Greene County Mental Health Center

905 Greene County Office Building
Cairo, New York 12413
518-622-9163 Fax: 518-621-4228

For Office Use Only

Confidential

Today's Date: _____

Account #_____

Intake Person_____

Is this Visit Court Ordered (Family/Criminal) YES or NO (Circle)

Patient Information Only: Please Print Clearly

Last Name: _____ Suffix: ____ First Name: _____ Middle Name: _____

Preferred Alias Name (Nickname): _____ Social Security Number: _____--_____--_____

Date of Birth: _____ Legal Gender at Birth: [ ] Female [ ] Male Gender Identity: [ ] FTM*[ ] MTF* [ ] Non-Binary [ ] Other [ ] No Response

Marital Status (Check): [ ] Single [ ] Married [ ] Domestic Partnership [ ] Divorced [ ] Widowed [ ] No Response

Physical Address: _____ City: _____ State: ___ Zip: _____

[ ] ***Check if mailing address is same a Physical Address if not please enter below***

Mailing Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (____) _____--_____ Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Ext: _____

Cell Phone Carrier: _____ Email: _____

Sexual Orientation: [ ] Homosexual [ ] Heterosexual [ ] Bisexual [ ] Something Else _____ [ ] No Response

How should we refer to you? Please Select All that Apply: He/Him She/Her They/Them

Race (Check): [ ] American Indian/Alaska Native [ ] Asian [ ] African American [ ] Native Hawaiian/Pacific Islander [ ] Hispanic [ ] Caucasian/White [ ] Patient Refused

Preferred Language: [ ] English [ ] Spanish [ ] French [ ] Italian [ ] German [ ] Hindu [ ] Hebrew [ ] Other _____

If Student - School District: _____ School Name: _____ Grade: _____

Highest Level of Education: [ ] Grade School [ ] High School [ ] Vocational School [ ] Some College [ ] Associates Degree

[ ] Bachelor's Degree [ ] Master's Degree [ ] other _____

Employment Status (Check): [ ] Full-time [ ] Part-Time [ ] Retired [ ] Disabled [ ] Unemployed [ ] Self-Employed [ ] Homemaker

Employer Name: _____

Have you ever previously served or are you currently serving in the Military? [ ] Prior Service [ ] Currently Serving [ ] Veteran

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Primary Care Physician: **Name: _____ Phone: _____**

Pharmacy: **Name: _____ Phone: _____**

Secondary Pharmacy: **Name: _____ Phone: _____**

If patient is a minor:

[ ] Mother or [ ] Guardian

Name: _____-_____ Address: _____

Home Phone: (____) _____-_____ Cell Phone: (_____) _____-_____ Work Phone: (____) _____-_____

[ ] Father or [ ] Guardian

Name: _____ Address: _____

Home Phone: (_____) _____-_____ Cell Phone: (___ _) _____-_____ Work Phone: (____) _____-_____

Members of your Household:

Name	Relationship	Age	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Party Responsible for Insurance. If self, please list your name exactly as it appears on your insurance card. (Please provide the front desk with a copy of the front and back of all insurance cards).

Insured's First Name: _____ Last Name: _____ MI: _____

Insured's Date of Birth: _____ Self-Pay (Y/N) _____ Note** *If (yes) please see receptionist.*

Address: _____ Apartment #: _____ City: _____ State: ____ Zip: _____

Primary Phone: (_____) _____--_____

* Primary Insurance Company/Medicare: _____

ID# _____ Group #_____

Relationship to Insured: [ ] Self [ ] Spouse [ ] Child (If Medicaid, please check Self)

*Secondary Insurance Company: _____

ID# _____ Group #_____

Relationship to Insured: [ ] Self [ ] Spouse [ ] Child (If Medicaid, please check Self)

*Tertiary (Third Payer) Insurance Company: _____

ID# _____ Group #_____

Relationship to Insured: [ ] Self [ ] Spouse [ ] Child (If Medicaid, please check Self)

GREENE COUNTY MENTAL HEALTH CENTER/COMMUNITY SERVICES BOARD CONSUMER INFORMED CONSENT & SERVICE AGREEMENT

Thank you for reading the Greene County Mental Health Center/Community Services Board Consumer Informed Consent and Service Agreement. Please direct any questions about this agreement to your clinician.

