may disclose information to doctors, nurses, psychologists, social workers, and other CCDHS/MHC personnel, volunteers, or interns who are involved in providing your care. For example, involved staff may discuss your information to develop and carry out your treatment or service plan and other CCDHS/MHC staff may share your information to coordinate different services you need, such as medical tests, respite care, transportation, etc. We may also need to disclose your information to other providers outside of CCDHS/MHC who are responsible for providing you with services.
- **Payment:** CCDHS/MHC will use your information so that we can bill and collect payment from you, a third party, an insurance company, Medicare or Medicaid, or other government agencies. For example, we may need to provide your health care insurer with information about the services you received in our agency or through one of our programs so they will pay us for the services. In addition, we may disclose your information to receive prior approval for payment for services you may need.
- **Health Care Operations:** CCDHS/MHC will use clinical information for administrative operations. These uses and disclosures are necessary to operate CCDHS/MHC programs and to make sure all individuals receive appropriate, quality care. For example, we may use information for quality improvement to review our treatment and services and to evaluate the performance of our staff in serving you.

We may also disclose information to clinicians and other personnel for on-the-job training. We will share your health information with other CCDHS/MHC staff for the purposes of obtaining legal services from our attorneys, conducting fiscal audits, and for fraud and abuse detection and compliance through our Compliance Program. We may also disclose

information to our business partners who need access to the information to perform administrative or professional services on our behalf.

Other uses and disclosures that do not require your permission: In addition to treatment, payment, and health care operations, CCDHS/MHC will use your information without your permission for the following reasons:

- When we are **required to do so by federal or state law**.
- For **public health reasons**, including prevention and control of disease, injury or disability, reporting births and deaths, reporting child abuse or neglect, reporting reactions to medication or problems with products, and to notify people who may have been exposed to a disease or are at risk of spreading the disease.
- To report **domestic violence and adult abuse or neglect** to government authorities if necessary to prevent serious harm.
- For **health oversight activities**, including audits, investigations, surveys and inspections, and licensure. These activities are necessary for government to monitor the health care system, government programs, and compliance with civil rights laws. Health oversight activities do not include investigations that are not related to the receipt of health care or receipt of government benefits in which you are the subject.
- For **judicial and administrative proceedings**, including hearings and disputes. If you are involved in a court or administrative proceeding, we will disclose information if the judge or presiding officer orders us to share the information.
- For **law enforcement purposes**, in response to a court order or subpoena, to report a possible crime, to identify a suspect or witness or missing person, to provide identifying data in connection with a criminal investigation, and to the district attorney in furtherance of a criminal investigation of client abuse.
- Upon your death, to **coroners or medical examiners** for identification purposes or to determine cause of death, and to **funeral directors** to allow them to carry out their duties.
- To organ procurement organizations to accomplish cadaver, eye, tissue, or **organ donations** in compliance with state law.
- For **research** purposes when you have agreed to participate in the research and the Privacy Oversight
- Committee has approved the use of the clinical information for the research purposes.
- To **prevent or lessen a serious and imminent threat** to your health and safety or someone else's.
- To authorized federal officials for intelligence and other **national security** activities authorized by law or to provide **protective services to the President** and other officials.
- To **correctional institutions** or **law enforcement officials** if you are an inmate and the information is necessary to provide you with health care, protect your health and safety or that of others, or for the safety of the correctional institution.
- To **governmental agencies that administer public benefits** if necessary to coordinate the covered functions of the programs.

Uses and disclosures that require your agreement: CCDHS/MHC may disclose information to the following persons if we tell you we are going to use or disclose it and you agree or do not object:

- To **family members and personal representatives** who are involved in your care if the information is relevant to their involvement and to notify them of your condition and location.
- To **disaster relief organizations** that need to notify your family about your condition and location should a disaster occur.
- For **fundraising** purposes, we may disclose information to a charitable program that assists us in fundraising with your permission. You have the right to refuse or opt out if you previously agreed to communications regarding fundraising.
- For **marketing** of health-related services, we will not use your health information for marketing communications without your permission.
- To disclose **psychotherapy** notes.

Authorization required for all other uses and disclosures: For all other types of uses and disclosures not described in this Notice, CCDHS/MHC will use or disclose information only with a written authorization signed by you that states who may receive the information, what information is to be shared, the purpose of the use or disclosure and an expiration for the authorization. Written authorizations are always required for the sale of PHI and use and disclosure for marketing purposes, such as agency newsletters and press releases.

Note: If you cannot give permission due to an emergency, CCDHS/MHC may release information in your best interest. We must tell you as soon possible after releasing the information. You may revoke your authorization at any time. If you revoke your authorization in writing, we will no longer use or disclose your information for the reasons stated in your authorization. We cannot, however, take back disclosures we made before you revok and we must retain information that indicates the services we have provided to you.

Changes to this Notice: **We reserve the right to change this Notice**. We reserve the right to make changes to terms described in this Notice and to make the new Notice terms effective to all information that CCDHS/MHC maintains. We will post the new Notice with the effective date in our facilities. In addition, we will offer you a copy of the revised Notice at your next scheduled service planning meeting.

Complaints: If you believe your privacy rights have been violated you can file a complaint with the:

- CCDHS/MHC Privacy Officer, Jim Breig; (518) 828-8561
- Director of Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201, (877) 696-6775; or,
- Office of Civil Rights by calling or writing Region II – US Department of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza, Suite 3312, New York, New York 10278, Voice Phone (800) 368-1019, FAX (212) 264-3039, TDD (800) 537-7697.

