

Essex



County

Community Services Board

Laurie Kelley
Chairperson
Terri Morse, LMH, CASAC-Master
Director

P.O. Box 8 – 7513 Court Street
Elizabethtown, NY 12932
(518) 873-3670
Fax (518) 873-3777

Mental Health Services

Terri Morse, LMHC, CASAC-Master
Director
Dava Clement, LMHC
Director of Clinical Services

WELCOME TO ESSEX COUNTY MENTAL HEALTH

Congratulations on taking this first step to improve your mental health! Our vision is to be a trusted health leader by strengthening, healing and empowering our community members.

Registration Steps.

Please refer to the checklist on the reverse side of this page and review the enclosed information. We ask that you return the completed forms to the reception desk. At that time, you will be offered a registration appointment. During this session, you will meet with a clinician for approximately one hour. These appointments must be done face to face. In 3-5 business days after you have completed the initial intake appointment, you will be assigned a therapist and contacted to set up your first couple of appointments.

Essex County Mental Health provides an accessible and safe pathway to emotional, behavioral, physical and psychological health and well-being to all clients and families. We strive to create a customized plan of treatment to address your needs with your collaboration, and community partners. 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 our services or have any concerns or suggestions about your treatment.

Thank you for allowing us to be a part of your recovery and choosing Essex County Mental Health as your provider. We understand that asking for help can be a difficult choice and many people are hesitant to seek counseling. You are making the choice to pursue a path of wellness and recovery intended to strengthen your health and emotional well-being.

Checklist of Registration Packet Items

This packet contains the following documents.

Forms for you to keep:

Welcome letter and this checklist

Clinic Fee Guidelines

Patient Bill of Rights

Notice of Privacy Practices

Forms for you to sign and return:

Patient Information

Acknowledgement of Receipt of Patient Bill of Rights

Statement of Understanding with Essex County Mental Health Services

Fee and Financial Information Contract

Telehealth Consent Form

Hixny Electronic Data Access Consent

PSYKES Consent

AAFP Social Needs Screening Tool

Information Release Authorization

**Please
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PATIENT INFORMATION

Client Name: First _____ MI _____ Last _____

DOB: _____ SSN: _____ - _____ - _____

Sex: _____ Gender Identity: _____ Marital Status: _____

Would you like reminder calls? Y N May we leave a Voicemail? Y N

Phone Number: (home) _____ (cell) _____

Email Address: _____

Physical address: _____ Town: _____

Mailing address: _____ Town: _____

Race: _____ Ethnicity: _____

Preferred language? English Spanish Other Language _____

Preferred method of communication? Phone Email Letter

Have you ever served in the Military? Y N

Do you have a Care Manager? Y N

Name: _____ Agency: _____

Phone: _____

Have you had any recent hospitalizations for mental health reasons? Y N

Hospital: _____ Discharge Date: _____

Reason for Admission: _____

Primary Care Provider: [Doctor's Name] _____

Facility: _____ Phone: _____

Preferred Lab: _____ Phone: _____

Name of Parent/Guardian (If under 18) _____

Client's School District: _____ Grade: _____

Client's Name: _____

DOB: _____

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Insurance Information

Insurance Info: *Please provide copy of Insurance card*

Insurance Company: _____

Policy Number: _____

Group Number: _____

Policy Holder Info:

Name: _____

DOB: _____ SSN: _____ - _____ - _____

Employer: _____

Relation to Client: _____ Phone: _____

Address if other than Client: _____

Contacts

Parent/Guardian for minors or adult dependents (*Send Legal Documentation if Guardian*).

Name: _____ Phone: _____

Relationship to Client: _____

Emergency Contact

Name: _____ Phone: _____

Relationship to Client: _____

Referral

Who referred you? _____

Reason for referral: _____

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.

ESSEX COUNTY HEALTH DEPARTMENT HAS A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI). All employees, volunteers, staff, doctors, health professionals and other personnel are legally required to and must abide by the policies set forth in this notice to protect the privacy of your health information.