Please complete the form below confirming you have read the agreement, understand its contents, and agree to its terms.

Client Name: _____ For Office Use/Account #:_____

*Name of Emergency Contact: _____

Relationship to contact: _____

Address of contact: _____

Home Phone: _____ Cell Phone: _____

☐ ***My Emergency Contact has permission to change, cancel, reschedule, or confirm appointments on my behalf.***

*Name of Emergency Contact: _____

Relationship to contact: _____

Address of contact: _____

Home Phone: _____ Cell Phone: _____

☐ ***My Emergency Contact has permission to change, cancel, reschedule, or confirm appointments on my behalf.***

Special Instructions:

_____

_____

_____

Greene County Mental Health Center utilizes an automated telephone service that notifies you of your future appointments. If you would like to opt out of this appointment reminder system please check the box below otherwise select your preferred reminder option.

☐ ***I do not wish to have automated reminders about my upcoming appointments.***

☐ **Text:** I _____ authorize Greene County Mental Health center to confirm my upcoming appointments by texting phone number: (_____) _____-_____. *I recognize that normal text messaging rates may apply.*

☐ **Email/Portal:** I _____ authorize Greene County Mental Health center to confirm my upcoming appointments to my email address: _____.

By signing below I acknowledge that I have read this agreement, understand its contents, and agree to its terms.

_____ _____

Patient Signature or Legal Guardian (if client is under 18 yeArs of age) Date

GREENE COUNTY MENTAL HEALTH CENTER
905 Greene County Office Building
Cairo, NY 12413-2868

Phone: 518-622-9163 Fax: 518-621-4228

Disclosure Statement, Services Agreement, Privacy Notice, and Consent Form FOR

_____ **For Office Use:** Account # _____

(Print Patient Name)

I have received and read the *Disclosure Statement, Services Agreement, and Privacy Notice* from GREENE COUNTY MENTAL HEALTH CENTER.

I agree to participate in assessment and treatment services while abiding by the terms and conditions described in the Services Agreement and Privacy Notice.

I understand that I can revoke this Agreement in writing at any time.

ADDITIONAL CONFIDENTIALITY AGREEMENT FOR ADOLESCENT PATIENTS:
In the interest of promoting privacy and efficacy for my child in psychotherapy, I consent to waive my rights to access to my child's Clinical Record, except for summary information. I have discussed this with my child's clinician and agree to treatment in accordance with the policy described in the *Minors and Parents* section of the Services Agreement.

_____ _____ _____
Signature of Parent/Guardian Relation to Patient Date

_____ _____
Signature of Patient (14 years and older) Date

NEW YORK
STATE OF
OPPORTUNITY

Office of
Mental Health

☐ Patient Declined to Answer
☐ Patient Unable to Complete Due to Severe Mental Illness

PSYCKES CONSENT FORM

The Psychiatric Services and Clinical Enhancement System (PSYCKES) is a web-based application maintained by the New York State (NYS) Office of Mental Health (OMH). It contains health information from the NYS Medicaid database, health information from clinical records, and information from other NYS health databases. For an updated list and more information about the NYS health databases in PSYCKES, visit www.psyckes.org and see "About PSYCKES."

PSYCKES data includes identifying information (such as your name and date of birth), information about health services that have been paid for by Medicaid, information about your health care history (such as treatment for illnesses or injuries, test results, lists of medication you have taken), and information entered by you or your treatment provider into the PSYCKES application (such as a Safety Plan).

The health information in PSYCKES can help your provider deliver better care. In this Consent Form, you can choose whether or not to give your provider electronic access to your health information that is in PSYCKES. 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 will not be the basis for denial of health services.**

If you check the "**I GIVE CONSENT**" box below, you are saying "Yes, this provider's staff involved in my care may get access to all of my medical information that is in PSYCKES."