All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Columbia County
Mental Health Center

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT RECEIPT

I hereby acknowledge that I have reviewed and been offered a printed copy of **Columbia County Department of Human Services/Mental Health Center's** Notice of Privacy Practices.

Client Signature (*or legal representative if client is a minor*) Date

Print Name Phone number

If acknowledgement signed by client's legal representative, please indicate relationship to client:
☐ Parent or guardian of individual ☐ Health Care Proxy or Agent
☐ Beneficiary or personal representative of deceased individual ☐ Other

Name of Client (*if client is a minor*)

***For Office Use Only*:**

If client refuses to sign this Acknowledgment, document their reasons for refusal:

☐ Client declined to give a reason

and note the following:
☐ Client was offered a printed copy of this Notice of Privacy Practices
☐ Client was offered assistance in reading and/or understanding this Notice
☐ An offer was made to contact the Privacy Officer to explain this Notice

staff initials *date*

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Daniel S. Almasi, LCSW-R, Department Head/Director of Community Services
Kathleen Sprague, LCSW, Deputy Director/Director of Clinical Services

Columbia County Mental Health Center

Agreement between Columbia County Department of Human Services/Mental Health Center and

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Client's Name Date of Birth

The staff at Columbia County Department of Human Services/Mental Health Center (CCDHS/MHC) respects and assures your rights to privacy, confidentiality and dignity of treatment at all times.

The mission of CCDHS/MHC is to foster the health and welfare of residents of Columbia County by providing mental health services to adults, children and families especially to those who have no other provider options.

The staff at CCDHS/MHC will keep scheduled appointments, except in the case of an emergency or illness. If cancellation is necessary, CCDHS/MHC will attempt to do so 24 hours in advance of the scheduled appointment.

The staff at CCDHS/MHC works as a multi-disciplinary team and may consult amongst one another to develop an appropriate course of treatment for each client.

Clients may be asked to sign "Authorization to Use or Disclose Protected Health Information" consents so that CCDHS/MHC can obtain information from other sources and/or providers. However, in the event of an emergency, information may be provided to the emergency contact listed in this Agreement, without the client's consent and/or to other appropriate providers/agencies deemed necessary concerning such emergency.

CCDHS/MHC will attempt to ensure client's appointments begin promptly.

The work of CCDHS/MHC is funded through insurance reimbursements and client fees which are a critical source of income supporting the continuation of our purpose.

Client's failure to uphold financial responsibility impacts CCDHS/MHC's ability to provide services to others.

Payment for service is due at the time of service. Co-pays are due for *each* service on a given day. Cash, check, MasterCard/Visa and Discover are acceptable forms of payment. If paying by credit card, there is a fee of 2.35% plus $1.00 automatically added to the amount being charged. This fee is imposed by the banking/credit card industry and is not kept by CCDHS/MHC. This fee is subject to change.

It is the client's responsibility to know the level of coverage for services any payment by their insurance company. The client is responsible for any amounts not covered by their plan.

If the insurance plan requires a referral, the client is responsible for working with the insurance company and with CCDHS/MHC to ensure that this is in place. If CCDHS/MHC is an **in-network provider** with the insurance plan, co-pay is expected at time of service.

As an **in-network provider,** CCDHS/MHC will bill the insurance company for reimbursement. If CCDHS/MHC's charges apply to the client's deductible, or are not covered by the insurance plan, the client is responsible for any unpaid amounts.

It is the client's responsibility to notify CCDHS/MHC of any changes in insurance. Failure to notify CCDHS/MHC of changes in insurance *does not* alleviate the client's responsibility for full payment of services rendered. CCDHS/MHC reserves the right to discontinue contracting with insurance providers with 30 days advanced notice.

There are some services that CCDHS/MHC may provide to you that may not be covered by your insurance plan or may incur co-pay such as drug/alcohol screenings, court testimony, reports, copies of medical records, etc. Should you require these services; fees will be discussed with you. Co-pays are determined by your insurance company. In order to release your medical records outside of this agency, you will be required to sign an approved release of information form.

For clients who are not eligible for insurance for which proof has been provided, CCDHS/MHC offers a sliding fee scale. You will be asked to complete a fee sheet and bring in specific documentation such as pay stubs or tax returns to verify your source(s) of income. CCDHS/MHC will apply that information to an approved fee chart and determine your financial responsibility. You will be notified by the CCDHS/MHC Billing Department once this fee is established. Please note that this fee applies to each and every session including individual, group, and family therapy sessions. This fee will also apply whenever you see one of CCDHS/MHC's prescribers**.** Eligibility for remaining on the sliding scale will be reviewed every 6 months and you will be asked to provide updated information. ***For Medicaid pending clients you must provide proof from the Department of Social Services of your pending status.***

It is understood that it is the policy of CCDHS/MHC that:

1) A $10.00 "no show fee" may be charged to clients for any missed appointment and any appointment NOT cancelled and/or rescheduled before 4 pm the day before the clients scheduled appointment. Insurance companies do not pay this fee. I understand that a pattern of missed or cancelled appointments will be interpreted as a lack of readiness to commit to therapy and further appointments may not be afforded to you.

2) Fees incurred for returned bank checks, for any reason, are the client's responsibility.