This "protected health information", or PHI for short, includes information that can be used to identify you. We collect or receive this information about your past, present or future health condition to provide health care to you, or to receive payment for this health care. We must provide you with this notice about our privacy practices that explain how, when and why we use and disclose (release) your PHI. With some exceptions, we may not use or release any more of our PHI than is necessary to accomplish the need for the information. We must abide by the terms of the notice of privacy practices currently in effect. We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes to this notice will apply to the PHI already in existence. Before we make any change to our policies, we will promptly change this notice and post a new notice in our lobby. You can also request a copy of this notice from the contact person listed at the end of this notice at any time and can view a copy of the notice.

WE MAY USE AND RELEASE YOUR PROTECTED HEALTH INFORMATION for many different reasons. For some of these reasons, we will need your permission or a specific, signed authorization. Below, we describe the different categories of when we use and release your PHI, give you some examples of each category and tell you when we need your permission.

A. WE MAY USE, OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. YOUR AUTHORIZATION IS NOT REQUIRED FOR THESE PURPOSES.

1. For Treatment. We may release your PHI to physicians, nurses, medical students, and other health care personnel and agencies and business associates who provide or are involved in your health care. For example, if you are being assisted because you are pregnant or require home health care, we may release your PHI to other county departments/programs in order to provide you with all the services you need.

2. To obtain payment for treatment. We may use and release your PHI in order to bill and collect payment for services provided to you. It is important that you provide us with correct and up-to-date PHI. For example, we may release portions of your PHI with our billing department and your health plan to get paid for the health care services we provided to you. We may also release your PHI to our business associates, such as billing companies, claims processing companies and others.

3. To run our health care business. We may release your PHI in order to operate our facility in compliance with healthcare regulations. For example, we may release your PHI to a business associate to review the quality of our services and to evaluate the performance of our staff in caring for you.

4. To New York State and Other Departments of Essex County. We communicate information required to be provided to New York State. We also communicate information with other departments/programs of Essex County to give you the best treatment plan possible, as well as for our payment and business operations purposes.

B. WE ALSO DO NOT REQUIRE YOUR CONSENT TO USE OR RELEASE YOUR PHI:

1. When federal, state, or local law; judicial or administrative proceedings; specialized government functions; or law enforcement agencies request your PHI. We release your PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; for notification and identification purposes when a crime has occurred or in missing person cases; for specialized government functions such as in national security situations; when a crime has taken place on our premises; about victims of a crime with their consent or in an emergency situation; or when ordered in a judicial or administrative proceeding.

2. For public health activities. We report information about births, deaths, and various diseases to government officials in charge of collecting that information and we provide coroners, medical examiners and funeral directors necessary information relating to an individual's death.

3. For purposes of organ donation. For patients that have previously agreed to organ donation, we may notify organ procurement to assist them in organ, eye or tissue donation and transplants.

4. To avoid harm. In order to avoid a serious threat to health or safety of a person or the public, we may provide your demographic PHI to law enforcement personnel or persons able to prevent or lessen such harm.

5. For worker's compensation purposes. We may release your PHI in order to comply with worker's compensation laws. If you do not want worker's compensation notified, alternate insurance or payment information must be supplied.

6. For appointment reminders and health-related benefits and services. We may use your demographic PHI to contact you as a reminder that you have an appointment or to recommend possible treatment options or alternatives that may be of interest to you.

7. For health oversight activities. We may use PHI and may disclose PHI to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for oversight of the health care system, government benefit programs, or entities subject to government regulation or civil rights laws.

C. YOU HAVE THE OPPORTUNITY TO AGREE TO OR OBJECT TO THE FOLLOWING:

1. Information shared with family, friends or others. We may release your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. Your choice to object may be made at any time.