If you check the "**I DENY CONSENT**" box below, you are saying "No, this provider may not see or be given access to my medical information through PSYCKES," THIS DOES NOT MEAN YOUR PROVIDER IS COMPLETELY BARRED FROM ACCESSING YOUR MEDICAL INFORMATION IN ANY WAY. FOR EXAMPLE, IF THE MEDICAID PROGRAM HAS A QUALITY CONCERN ABOUT YOUR HEALTHCARE, THEN UNDER FEDERAL AND STATE REGULATIONS YOUR PROVIDER MAY BE GIVEN ACCESS TO YOUR DATA TO ADDRESS THE QUALITY CONCERN. QUALITY CONCERNS HELP HEALTHCARE PROFESSIONALS DETERMINE WHETHER THE RIGHT SERVICES ARE BEING DELIEVERED AT THE RIGHT TIME TO THE RIGHT PEOPLE. THERE ARE ALSO EXCEPTIONS TO THE CONFIDENTIALITY LAWS THAT MAY PERMIT YOUR PROVIDER TO OBTAIN NECESSARY INFORMATION DIRECTLY FROM ANOTHER PROVIDER FOR TREATMENT PURPOSES UNDER STATE AND FEDERAL LAWS AND REGULATIONS.

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 this provider to access ALL** of my electronic health information that is in PSYCKES in connection with providing me any health care services.

☐ **I DENY CONSENT for this provide to access** my electronic health information that is in PSYCKES; however, I understand that my provider may be able to obtain my information even without my consent for certain limited purposes if specifically authorized by state and federal laws and regulations.

*If you choose "Deny Consent" on that form, GCMH **will not** refuse treatment to you.*

_____ _____
Print Name of Patient Date of Birth of Patient

_____
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 to Patient (if applicable)

For Office Use: Patient Account #: _____ ☐ **Entered QDPM** ☐ **PSYCKES**

Details about patient information in PSYCKES and the consent process:

1. **How Your Information Can be Used.** Your electronic health Information can only be used by your treatment provider to:
   - Provide you with medical treatment, care coordination, and related services
   - Evaluate and improve the quality of medical care provided to all patients.
   - Notify your treatment providers if you have an emergency (e.g., go to an emergency room).

2. **What Types of Information About You are Included?** If you give consent Greene County Community Services Board (GCCSB) can access ALL of your electronic health information available through PSYCKES. This includes information created before and after the date of this Consent Form. The information in PSYCKES includes information from your health records, such as a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays, blood tests, or screenings), assessment results, and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

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

3. **Where Health Information About You in PSYCKES Comes From.** If you received health related services that were paid for by Medicaid, information about those services will be in PSYCKES. If you received services from a State operated psychiatric center, health related information taken from your clinical records will also be in PSYCKES. However, although the information contained in PSYCKES may come from your clinical record, your PSYCKES record is not the same thing as your complete clinical record. PSYCKES information can also be included in PSYCKES. Health information from other databases maintained by NYS is also included in PSYCKES. New health database may be added to PSYCKES as available. For an updated list and more information about the data available in PSYCKES, visit the PSYCKES website at www.psyckes.org and see "About PSYCKES" or ask your treatment provider to print the list for you.

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: Greene County Community Services Board's doctors and other treatment providers who are involved in your care; health care providers who are covering or on call for Greene County Community Services Board and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Greene County Community Services Board at (518) 622-9163 or call the NYS Office of Mental Health Customer Relations at 800-597-8481.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by Greene County Community Services Board 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 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.

7. **Effective Period.** This Consent Form will remain in effect until 3 years after the last date you received any medical services from Greene County Community Services Board 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 a Withdrawal of Consent Form and giving it to Greene County Community Services Board. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from this provider or from the PSYCKES website at www.psyckes.com, or by calling Greene County Community Services Board at (518) 622-9163. Note: Organizations that access your health information through Greene County Community Services Board while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

9. **Copy of Form.** You are entitled to receive a copy of this Consent Form after you sign it.