3) If services are rendered at a school satellite, any co-pays or other fees due will be billed to the responsible party listed in the chart.

4) If you have not been active in treatment for three (3) months or have failed to pay for services, your case may be closed. Your case may remain open if it is clinically indicated and is approved by your clinician's supervisor. If you wish to return after you have been discharged from treatment, you are welcome to call and request a new intake appointment. **Any money owed to the CCDHS/MHC must be paid in full, or a repayment plan must be established.**

5) **As previously noted all insurance co-pays, deductibles and sliding scale fees and any other fees that might be incurred by securing services at CCDHS/MHC are expected to be paid in full and always at the time of service.** If you incur a financial hardship and are having difficulty in meeting your financial obligation, please ask to speak to the engagement specialist. All reviews of financial hardship concerns will be conducted on a case by case basis, and any payment plan will remain your responsibility until your financial obligation is met. **Non-compliance with your payment plan may affect the level of services you receive.**

ADDITIONAL INFORMATION IMPORTANT FOR CLIENTS TO KNOW:

Crisis services are available 24 hours a day to anyone in Columbia County regardless of participation in our services. If you feel you are at immediate risk of harm, ask to speak with a crisis screener. Crisis screeners are available in person or on the phone during clinic business hours; or if the clinic is closed, can be reached by calling the main clinic phone number, 518-828-9446.

CCMHC is committed to offering its clients the most comprehensive level of care possible. We know that life circumstances can have a major influence on the wellness and recovery that a client experiences during their treatment. The process of understanding your needs starts with what is known as the Comprehensive Assessment. This assessment usually consists of a therapist asking questions about different aspects of your history. In addition, CCMHC uses written screening tools such as the CRAFFT, Simple Screening Instrument for Substance Abuse, and a tobacco screen to see if you have any additional needs. Research has shown that as many as 40-50% of people seeking mental health services also struggle with substance abuse. CCMHC believes that it's important to ask all clients about their drinking or drug use patterns. Some clients may also be offered an oral fluid test which will test for the presence of alcohol and specific drugs. Currently, CCMHC uses Quest Diagnostics as its laboratory for processing fluid test results. Costs associated with the test are billed directly through Quest Diagnostics. Clients who are under a Managed Medicaid policy may be required to pay laboratory co-pay. If you have questions or concerns please contact your insurance company directly to ask about your coverage.

CCDHS/MHC utilizes the PMP (Prescription Monitoring Program) at admission as part of the assessment process to get a complete picture of the individual's medication profile. It may also be used periodically throughout the treatment process. The PMP is a registry of all controlled substances prescribed for individuals in New York. Use of the PMP is required prior to writing or filling any prescription for a controlled substance in the State of New York. Other states have similar databases, and those will be consulted if necessary. If you have any questions about this issue please contact our Medical Director, Carlos Valle, MD.

IN CASE OF A BUILDING EMERGENCY: The Human Services Building at 325 Columbia Street, Hudson, NY, has a *Building Wide Emergency Management Plan* which addresses procedures to be followed in the event of various emergency type situations. The CCDHS/MHC has emergency policies and procedures specific to the third floor. These policies are available upon request.

I understand that I am responsible for all charges and fees. I give CCDHS/MHC permission to release any information, including psychotherapy notes that is necessary to support any insurance claims on my account and secure timely payments due to the assignee or myself. If CCDHS/MHC is an in-network provider for my insurance plan, I hereby assign medical benefits, including those from government sponsored programs and other health plans, to be paid directly to CCDHS/MHC. This assignment or a photocopy hereof is acceptable.

I have read and understand the above policies. To the best of my knowledge, I certify that all financial and insurance information that I have provided is accurate and complete and I will inform CCDHS/MHC of any change(s) in my circumstances.

Signature of Client *(or legal representative if client is a minor)* Date

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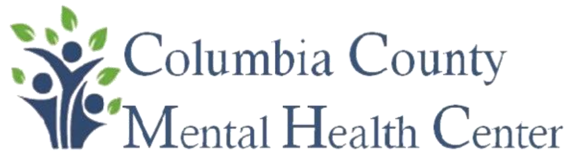
Witness Date

Clinic Use Only: Client/Legal Representative received copy of this Agreement:
☐Yes ☐No *(declined)*
Date__________ Staff Initials__________



Emergency Contact Information

IMPORTANT
At times Columbia County Department of Human Services/Mental Health Center (CCDHS/MHC) may need to speak with someone you choose regarding an emergency and/or a non-emergency situation. An emergency would be a situation where your well being and/or the well being of someone else are at risk. A non-emergency would be a situation where CCDHS/MHC have questions and/or concerns about your attendance and/or may need to obtain updated contact information so that we can reach you. Your emergency/non-emergency contact can be the same person if you choose.
You may cancel (revoke) your permission for us to speak to your emergency and/or non-emergency contact at any time by notifying us in writing.
Your permission for us to speak with your emergency and non-emergency contacts will automatically end when you are no longer receiving services and have been discharged from the clinic.