D. YOUR PRIOR WRITTEN AUTHORIZATION IS REQUIRED FOR ANY USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION NOT INCLUDED ABOVE. We will ask for your written authorization before using or releasing any of your PHI except as previously stated, or in an emergency situation. If you choose to sign an authorization to release your PHI, you may later cancel that authorization in writing. This will stop any future release of your PHI for the purposes you previously authorized.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

A. You Have the Right to Request Limits on How We Use and Release Your PHI. If we accept your request, will put any limits in writing and abide by them except in emergency situations. You may not limit PHI that we are legally required or allowed to release.

B. You Have the Right to Choose How We Communicate PHI to You. All of our communications to you are considered confidential. You have the right to ask that we send information to you to an alternative address (for example, sending information to your work address rather than your home address) or by alternative means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested. Any additional expenses will be passed onto you for payment.

C. You Have the Right to See and Get Copies of Your PHI. You must make the request in writing. We will respond to you within 5* days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, why we denied your request. You have the right to have the denial reviewed if you make a request in writing within 30* business days. We will choose another licensed healthcare professional to review your request and the denial. The person conducting the review will not be the person who denied your first request and must make a decision within 7* business days. You can request a summary or a copy of the entire medical record as long as you agree to the cost in advance. If your request to see the medical information is approved, we will arrange this in accordance with established hospital policy. Please submit all requests for this information to: Linda Beers, Public Health Director.

D. You Have the Right to Get a List of Instances of When and to Whom We Have Disclosed Your PHI.

This list **will not** include uses you have already authorized, or those for treatment payment or operations. This list **will not** include uses made for national security purposes, to corrections or law enforcement personnel, if you were in custody, or disclosures

made before April 14, 2003. We will respond within 60 days of receiving your request. The list we provide will include the last six years of activity unless you request a shorter time. The list will include dates when your PHI was released and why, with whom your PHI was released (including their address if known), and a description of the information released. The first list you request within a 12-month period will be free. You will be charged a reasonable fee for additional lists within that time frame. Please submit all requests for this information to: Essex County Mental Health, 7513 Court Street, Elizabethtown, NY 12932.

E. You have the Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing or add the missing information. We can do this for as long as the information is retained by our facility. You must provide the request and your reason for the request in writing. We will respond within 30* days of receiving your request. If we deny your request, our written denial will state our reasons and explain your right to file a written appeal* within 7* business days. If you choose to appeal, your appeal must be processed within 30* business days. You may also choose to submit a written statement of disagreement. If you do not file a written statement of disagreement, you have the right to request that your request and our denial be attached to all future uses or releases of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change or amendment to your PHI. Please submit all requests for this information to: Terri Morse, Essex County Mental Health Director

F. You have the Right to Get This Privacy Notice by email. Even if you have agreed to receive notice via email, you also have the right to request a paper copy of this notice. Please submit this request to: Terri Morse, Essex County Mental Health Director

HOW TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES: If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed below or with the Secretary of the DHHS:

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES:

**Daniel T. Manning III
Essex County Privacy Officer
(518) 873-3380**

You will not be penalized for filing a complaint.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

* Are New York State law requirements

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ESSEX COUNTY MENTAL HEALTH PATIENT BILL OF RIGHTS

Any individual admitted to, applying for, or receiving services from Essex County Mental Health (ECMH) is entitled to the following rights:

1. The right to be treated with courtesy and respect for your dignity, cultural background and civil rights.
2. The right to services without regard to financial status, ethnicity, race, creed, sex, age, national origin, citizenship, sexual orientation or gender identification. If you are a person with a disability, you have the right to a reasonable accommodation in order to access services.
3. The right to receive clinically appropriate care provided by licensed professionals whose credentials are available for your verification.
4. The right to receive clear explanations for services and to fully participate in your individual plan of treatment, including the right to refuse any services offered unless such services are court mandated.
5. The right to have your privacy respected and the confidentiality of your records protected.
6. The right to know how your records will be maintained and how to obtain copies.
7. The right to file a complaint about a licensed professional or unlicensed practitioner with the NY State Education Department.
8. The right to be informed of the clinic's Grievance Procedure.

