Behavioral Health Services of the Hudson Valley

633 Gidney Ave. Suite 6, Newburgh, NY 12550 Phone: 845.569.2900 Fax: 866.619.5710 Web: BHSHV.com

Informed Consent for Treatment

I give consent for evaluation and treatment to be provided for myself/my child by

_____.
(Provider Name)

I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.

The risks, benefits, side effects, and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.

I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree to play an active role in my treatment process.

In order to occasionally provide/exchange psycho-educational materials or communicate with patients during non-emergency times, email or text messaging is sometimes employed for a patient's convenience. However, this method of communication should never be used for any clinical concern you have about yourself or your child (emotional, behavioral, psychiatric or otherwise). Any/all clinical questions or concerns should always be directed to 845-569-2900.

Friend requests from current or former clients on social networking sites, such as Facebook, are not permitted. Communicating via such sites can compromise privacy and confidentiality as well as the neutrality and professional nature of the therapeutic relationship. For this reason, I agree that I will not communicate with my clinician via any interactive or social networking web sites.

For any psychiatric or life-threatening emergencies you should call 911 or go to your nearest emergency room.

Session length is 45 minutes unless other arrangements have been made or when specialized therapies are being employed. I understand that I may terminate treatment at any time.

My signature below shows that I understand and agree with all of the above statements. I have had the opportunity to ask questions about the treatment process. If the patient is a minor or has a legal guardian appointed by the court, the parent or legal guardian must sign this consent.

_____ _____
Signature of Patient or Parent/Guardian Date

_____
Printed Name

_____
Relationship to Patient (if applicable)

_____ _____
Witness Signature Date

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NEW YORK NOTICE FORM

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions: "PHI" refers to information in your health record that could identify you. "Treatment, Payment and Health Care Operations" Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another therapist. Payment is when I obtain reimbursement for your healthcare. Examples of payment are Disclosure of your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. "Use" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. "Disclosure." applies to activities outside of my [office, clinic, practice group, etc.] such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An ""authorization"" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes*. "Psychotherapy notes"" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.* You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent no Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances: *Child Abuse:* If, in my professional capacity, a child comes before me which I have reasonable cause to suspect is an abused or maltreated child, or I have reasonable cause to suspect a child is abused or maltreated where the parent, guardian, custodian or other person legally responsible for such child comes before me in my professional or official capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child, I must report such abuse or maltreatment to the statewide central register of child abuse and maltreatment, or the local child protective services agency. *Health Oversight:* If there is an inquiry or

complaint about my professional conduct to the NYS Office of the Professions, I must furnish to the New York Commissioner of Education, your confidential mental health records relevant to this inquiry. *Judicial or Administrative Proceedings:* If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without your written authorization, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I must inform you in advance if this is the case. *Serious Threat to Health or Safety:* I may disclose your confidential information to protect you or others from a serious threat of harm by you in accordance with NYS Mental Hygiene Law. *Worker's Compensation:* If you file a worker's compensation claim, and I am treating you for the issues involved with that complaint, then I must furnish to the chairman of the Worker's Compensation Board records which contain information regarding your psychological condition and treatment.

IV. Patient's Rights and Psychotherapist's Duties

Patient's Rights *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request. *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*–You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (i.e. you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.) *Right to Inspect and Copy*–You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss the request and denial process. *Right to Amend*–You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss the details of the amendment process. *Right to an Accounting*– You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process. *Right to a Paper Copy*– You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychotherapist's Duties I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will mail the revised Notice to you, as well as making it available in my office.

V. Questions and Complaints

You may send a written complaint to the Secretary of the U.S. Department of Health and Human Services. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy This notice will go into effect on September 1, 2017. If I change the terms, I will provide you with a revised notice by either distributing it to you in the office or mailing it to your home address.