Signature of Client *(or legal representative if client is a minor)* **Date**

Emergency Contact

Name/First/Last/Middle Relationship

Address City State Zip

Home Phone Cell Phone Work Phone

Non-Emergency Contact

Name/First/Last/Middle Relationship

Address City State Zip

Home Phone Cell Phone Work Phone

Clinic Use Only - Revoked Date:

Authorization To Disclose Or Exchange Protected Health Information

NAME OF PATIENT:	DOB:
NAME OF PERSON ACTING FOR PATIENT:____________________ RELATIONSHIP TO CLIENT:	

1. I authorize the following designee to **DISCLOSE OR EXCHANGE** my protected health information:

Mental Health Association – Columbia & Greene Counties
Mobile Crisis Assessment Team
713 Union Street
Hudson, NY 12534
Telephone: (518) 943-5555 Fax: (518) 947-6400

2. **WITH:**

Columbia County Mental Health Center
325 Columbia Street
Hudson, NY 12534
Telephone: (518) 828-9446 Fax: (518) 828-9450

3. **Specify the Health Information to be disclosed or exchanged when requested:** (check all that apply) ☐ Transportation/Accessibility Needs ☐ Financial/Billing ☐ Admission/Assessment ☐ Progress Notes ☐ Service Plan ☒ Diagnosis ☐ Lab Results ☐ History and Physical ☒ Psychiatric Evaluations ☐ Psychological Testing/Reports ☐ Discharge Summary ☒ Medication Information ☒ Medical Information ☒ Dates and Types of Services Received ☐ **HIV+, AIDS** information ☐ **HBV, HCV** information ☐ Other *(specify)*__________________

4. **Required for disclosure of Substance Use Treatment information:**
☒**Substance Use Treatment Information/Drug Screenings**

NOTICE: The information approved for disclosure by this authorization may be protected by Federal Regulations (42 CFR Part 2) which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or otherwise permitted by 42 CFR Part 2.

5. **PURPOSE:** I understand that this information will be used for the following: (check all that apply)
☒ Evaluation/Treatment ☐ Legal Purposes ☐Insurance/Billing Purposes ☒Care Coordination ☐Other *(specify)*__________________

6. **As the person signing this Authorization form**, I understand that I am giving my permission to **Columbia County Mental Health** to disclose or use confidential health care records (protected health information) for me, or the individual named above.

I understand that:

A. Information disclosed may include documents placed in the record after the signature / effective date, but prior to expiration date or revocation.
B. I may refuse to sign this form, that treatment or payment will not be conditioned upon my willingness to sign this form, (unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization), and I affirm that I have not been coerced or forced to sign this form.
C. An original or copy of this authorization and a notation concerning the persons or agencies to which disclosure were made shall be included with my original health records, and that paper and electronic copies may be used to facilitate use or disclosure of the information.
D. Information disclosed under this authorization may be subject to **re-disclosure** by the recipient and may no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.
E. I have the right to revoke this authorization at any time, but not retroactive to information already disclosed in accordance with the authorization. My revocation is not effective until delivered in writing to the person who is in possession of my records.
F. This authorization is automatically revoked upon termination of services. If the named individual is a minor, and a parent or guardian signs this form, this authorization will become invalid when the individual reaches the age of 18 years.

Signature of Patient: ____ **Date:**___/___/___

Signature of Person Acting for Patient: ______________________________________ **Date:**___/___/___

☐Provide the individual served with a copy ☐Staff initials____________ ☐Place the original in the service record

REVOCATION of AUTHORIZATION: THIS AUTHORIZATION FORM MAY BE ***REVOKED*** AT ANY TIME BY COMPLETING THE FOLLOWING IN PERSON:

Authorization revoked by (PRINT NAME):	**Relationship:**
Signature of Person Revoking Authorization:	Date: / /

Authorization To Disclose Or Exchange Protected Health Information

NAME OF PATIENT:	**DOB:**
NAME OF PERSON ACTING FOR PATIENT:______________________________ **RELATIONSHIP TO CLIENT:**	

1. I authorize the following designee to **DISCLOSE OR EXCHANGE** my protected health information:

Primary Care Physician: ______________________________

____

____

Telephone: ____________________ **Fax:** ____________________

2. **WITH:**

Columbia County Mental Health Center
325 Columbia Street
Hudson, NY 12534
Telephone: (518) 828-9446 Fax: (518) 828-9450

3. **Specify the Health Information to be disclosed or exchanged when requested:** (check all that apply) ☐ Transportation/Accessibility Needs
☐ Financial/Billing ☒ Admission/Assessment ☒ Progress Notes ☒ Service Plan ☒ Diagnosis ☒ Lab Results ☒ History and Physical
☒ Psychiatric Evaluations ☒ Psychological Testing/Reports ☒ Discharge Summary ☒ Medication Information ☒ Medical Information
☒ Dates and Types of Services Received ☐ **HIV+, AIDS** information ☐ **HBV, HCV** information ☐ Other *(specify)*____________________

4. **Required for disclosure of Substance Use Treatment information:**
☒ **Substance Use Treatment Information/Drug Screenings**

NOTICE: The information approved for disclosure by this authorization may be protected by Federal Regulations (42 CFR Part 2) which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or otherwise permitted by 42 CFR Part 2.

5. **PURPOSE:** I understand that this information will be used for the following: (check all that apply)
☒ Evaluation/Treatment ☐ Legal Purposes ☐ Insurance/Billing Purposes ☒ Care Coordination ☐ Other *(specify)*____________________

6. **As the person signing this Authorization form**, I understand that I am giving my permission to **Columbia County Mental Health** to disclose or use confidential health care records (protected health information) for me, or the individual named above.