The websites and phone numbers below are organizations that have an interest in ensuring proper operation of this clinic and in protecting the rights of individuals engaged in mental health treatment in New York State.

NY State Education Department Office of the Professions nysed.gov 518-474-3817

NY State Justice Center 1-855-373-2122 or 518 549-0200

NYS Office of Mental Health 800-597-8481

National Alliance for Mental Illness for Champlain Valley 518-561-2685

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT BILL OF RIGHTS

This form is being provided to acknowledge your receipt of a Notice of Privacy Practices and Patient Bill of Rights and Responsibilities from Essex County Mental Health.

What is the Notice of Privacy Practices?

The Notice of Privacy Practices explains how your health information may be used or disclosed by the Essex County Health Department. In addition, it explains your rights in regard to your health information as well as our legal responsibilities.

By signing below you are acknowledging the Notice of Privacy Practices and Patient Bill of Rights have been provided for you and you have had an opportunity for them to be read to you.

Acknowledgement of Receipt

I, _____,
Residing at Street Address: _____ PO Box (if any) _____
City/Town _____ State _____ Zip _____

Have received the Essex County Mental Notice of Privacy Practices and Patient Bill of Rights.

_____, 20, _____
Date

Signature Patient or Guardian

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STATEMENT OF UNDERSTANDING WITH ESSEX COUNTY MENTAL HEALTH SERVICES

Listed here are a few items that we would like to share with you, such as what you can expect from us and our expectations of you. Your therapist will review this document with you. Please feel free to ask any questions.

TREATMENT TEAM. While you will be working with a primary therapist, we also work in a treatment team approach. Your therapist will develop a Treatment Plan, identifying your goals for seeking services. If psychiatric medications are recommended, you may choose to work with our psychiatrist or nurse practitioner for your medication needs. The psychiatric prescriber will work with your therapist to coordinate your care. Your progress will regularly be discussed during Treatment Team reviews.

COORDINATION OF CARE. If you are receiving services from other providers such as a school, social services, Families First, Mental Health Association, or a case manager, your therapist may contact these agencies to coordinate care. If your primary care provider prescribes psychiatric medications for you, or is treating you for medical concerns, your therapist may need to contact them periodically as well. It is your responsibility to inform us if you are receiving psychiatric and/or opioid medications from another prescriber. Any outside agency contact will require a release of information signed by you (or your parent/guardian, if a minor). We may not prescribe psychiatric medications for you if another provider is doing so.

CONFIDENTIALITY. Confidentiality is maintained to the standards outlined by the New York State Office of Mental Health as well as New York State and Federal Law. What you say in session is held confidential within the clinic. There are exceptions to confidentiality, such as in the reporting of child abuse, expression of suicidal/homicidal plan or intent, or a court order. Also, your insurance company has the right to access your records. Anyone to whom you authorize release of information, also has

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right of access to information. Please refer to the Essex County Notice of Privacy Practices and/or talk with your therapist for more details regarding confidentiality.

SURESCRIPTS. This is an electronic network that connects pharmacies, care providers, benefit managers, and technology partners with access to your current and past medications. This allows our prescribers to have up to date medical information to inform your care and to manage prescriptions electronically, making prescribing more convenient and efficient. Surescripts is a component of our Electronic Health Record. Surescripts health information transmission is HIPAA compliant.

KEEPING APPOINTMENTS. The professionals in this clinic are committed to quality care and to working with you in achieving optimal mental health. Your frequency of sessions is based on your specific needs. We have the expectation that you attend appointments as scheduled. If you cannot keep an appointment, we expect you to call at least 24 hours in advance. Please refer to our Attendance Policy or ask a staff person for guidelines on attendance. Please be aware that your referral may be cancelled if you do not attend any of your first three appointments.

COMPLAINTS. If you have a complaint as to your care, please try to discuss this with your therapist or psychiatrist first. If it is not resolved, please call the Clinical Director. You may also request a copy of our grievance procedure, and a copy of the Patient Bill of Rights, at any time.