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NEW YORK NOTICE FORM

Notice of Policies and Practices to Protect the Privacy of Your Health Information

I have received a copy of HIPAA Rights and Disclosures

_____
Signature of Patient/Date

_____
Print Name/Date

_____
Signature of Witness/Date

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AUTHORIZATION FOR RELEASE OF BEHAVIORAL HEALTH INFORMATION

PART I:

I, _____, hereby authorize _____ to
(Name and DOB of Patient) (Psychiatrist/Clinician-address above)
release/receive the general, mental health and substance use related health care information described below to:

Name, address and phone of person/organization releasing/receiving information:
Insurance: _____
_____
_____

This request and authorization applies to the following protected healthcare information:
- ☐ Psychosocial Assessment
- ☐ Progress Notes
- ☐ Other:_____
- ☐ History
- ☐ Relevant Case Data

The purpose for use or release/receipt of this information is:
- ☐ Coordination of treatment services
- ☐ Referral
- ☐ Discharge planning
- ☐ Specific purpose:_____

This request and authorization will expire:
- ☐ 3 years after last date of service
- ☐ When acted upon/once specific disclosure has been made
- ☐ On this specific date:_____

I understand that, except for action already taken, I may revoke this authorization in writing at any time by delivering or sending written notification to my therapist or physician at 633 Gidney Ave., Suite 6, Newburgh, NY 12550.

I also understand that I have the right to receive a copy of this authorization and that a copy will be maintained in my patient record. I understand that I have the right to refuse to sign this authorization.

I request that payment of authorized benefits be made on my behalf to Behavioral Health Services if the Hudson Valley or my specific provider for services furnished to me by the provider. I authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits or the benefits payable for related services.

The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. If I am authorizing the release of my federal social security number, HIV/AIDS-related, alcohol or drug treatment, the receiving entity is prohibited from redisclosing such information or using the disclosed information for any purpose other than the purpose indicated by this authorization without my further authorization unless permitted to do so under federal or state law.

Please sign below to authorize the use or release of your personal health information for the reasons and with the conditions established above:

_____ _____
Signature of Patient Date

_____ _____
Witness Date

PART II: Cancellation/Refusal to Release Information

☐ I hereby cancel my permission to release/receipt information indicated in Part I, to the person/organization whose name and address is: _____

☐ I hereby refuse to authorize the release/receipt of information indicated in Part I, to the person/organization whose name and address is:_____

_____ _____
Signature of Patient Date

_____ _____
Witness Date

Part III: Consent Review and Update:
I have reviewed the above information and agree that it remains accurate and I continue to consent to its release.

_____ Patient Initials _____Date _____ Patient Initials _____ Date
_____Patient Initials _____ Date _____ Patient Initials _____ Date

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(Name and DOB of Patient) (Psychiatrist/Clinician-address above)
release/receive the general, mental health and substance use related health care information described below to:

Name, address and phone of person/organization releasing/receiving information:
Primary Care Physician
_____
_____
_____

This request and authorization applies to the following protected healthcare information:
- ☐ Psychosocial Assessment
- ☐ Progress Notes
- ☐ Other:_____
- ☐ History
- ☐ Relevant Case Data

The purpose for use or release/receipt of this information is:
- ☐ Coordination of treatment services
- ☐ Referral
- ☐ Discharge planning
- ☐ Specific purpose:_____

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Signature of Patient Date

_____ _____
Witness Date

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_____ _____
Signature of Patient Date

_____ _____
Witness Date

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I have reviewed the above information and agree that it remains accurate and I continue to consent to its release.

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AUTHORIZATION FOR RELEASE OF BEHAVIORAL HEALTH INFORMATION

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(Name and DOB of Patient) (Psychiatrist/Clinician-address above)
release/receive the general, mental health and substance use related health care information described below to:

Name, address and phone of person/organization releasing/receiving information:
Emergency Contact: _____
_____
_____

This request and authorization applies to the following protected healthcare information:
- ☐ Psychosocial Assessment
- ☐ Progress Notes
- ☐ Other:_____
- ☐ History
- ☐ Relevant Case Data

The purpose for use or release/receipt of this information is:
- ☐ Coordination of treatment services
- ☐ Referral
- ☐ Discharge planning
- ☐ Specific purpose:_____

This request and authorization will expire:
- ☐ 3 years after last date of service
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- ☐ On this specific date:_____

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The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. If I am authorizing the release of my federal social security number, HIV/AIDS-related, alcohol or drug treatment, the receiving entity is prohibited from redisclosing such information or using the disclosed information for any purpose other than the purpose indicated by this authorization without my further authorization unless permitted to do so under federal or state law.