I understand that:

A. Information disclosed may include documents placed in the record after the signature / effective date, but prior to expiration date or revocation.
B. I may refuse to sign this form, that treatment or payment will not be conditioned upon my willingness to sign this form, (unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization), and I affirm that I have not been coerced or forced to sign this form.
C. An original or copy of this authorization and a notation concerning the persons or agencies to which disclosure were made shall be included with my original health records, and that paper and electronic copies may be used to facilitate use or disclosure of the information.
D. Information disclosed under this authorization may be subject to **re-disclosure** by the recipient and may no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.
E. I have the right to revoke this authorization at any time, but not retroactive to information already disclosed in accordance with the authorization. My revocation is not effective until delivered in writing to the person who is in possession of my records.
F. This authorization is automatically revoked upon termination of services. If the named individual is a minor, and a parent or guardian signs this form, this authorization will become invalid when the individual reaches the age of 18 years.

Signature of Patient: ______________________________ **Date:** ___/___/___

Signature of Person Acting for Patient: ______________________________ **Date:** ___/___/___

☐ Provide the individual served with a copy ☐ Staff initials____________ ☐ Place the original in the service record

REVOCATION of AUTHORIZATION: THIS AUTHORIZATION FORM MAY BE ***REVOKED*** AT ANY TIME BY COMPLETING THE FOLLOWING IN PERSON:

Authorization revoked by (PRINT NAME):	**Relationship:**
Signature of Person Revoking Authorization:	Date: / /

Authorization To Disclose Or Exchange Protected Health Information

NAME OF PATIENT:	DOB:

NAME OF PERSON ACTING FOR PATIENT:____
RELATIONSHIP TO CLIENT:

1. I authorize the following designee to **DISCLOSE OR EXCHANGE** my protected health information:

Pharmacy: ____

____

____

Telephone: _____________________ **Fax:** _____________________

2. **WITH:**

Columbia County Mental Health Center
325 Columbia Street
Hudson, NY 12534
Telephone: (518) 828-9446 Fax: (518) 828-9450

3. **Specify the Health Information to be disclosed or exchanged when requested:** (check all that apply) ☐ Transportation/Accessibility Needs
☐ Financial/Billing ☐ Admission/Assessment ☐ Progress Notes ☐ Service Plan ☒ Diagnosis ☒ Lab Results ☐ History and Physical
☐ Psychiatric Evaluations ☐ Psychological Testing/Reports ☐ Discharge Summary ☒ Medication Information ☒ Medical Information
☒ Dates and Types of Services Received ☐ **HIV+, AIDS** information ☐ **HBV, HCV** information ☐ Other *(specify)*__________________________

4. **Required for disclosure of Substance Use Treatment information:**
☒ **Substance Use Treatment Information/Drug Screenings**
NOTICE: The information approved for disclosure by this authorization may be protected by Federal Regulations (42 CFR Part 2) which prohibit a recipient from making any further disclosure of alcohol or substance abuse treatment information unless expressly permitted by written authorization of the person to whom it pertains or otherwise permitted by 42 CFR Part 2.

5. **PURPOSE:** I understand that this information will be used for the following: (check all that apply)
☒ Evaluation/Treatment ☐ Legal Purposes ☐ Insurance/Billing Purposes ☒ Care Coordination ☐ Other *(specify)*________________________

6. **As the person signing this Authorization form**, I understand that I am giving my permission to **Columbia County Mental Health** to disclose or use confidential health care records (protected health information) for me, or the individual named above.

I understand that:

A. Information disclosed may include documents placed in the record after the signature / effective date, but prior to expiration date or revocation.
B. I may refuse to sign this form, that treatment or payment will not be conditioned upon my willingness to sign this form, (unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization), and I affirm that I have not been coerced or forced to sign this form.
C. An original or copy of this authorization and a notation concerning the persons or agencies to which disclosure were made shall be included with my original health records, and that paper and electronic copies may be used to facilitate use or disclosure of the information.
D. Information disclosed under this authorization may be subject to **re-disclosure** by the recipient and may no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.
E. I have the right to revoke this authorization at any time, but not retroactive to information already disclosed in accordance with the authorization. My revocation is not effective until delivered in writing to the person who is in possession of my records.
F. This authorization is automatically revoked upon termination of services. If the named individual is a minor, and a parent or guardian signs this form, this authorization will become invalid when the individual reaches the age of 18 years.

Signature of Patient: ____ **Date:**___/___/____

Signature of Person Acting for Patient: ______________________________________ **Date:**___/___/____

☐Provide the individual served with a copy ☐Staff initials____________ ☐Place the original in the service record

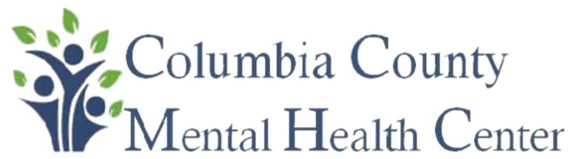
REVOCATION of AUTHORIZATION: THIS AUTHORIZATION FORM MAY BE ***REVOKED*** AT ANY TIME BY COMPLETING THE FOLLOWING IN PERSON:

Authorization revoked by (PRINT NAME):	**Relationship:**
Signature of Person Revoking Authorization:	Date: / /

Helping Columbia County Residents Find Hope & Healing For Over 50 Years

columbiacountymhc.com

Medical Record # _________________



Hixny Electronic Data Access Consent Form

In this consent form, you can choose whether to allow **Columbia County Department of Human Services/Mental Health Center (CCDHS/MHC),** to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), 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 **CCDHS/MHC** 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, the staff of **CCDHS/MHC** 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, the staff of **CCDHS/MHC** 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). **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.
You have two choices.