CLINIC FEES. Payment is expected at the time of service. Please refer to our Clinic Fee Guidelines Policy for further information and/or support.

The Essex County Mental Health Statement of Understanding has been reviewed with me. I understand and agree to the information contained therein.

Client (parent/guardian) Signature _____ Date _____

Therapist Signature _____ Date _____

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ESSEX COUNTY MENTAL HEALTH CLINIC FEE GUIDELINES

Our clinic fee policy is intended to help keep you from building a past due balance which is unmanageable and can become a barrier to successful treatment.

- If you have health insurance, your plan may have a co-pay. We are required by law to collect the full co-pay fee, even if your self-pay fee is lower.
- **Your self-pay fee or co-pay fee is expected to be paid in full every time you come for services.** We accept payment by cash, check or credit/debit card.
- If you feel that you cannot afford your self-pay fee or co-pay fee, you can request a fee adjustment. Please tell the receptionist or your therapist right away so that we can help you start the process quickly. This will help you to avoid building a past due balance.
- If you owe Essex County Mental Health for 2 sessions or more, we will not schedule any new appointments until you: (1) pay your balance down to one session or less, OR (2) complete a Payment Plan Agreement (PPA).
- If you have a past due balance from prior treatment, you will be expected to pay the balance in full OR submit a PPA, before being seen by a therapist for your registration appointment. Our staff will help you complete the PPA.
- If you agree to a PPA, you must pay the amount in your PPA plus your self-pay or co-pay fee before each appointment, or you will not be seen that day.
- **Please contact us at 518-873-3670 during business hours if you have questions regarding the clinic fee schedule and/or need further assistance.**

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FEE AND FINANCIAL INFORMATION CONTRACT

Essex County Mental Health (ECMH) is a county agency funded by a combination of patient fees, Medicare, Medicaid, commercial insurance, and state and county funds. We offer a sliding fee scale for those unable to pay full price for services. Financial arrangements are made at the time of intake.

A part of recovery is a commitment to financial accountability. It is your responsibility to contact our office as soon as possible regarding any change in financial status or insurance that may affect payment for services.

SELF-PAY/COPAY. Our per visit fee is \$135.00. We expect that you will pay for each visit, including any copay, at the time of service. For us to set a reduced fee, we must have the completed sliding fee program application and documentation of income. The Sliding Fee Program application can be obtained from the receptionist. An example of income can include a copy of your pay stub, bank statement, most recent tax return, or proof of other income.

Upon approval of the sliding fee, any outstanding balance will be adjusted. If you are unable to provide the required financial documents, we will request that you apply for insurance through the NY Health Plan Marketplace (nystateofhealth.ny.gov).

MEDICARE. If you have Medicare, you are responsible for:

- (1) Providing us with a copy of your Medicare card;
- (2) The Copay/sliding fee scale due; (3) Agreeing to the following statement:

"I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and I request that payment under the Medical Insurance program be made to Essex County Mental Health on any bills for services furnished me by that provider."

MEDICARE AND MEDICAID. If you have Medicare and Medicaid, we are required to bill Medicare prior to billing Medicaid for any balance. Whatever Medicaid pays us is considered payment in full. You will not be responsible for further payment.

MEDICAID FEE FOR SERVICE/MEDICAID MANAGED CARE (EXAMPLE FIDELIS). If you have Medicaid, you are responsible for (1) providing us with a Medicaid card/Managed Care Plan insurance identification card, and (2) presenting your insurance card to the receptionist at each visit for Medicaid coverage.

THIRD PARTY/PRIVATE INSURANCE. If you have private insurance, you are responsible for providing us with a copy of your insurance card, as well as any information needed regarding the policy holder for billing purposes. You are responsible for all copays and deductibles. If we are not a participating provider with your health insurance company, we will still submit claims to them for the services we provide. In this case, your health insurance company may send checks and statements directly to you. We will not expect payment from you until your insurance company sends the check or the statement, with the understanding that you:

1. Pay your co-pay every time you come to the clinic and receive services.
2. Provide all insurance checks and statements to the clinic as soon as you receive them.