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_____ _____
Signature of Patient Date

_____ _____
Witness Date

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Signature of Patient Date

_____ _____
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_____Patient Initials _____ Date _____ Patient Initials _____ Date

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Phone, Mail and eCommunication

In order to communicate with patients for a variety of reasons, mail, phone, email or text messaging are employed. Below, you are giving this office permission to communicate with you in the following ways:

Phone

1. We may call you and leave a message on your home or cell phone **Y or N**
2. We may call you and leave a brief message with a person who answers the phone **Y or N**

Mail

1. You agree to accept mail to your home address from us **Y or N**

Electronic Communication

1. You would like to be able to communicate with us via email **Y or N**

contactus@bhshv.com is a HIPPA compliant email, however; there is a chance that someone could intercept a message sent or received. Please never send emergency info via email. Always call the office and in true psychiatric or medical emergencies call 911 and/or go to your nearest Emergency Room.

2. You would like to be able to communicate with us via text message to 845-372-9346 **Y or N**

(Note: DO NOT SEND ANY PRIVATE OR CLINICAL INFORMATION, EMERGENCY INFORMATION OR SENSITIVE PROTECTED HEALTH INFORMATION VIA TEXT ie, SS#, DOB, etc.)
Text should only be used for brief communication, reminders or appointment information. All electronics are password protected, however it is recommended that you use only initials, do not send lengthy or identifying information to me in this way for your own protection. Although unlikely, the message could be intercepted.

Special circumstances or special instructions for any of the above:

_____
_____
_____

_____ _____
Signature Date

Print Name: _____

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FINANCIAL AGREEMENT

FINANCIAL POLICY

It is the policy of this office to collect co-payments, co-insurance, deductibles and any other expenses incurred at the time of service unless other specific arrangements are made in writing. By signing this agreement, you are accepting responsibility for payment of any and all expenses related to the provision of care, regardless of insurance coverage expectations.

As indicated, deductible payments and copayments are due at the time of your visit; therefore no bill will be generated unless payment is not made as required. A $5.00 billing fee will be applied for accounts that require a bill to be generated.

INSURANCE INFORMATION AND FINANCIAL RESPONSIBILITY

While, we may accept your insurance plan, all services may not be covered. It is your responsibility to know and understand your benefit coverage and limitations. Services provided at this office fall under the category of mental health and substance abuse. As such, your primary insurance company (i.e. GHI, MVP, BCBS, NYSHIPS) may contract with another carrier (i.e. Magellan, UBH, Value Options, Beacon Health Options) for these specialty services. Your insurance company may require authorization for services. You are required to obtain authorization if your plan requires you to do so.

By accepting services at this office, you personally guarantee payment for all services provided which may include non-covered services. Examples of non-covered services include, but are not limited to: coordination of care with other providers, review and interpretation of medical records, treatment reports, preparation of disability papers, telephone consultation, clinical case reviews, services rendered for legal purposes.

MEDICATION POLICY

If medication is or will be part of your treatment, you are responsible for obtaining a list of your insurance company's authorized medications or formulary. This will prevent you from having to schedule an additional visit due to insurance coverage limitations. Prescriptions are dispensed at your appointment time with the prescribing provider. Medication needs are discussed at this visit. It is imperative that you be aware of your refill needs at this time.

MISSED APPOINTMENTS AND CANCELLATIONS

Fees will be applied for missed appointments. Our policy requires 24 hour notice to cancel an appointment. Exceptions may be made in the event of a true emergency. Failure to cancel an appointment with 24 hours notice will result in a $75.00 fee. After 3 missed appointments, you will be charged the full fee of $150.00.

AGREEMENT OF FINANCIAL RESPONSIBILITY

I agree to be responsible to pay for all non-covered services rendered by providers at this office.

I have received a copy of the HIPAA compliant privacy policy for this office as it pertains to services rendered by providers at this location. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim or outstanding balance. I understand that I am financially responsible for all charges beyond authorized insurance benefit payments.

This agreement is in effect until revoked by me in writing. A photocopy of this agreement is accepted as valid.

I have read and fully understand this agreement.

_____ _____

Signature of Insured/Guardian Date