O **I GIVE CONSENT for CCDHS/MHC to access ALL of** my electronic health information through Hixny in connection with providing me any health care services, including emergency care.

O **I DENY CONSENT for CCDHS/MHC 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 Client **Date of Birth**

____

Signature of Client or Client's Legal Representative **Date**

____

Print Name of Legal Representative *(if applicable)* **Relationship of Legal Representative to Client**

<u>Details about client information in Hixny and the consent process:</u>

How your information will be used: Your electronic health information will be used by **CCDHS/MHC** only to:

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

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.

What types of information about you are included: If you give consent, 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 medicines 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 (inherited) diseases or tests
- •HIV/AIDS
- •Mental health conditions
- •Sexually transmitted diseases

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 **CCDHS/MHC**. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

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 as the medical staff of **CCDHS/MHC** who are involved in your medical care; health care providers who are covering or on call for **CCDHS/MHC** doctors; and staff members who carry out activities permitted by this consent form as described above in paragraph one.

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 **CCDHS/MHC** at: (518) 828-9446; or call Hixny at (518) 640-0021; or call the NYS Department of Health at (877) 690-2211.

Re-disclosure of information: Any electronic health information about you may be re-disclosed by **CCDHS/MHC** 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.

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

Withdrawing your consent: You can withdraw your consent at any time by signing a ***Withdrawal of Consent form*** and giving it to **CCDHS/MHC**. 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, hixny.org, or by calling (518) 640-0021.

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.

Copy of consent form: You are entitled to get a copy of this consent form after you sign it.

OPT-IN CONSENT TO RECEIVE APPOINTMENT REMINDERS AND OTHER HEALTHCARE INFORMATION

Columbia County Mental Health Center (CCMHC) now has the ability to **CALL, TEXT, OR EMAIL** clients for appointment reminders, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. Limited personal information may be included in these communications; however no medical information or test results will be specified. If you would like to opt-in to receive communications in this manner, please read the consent below and sign where indicated.

CLIENT NAME: ______________________________

CELL PHONE NUMBER: ______________________________

HOME PHONE NUMBER: ______________________________

E-MAIL ADDRESS: ______________________________

CONSENT

REQUESTED METHOD OF APPOINTMENT CONFIRMATION
****CHOOSE ONE****

○ **HOME PHONE CALL** - I consent to receive phone calls at the phone number(s) listed above and any number forwarded or transferred to that number.

○ **CELL PHONE CALL** - I consent to receive phone calls at the phone number(s) listed above and any number forwarded or transferred to that number.

○ **TEXT MESSAGE** - I consent to receive text messages at the cell phone number listed above and any number forwarded or transferred to that number. Standard text messaging rates may apply as provided in your wireless plan.

○ **EMAIL -** I consent to receive email communications at the email address listed above.

I understand that this request to receive phone calls, text messages or emails will apply to all future appointments reminders/feedback/information unless I request a change in writing. It is important to note that phone, text, and email communications are not always secure. Messages can be intercepted by others and CCMHC disclaims any responsibility for such occurrences.

______________________________ ______________

Signature of Client *(or legal representative if client is a minor)* Date

Legal Representative Name (please print):______________________________

Relationship to Client: ______________________________

325 Columbia Street · Suite 300 · Hudson, New York 12534 · (518) 828-9446 · Clinic Fax (518) 828-9450
Daniel S. Almasi, LCSW-R, Department Head/Director of Community Services
Kathleen Sprague, LCSW, Deputy Director/Director of Clinical Services

Overdue Balance & Payment Agreement Process

Dear Client,

The Columbia County Mental Health Center strives to provide quality behavioral healthcare to all of our clients. As your provider, we commit to serving you in the best possible way. As a client, we expect that you participate in all aspects of your care. Throughout your care, there might be times when you accrue a balance. The following is an explanation of the process that the Columbia County Mental Health Center will use to work with you on such financial matters.

Upon admission to our services, every client is asked to complete a financial agreement. The agreement outlines your financial obligations as a client. If you fail to make payment on your account on two separate occasions or within a 30-day period, the following actions will occur:

- 2 attempts will be made by a member of our Billing Team to contact you about the missed payment(s).
- If the Billing Team is unable to contact you after 2 attempts, a hold will be put on your ability to schedule any further appointments.
- If the Billing Team is able to contact you, they will work with you to create a Payment Agreement. By completing a Payment Agreement, you are agreeing to pay an agreed upon amount on a regular schedule towards any overdue balance, as well as any payments due at the time of your appointment.
- If you decline the Payment Agreement, we cannot reach you, or you do not honor the Payment Agreement that you created, a hold will be placed on your ability to schedule any further appointments. The Billing Team will notify your therapist who will contact you to discuss your objections or lack of compliance with the Payment Agreement.
- Failure to agree to a Payment Agreement or not complying with the terms of the Payment Agreement can result in your case being closed.