We are willing to accept the health insurance payment plus your co-pay as payment in full for our services. If there is one incident in which you do not bring the health insurance check or statement to ECMH for payment for services we provided to you, we will not schedule additional appointments for you until you bring us copies of all insurance statements and pay the entire balance due in full.

(Please be aware that failure to do either 1 or 2 above could be considered insurance fraud.)

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AGREEMENTS

- I understand the above information.
- I agree to provide the required financial information to the ECMH office.
- If services are rendered at a satellite clinic, any copays or other fees due will be accepted at the time services are rendered by the satellite clinician.
- I understand that a \$135.00 fee per visit will be charged unless I am covered by insurance or a completed sliding scale fee application is submitted and approved by ECMH, in which case I agree to pay the fee set from the sliding fee scale.
- I agree to keep the ECMH office informed of any changes in my financial information.
- I understand that it is the policy of Essex County Mental Health to recover any and all costs of services provided by them from available health insurance programs and that the process of collection from those various insurance companies may in many instances be a lengthy one involving a period of up to six months. I also understand that if my individual health insurance policy(ies) denies coverage or does not cover the whole cost, I will be billed directly for these expenses.

By signing below, I am giving Essex County Mental Health permission to release all medical information necessary to my insurance company for payment of services. I request a payment of authorized benefits be made on my behalf.

PATIENT Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

Staff Signature: _____

Date: _____

For Office Use Only:

Applying for sliding fee program? Yes No Documentation Received Yes No

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Telehealth Consent Form

Client Name: _____

Date of Birth: _____

1. I (the undersigned) authorize Essex County Mental Health (ECMH) to allow the client named above to participate in telehealth services by agency staff.
2. I understand that this service is not the same as a direct client/provider/clinician visit, because the client will not be in the same room as the clinician/provider performing the service. The provider has thoroughly explained limitations to the therapeutic process using telehealth. I understand there is an option to see an ECMH provider in person.
3. ECMH has fully explained to me the nature and purpose of telehealth technology. I understand that there are potential risks to the use of this technology, including but not limited to, interruptions, unauthorized access by third parties, and technical difficulties. I am aware that either my/the client's healthcare provider or I can discontinue the telehealth service if we believe that the videoconferencing connections are not adequate for the situation.
4. I have been informed and consent that video links and appointment confirmations for telehealth appointments may be sent by email. I acknowledge awareness of the potential risk to privacy and security of these emails.
5. I agree to create and maintain a telehealth space that is quiet and private, with a minimum of distractions or disruptions, to the best of my abilities.
6. I understand that the telehealth session will not be audio or video recorded at any time. Likewise, I agree to not audio or video record the session.
7. I acknowledge that I have the right to request the following when non-medical personnel are present in the session (e.g., front office staff, case manager, or family member):
 - a. Omission of specific details of the medical history/physical examination that are personally sensitive, or
 - b. For the person to leave the telehealth session at any time, when applicable, or
 - c. Termination of the service at any time.
8. In the event of the need for crisis intervention during a telehealth session, the undersigned acknowledges that occasions may arise when ECMH staff will need to coordinate with appropriate ECMH staff or partner providers to arrange for necessary care and treatment to ensure safety.
9. It is the responsibility of the telehealth provider to fully disconnect the video conferencing session upon termination of the appointment.

Client Name: _____

Date: _____

- 10. I understand that the client's insurance will be billed for telehealth services. I understand that if the client's insurance does not cover telehealth services, the responsible party will be billed directly for the provision of the services.
- 11. My consent to participate in this telehealth service shall remain in effect for the duration of services with ECMH, or until the consent is revoked in writing.
- 12. I agree that there have been no guarantees or assurances made about the outcomes of this service.
- 13. I have been given an opportunity to ask questions about telehealth services, and all of my questions have been answered fully and satisfactorily.
- 14. I confirm that I have read and fully understand this *Telehealth Consent Form*. All blank spaces have been completed prior to my signing. I have crossed out and initialed any paragraphs or words above, which do not pertain to me.

Client/Relative/Guardian Signature*

Print Name

Relationship to Client (if required)

Date

*The signature of the client must be obtained unless the client is a minor unable to give consent or otherwise lacks capacity.

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment) the proposed procedure, have offered to answer any questions and have fully answered all such questions. I believe that the client/relative/guardian fully understands what I have explained and answered.

ECMH Staff Signature

Date

Cancellation of Telehealth Consent

I hereby revoke my consent to participate in Telehealth at Essex County Mental Health.

Client/Responsible Party Signature

Date

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE CLIENT'S MEDICAL RECORD



**Please
Return**

Hixny Electronic Data Access Consent Form

Essex County Community Services

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

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

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

Hixny is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT).

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.

- I GIVE CONSENT for** Essex County Community Services **to access ALL of my electronic health information through Hixny in connection with providing me any health care services, including emergency care.**
- I DENY CONSENT for** Essex County Community Services **to access my electronic health information through Hixny for any purpose, even in a medical emergency.**

NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through Hixny.

Print Name of Patient

Date of Birth

Date

Signature of Patient or Patient's Legal Representative

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

Keep
Do Not
Return

Details about patient information in Hixny and the consent process:

How Your Information will be Used

Your electronic health information will be used by Essex County Community Services only to:

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

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

What Types of Information about You Are Included

If you give consent, Essex County Community Services may access ALL of your electronic health information available through Hixny. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of 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

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

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 Hixny. 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 on

Essex County Community Services's medical staff who are involved in your medical care; health care providers who are covering or on call for Essex County Community Services's 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 Essex County Community Services at (518)873-3670; or call Hixny at (518) 640-0021; or call the NYS Department of Health at (518) 474-4987.

Re-disclosure of Information

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

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 Essex County Community Services. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 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 Form

You are entitled to get a copy of this Consent Form after you sign it.

hixny.org



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").

- 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	• Genetic (inherited) diseases or tests
• Alcohol or drug use	• HIV/AIDS
• Birth control and abortion (family planning)	• 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”).

Social Needs Screening Tool

HOUSING

1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?¹
 - Yes
 - No
2. Think about the place you live. Do you have problems with any of the following? (check all that apply)²
 - Bug infestation
 - Mold
 - Lead paint or pipes
 - Inadequate heat
 - Oven or stove not working
 - No or not working smoke detectors
 - Water leaks
 - None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.³
 - Often true
 - Sometimes true
 - Never true
4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.³
 - Often true
 - Sometimes true
 - Never true

TRANSPORTATION

5. Do you put off or neglect going to the doctor because of distance or transportation?¹
 - Yes
 - No

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?⁴
 - Yes
 - No
 - Already shut off

CHILD CARE

7. Do problems getting child care make it difficult for you to work or study?⁵
 - Yes
 - No

EMPLOYMENT

8. Do you have a job?⁶
 - Yes
 - No

EDUCATION

9. Do you have a high school degree?⁶
 - Yes
 - No

FINANCES

10. How often does this describe you? I don't have enough money to pay my bills:⁷
 - Never
 - Rarely
 - Sometimes
 - Often
 - Always

PERSONAL SAFETY

11. How often does anyone, including family, physically hurt you?⁸
 - Never (1)
 - Rarely (2)
 - Sometimes (3)
 - Fairly often (4)
 - Frequently (5)
12. How often does anyone, including family, insult or talk down to you?⁸
 - Never (1)
 - Rarely (2)
 - Sometimes (3)
 - Fairly often (4)
 - Frequently (5)



13. How often does anyone, including family, threaten you with harm?⁸
- Never (1)
 - Rarely (2)
 - Sometimes (3)
 - Fairly often (4)
 - Frequently (5)

14. How often does anyone, including family, scream or curse at you?⁸
- Never (1)
 - Rarely (2)
 - Sometimes (3)
 - Fairly often (4)
 - Frequently (5)

ASSISTANCE

15. Would you like help with any of these needs?
- Yes
 - No

SCORING INSTRUCTIONS:

For the housing, food, transportation, utilities, child care, employment, education, and finances questions: Underlined answers indicate a positive response for a social need for that category.