Thank you for your participating. Please sign below to acknowledge this agreement:

Client Signature: _______________________________________ Date: _________________________

Office of Mental Health | PSYCKES

Consent Form

Provider/Facility Name

About PSYCKES

The New York State (NYS) Office of Mental Health maintains the Psychiatric Services and Clinical Enhancement System (PSYCKES). This online database stores some of your medical history and other information about your health. It can help your health providers deliver the right care when you need it.

The information in PSYCKES comes from your medical records, the NYS Medicaid database and other sources. Go to **www.psyckes.org**, and click on **About PSYCKES**, to learn more about the program and where your data comes from.

This data includes:

- Your name, date of birth, address and other information that identifies you;
- Your health services paid for by Medicaid;
- Your health care history, such as illnesses or injuries treated, test results and medicines;
- Other information you or your health providers enter into the system, such as a health Safety Plan.

What You Need to Do

Your information is confidential, meaning others need permission to see it. Complete this form now or at any time if you want to give or deny your providers access to your records. What you choose will not affect your right to medical care or health insurance coverage.

Please read the back of this page carefully before checking one of the boxes below. Choose:

- "I GIVE CONSENT" if you want this provider, and their staff involved in your care, to see your PSYCKES information.
- "I DON'T GIVE CONSENT" if you don't want them to see it.

If you don't give consent, there are some times when this provider may be able to see your health information in PSYCKES – or get it from another provider – when state and federal laws and regulations allow it.[1] For example, if Medicaid is concerned about the quality of your health care, your provider may get access to PSYCKES to help them determine if you are getting the right care at the right time.

Your Choice. *Please check 1 box only.*

◯ **I GIVE CONSENT** for the provider, and their staff involved in my care, to access my health information in connection with my health care services.

◯ **I DON'T GIVE CONSENT** for this provider to access my health information, but I understand they may be able to see it when state and federal laws and regulations allow it.

Print Name of Patient

Patient's Date of Birth

Patient's Medicaid ID Number

Signature of Patient or Patient's Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative Patient (if applicable)

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health | PSYCKES

Information and Consent

1. **How providers can use your health information.** They can use it only to:
   - Provide medical treatment, care coordination, and related services.
   - Evaluate and improve the quality of medical care.
   - Notify your treatment providers in an emergency (e.g., you go to an emergency room).

2. **What information they can access.** If you give consent, ______________________________ can see ALL your health information in PSYCKES. This can include information from your health records, such as illnesses or injuries (for example, diabetes or a broken bone), test results (X-rays, blood tests, or screenings), assessment results, and medications. It may include care plans, safety plans, and psychiatric advanced directives you and your treatment provider develop. This information also may relate to sensitive health conditions, including but not limited to:
   - Mental health conditions
   - Alcohol or drug use
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Sexually transmitted diseases

3. **Where the information comes from.** Any of your health services paid for by Medicaid will be part of your record. So are services you received from a state-operated psychiatric center. Some, but not all information from your medical records is stored in PSYCKES, as is data you and your doctor enter. Your online record includes your health information from other NYS databases, and new databases may be added. For the current list of data sources and more information about PSYCKES, go to: www.psyckes.org and see "About PSYCKES", or ask your provider to print the list for you.

4. **Who can access your information, with your consent.** ______________________________'s doctors and other staff involved in your care, as well as health care providers who are covering or on call for ______________________________. Staff members who perform the duties listed in #1 above also can access your information.

5. **Improper access or use of your information.** There are penalties for improper access to or use of your PSYCKES health information. If you ever suspect that someone has seen or accessed your information – and they shouldn't have – call:
   - ________________________ at ____________________, or
   - the NYS Office of Mental Health Customer Relations at **800-597-8481**.

6. **Sharing of your information.** ______________________________ may share your health information with others only when state or federal law and regulations allow it. This is true for health information in electronic or paper form. Some state and federal laws also provide special protections and additional requirements for disclosing sensitive health information, such as HIV/AIDS, and drug and alcohol treatment.[1]

7. **Effective period.** This Consent Form is in effect for 3 years after the last date you received services from ______________________________, or until the day you withdraw your consent, whichever comes first.

8. **Withdrawing your consent.** You can withdraw your consent at any time by signing and submitting a Withdrawal of Consent Form to_________________________. You also can change your consent choices by signing a new Consent Form at any time. You can get these forms at **www.psyckes.org** or from your provider by calling ______________________at_____________. Please note, providers who get your health information through ______________________________while this Consent Form is in effect may copy or include your information in their medical records. If you withdraw your consent, they don't have to return the information or remove it from their records.

9. **Copy of form.** You can receive a copy of this Consent Form after you sign it.

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

325 Columbia Street · Suite 300 · Hudson, New York 12534 · (518) 828-9446 · Clinic Fax (518) 828-9450
Daniel S. Almasi, LCSW-R, Director of Community Services
Kathleen Sprague, LCSW, Deputy Director/Director of Clinical Services

NOTICE FOR USE OF CREDIT CARD FOR PAYMENT

If you are using a credit card for payment, New York General Business Law 519-a requires the you receive the following notice and make an acknowledgement of the notice by signing below.

As a health care provider, we cannot require credit card pre-authorization or require you to have a credit card on file prior to providing emergency or medically necessary medical services to you as a patient.

There is a risk of payment of medical bills by credit card. Medical bills paid by credit card are no longer considered medical debt. You are notified that if you are using a credit card to pay for medical services, that you are forgoing state and federal protections that apply to medical debt.

If you pay by credit card, you will not have the benefit of:

1. Prohibitions against wage garnishment and property liens
2. Prohibitions against reporting medical debt to credit bureaus
3. Limitations on interest rates

If you pay by credit card on file, you have the right to revoke the authorization of automatic credit card charges.

I acknowledge the above: ___________________________________

Date: ____________________

Columbia County
Mental Health Center

Informed Consent for Telemental Health Services

Client Name: ___________________________________ DOB:__________________________

Medical Record No: _________________

1. I understand that my health care provider may offer a telemental health session on an as needed basis.

2. My health care provider has explained to me how the video conferencing technology is used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I have had the alternative to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical test may be conducted by individuals at my location at the direction of the consulting health care provider.

5. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

6. I understand that billing will occur from the facility from which I receive services.

7. I have had a direct conversation with a staff person from the CCDHS, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_______________________________________ ________________ _______________

Client's/parent/guardian signature Date Time

_______________________________________ ________________ _______________

Witness signature Date Time

COLUMBIA COUNTY MENTAL HEALTH CENTER

325 Columbia Street
Hudson, New York 12534

PHOTO CONSENT AND RELEASE FORM

I hereby give consent for photographs to be taken of me by the Columbia County Mental Health Center, its employees or representatives. I understand that these images will be a part of my medical record and may be used for purposes related to my treatment and/or in case of emergency.

I acknowledge my consent is voluntary and that I am not required to sign this form in order to receive treatment.

I hereby release the Columbia County Mental Health Center, its employees, and any third parties involved in the use of any photographs of me for the above-stated purposes from liability for any claims by me or any third party in connection with this authorization.

I understand if I wish to revoke my consent in the future, I may do so by written request to the Columbia County Mental Health Center. I further understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand and agree that all photos will become the property of the Columbia County Mental Health Center and will not be returned.

I understand that this authorization will expire at the conclusion of my treatment with the Columbia County Mental Health Center unless I have given written notification stating otherwise.

By signing this form, I confirm understanding of this consent.

____
Print Name

______________________________ ______________________
Signature Date

☐ I am the Patient

☐ I am the Patient's Parent/Legal Guardian/Personal Representative (If patient/subject is under 18 or incapable of signing)

COLUMBIA COUNTY MENTAL HEALTH CENTER MEDICAL HISTORY

Name: ______________________________ **Date:** ______________________________

DOB: ____________________________ **Drug Allergies:** ____________________________________

Please provide the names of other providers that treat you:

Primary Care Doctor: ________________________________ **Women's Health:** ________________________

Specialists: ____________________________________ ____

Current Medications:

Name of medication	Dose and frequency	Reason	Date started	Doctor
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Please list non-prescribed or over the counter (OTC) medications you take, including herbal or "natural" remedies:

1.____________________________________ 2. ____________________________________

3. ___________________________________ 4. ____________________________________

How much of the following do you drink each day?

coffee __________ **tea (hot or iced)** ___________ **colas**____________ **energy drinks** ____________

If you smoke tobacco, how many packs or cigarettes do you smoke each day? _______________
Do you use chewing tobacco? If so, how often? __________________________

Height: ___________ **Current weight:** ____________ **Weight range:** _______________________

How much, and what kind of exercise do you get each day? _______________________________________

List the dates of your most recent:

Physical Exam________________________ **Eye Exam**_____________________________

Dental Exam ________________________ **Lab work (type)** ________________________

Women's Health Exam ________________ **Mammogram** ___________________________

COLUMBIA COUNTY MENTAL HEALTH CENTER MEDICAL HISTORY

Name:____

Please list the dates and reasons of any past surgeries: ____

Please list the dates, location, and reasons of any past MEDICAL hospitalizations: ______________________

Please check if you have or have had any of the following conditions:

____ High Blood Pressure
____ Heart Attack Date:________________
____ Coronary Artery Disease
____ Irregular heart beat
____ Heart Murmur
____ Anemia
____ Blood Clots (location):________________
____ Bleeding disorder: ________________

____ Kidney problem (specify): ________________
____ Diabetes
____ Thyroid Problem (specify): ________________
____ Glaucoma
____ Hearing Impairment

____Sexually Transmitted Disease
____Cancer (please specify):________________
____Lyme Disease
____Chronic Fatigue Syndrome
____Fibromyalgia
____Sleep Apnea
____Have you ever had a sleep study?
If yes, where and when?________________

____ Hepatitis B
____ Hepatitis C
____ Cirrhosis
____ Acid reflux
____ Stomach Ulcer
____ Gallbladder Disease
____ Pancreatitis
____ Have you had gastric bypass surgery? Date: ________________

____Stroke Date: ________________
____Aneurysm
____Migraine Headaches
____Seizure Disorder
____Multiple Sclerosis
____Parkinson's Disease
____Documented Head Injury Date: ________________

____Asthma
____Chronic lung disease
____Emphysema
____Bronchitis
____Tuberculosis

____Menstrual problems
____Perimenopausal
____Hot flashes/night sweats
____Do you take birth control pills?
____Other contraception

Accidents/Injuries: (details)________________________

____ Are you currently being treated for chronic pain?
Location(s) of pain: ________________________

Other medical problem not listed above: ________________

* * * * * * * * * * * * * * *

(For Staff Use Only)

Medical Staff Review: ____________________________ **Date:**____________________

Recommendations (including referrals if necessary):