For the personal safety questions: A value greater than 10, when the numerical values are summed for answers to these questions, indicates a positive response for a social need for personal safety.

Sum of questions 11–14: _____

Greater than 10 equals positive screen for personal safety.

REFERENCES

1. https://www.va.gov/HOMELESS/Universal_Screening_to_Identify_veterans_Experiencing_Housing_Instability_2014.pdf
2. Nuruzzaman N, Broadwin M, Kourouma K, Olson DP. Making the social determinants of health a routine part of medical care. *J Health Care Poor Underserved*. 2015;26(2):321-327.
3. Hager ER, Quigg AM, Black MM, et al. Development and validity of a 2-item screen to identify families at risk for food insecurity. *Pediatrics*. 2010;126(1):e26-e32.
4. Cook JT, Frank DA, Casey PH, et al. A brief indicator of household energy security: associations with food security, child health, and child development in US infants and toddlers. *Pediatrics*. 2008;122(4):e867-e875.
5. Children's HealthWatch. Final: 2013 Children's Healthwatch survey. <http://www.childrenshealthwatch.org/methods/our-survey/>. Accessed October 3, 2018.
6. Garg A, Butz AM, Dworkin PH, Lewis RA, Thompson RE, Serwint JR. Improving the management of family psychosocial problems at low-income children's well-child care visits: the WE CARE project. *Pediatrics*. 2007;120(3):547-558.
7. Aldana SG, Liljenquist W. Validity and reliability of a financial strain survey. *J Financ Couns Plan*. 1998;9(2):11-19.
8. Sherin KM, Sinacore JM, Li XQ, Zitter RE, Shakil A. HITS: a short domestic violence screening tool for use in a family practice setting. *Fam Med*. 1998;30(7):508-512.



ESSEX COUNTY MENTAL HEALTH SERVICES

P.O. BOX 8, 7513 COURT STREET
ELIZABETHTOWN, NY 12932
PHONE: (518)873-3670; FAX: (518)873-3777

**Please
Return**

INFORMATION RELEASE AUTHORIZATION

NAME: _____ DOB: _____ SS#: _____

I authorize Essex County Mental Health Services to: _____ obtain from _____ provide to:

Person or Agency: _____
(address) _____

Phone _____ Fax _____

the following information:

- | | |
|---|---|
| <input type="checkbox"/> Treatment Plan/Summary | <input type="checkbox"/> Academic Status/School Records |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Educational Testing |
| <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> Involvement in Program |
| <input type="checkbox"/> Progress in Treatment | <input type="checkbox"/> Social/Family History |
| <input type="checkbox"/> Recommendations | <input type="checkbox"/> Physical/Medical History |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Drug and/or Alcohol Evaluation |
| <input type="checkbox"/> Verbal Consultation | |
| <input type="checkbox"/> Other (specify) _____ | |

This information will be used for the following purpose(s):

Coordinating Care Evaluation & Continuing Treatment Other (specify) _____

This information is being released: one time only periodically as needed

For information being provided by or obtained from Essex County Mental Health Services, this authorization expires after one year unless otherwise specified below:

(x) 90 days following discharge from treatment () will expire on __/__/__

() when following condition is fulfilled _____

I understand that the information to be released is confidential and protected from disclosure. I understand that this authorization can be revoked by a written statement at any time, except for action already taken.

Signature of client/person acting for client Relationship Date

Signature of Witness Title Date



Cancellation of Authorization to Release Information
I hereby cancel my permission to release information to the person/agency listed above:

Signature: _____

Date: _____