GREENE COUNTY MENTAL HEALTH CENTER
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FINANCIAL POLICY

Medicare/PPO/HMO/Managed Care: You are responsible for remitting co-pays at the time of service and unless otherwise indicated, responsible for obtaining the necessary referrals/authorizations your plan requires. If you fail to do so, you will be responsible for payment. These are policy provisions which you agreed to adhere to when you signed up for the plan. We will submit all charges and follow-up with your carrier for payment. You are responsible for all deductibles, co-pays and any other non-covered charges.

No-Fault/Workers Compensation: You are responsible for providing our office with the necessary information needed to properly submit charges. If you fail to do so, the fees mandated by NY State will be changed to reflect our private fees and you will be responsible for payment. Some No-fault carriers have deductibles on medical charges, for which the **patient** (not the insured) is responsible. If you have private insurance we will submit on your behalf and bill you for any unpaid balances.

Medicaid: You are responsible for providing our office with your ID# (begins with 2 alpha letters, followed by numerical digits & ending with 1 alpha letter). If you have a Managed Medicaid plan (Fidelis Care, Total Care, etc) you are responsible for obtaining a referral from your Primary Care Physician; otherwise payment will not be made. If you fail to do so, you will be responsible for payment.

Non-participating Carriers: You are ultimately responsible for all charges if we do not have a participation agreement with your insurance carrier. If you provide our office with the necessary information needed to properly bill, we will submit on your behalf. You are responsible for following-up with your insurance carrier for unpaid claims and/or appeals. You are responsible for all deductibles, co-pays, and non-covered charges.

Liability: Carriers usually remit payment to the patient or the patient's attorney if one has been retained. OUR POLICY DOES NOT ALLOW US TO HOLD ACCOUNTS WHICH ARE PENDING RESOLUTION OF ANY LIABILITY OR LITIGATION ISSUES. **WE DO NOT, UNDER ANY CIRCUMSTANCE, BILL ATTORNEYS.** If you provide a letter from the liability carrier indicating they accept full responsibility and will remit payment, we will submit on your behalf. Otherwise, you may either have charges submitted to your private carrier or pay for services and obtain reimbursement upon resolution/settlement.

Self-pay: If you are uninsured, you are responsible for remitting payment in full at the time of service, unless prior arrangements have been made with the Billing Dept. If you are unable to remit payment in full and need to discuss payment options available to you, you must contact our **Billing Department: Monday-Friday, 8:30am - 4:00pm.** If you need further explanation of any of the above policies, please contact the Billing Department directly. Thank you for your cooperation in this matter.

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare Benefits be made on my behalf to provider for any services rendered to me by the physician. I authorize any holder of medical information about me to be release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Print Patient Name: _____ Date: _____

Parent/Guardian Signature: _____

☐ **I have read and/or been advised to read the entire Financial Policy.**

Office Use Only: Account # _____ Staff Initial: _____

Greene County Mental Health Center

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PATIENT BILL OF RIGHTS

YOU HAVE THE RIGHT:

- To quality care and treatment
- To be treated with dignity and respect
- To know about and help plan all aspects of your care, treatment and recovery program
- To object to any part of your care and treatment which you do not feel is helping you (except when there is risk of harm to yourself or others)
- To appeal any decisions about your program and to have those decisions reviewed by a higher authority
- To have all medical records and files kept private
- To have an individual program based on your changing needs
- To review treatment records and receive a copy of the records
- To participate voluntarily in and consent to treatment
- To have access to the advocacy groups listed below:

NYS Commission on Quality of Care for the Mentally Disabled
401 State Street, Schenectady, NY 12305
518-388-2888

NYS Office of Mental Health
44 Holland Avenue, Albany, NY 12229
800-597-8481

National Alliance for the Mentally Ill of NYS
260 Washington Avenue, Albany, NY 12210
518-462-2000

Protection & Advocacy for Individuals Who Are Mentally Ill
PAIMI of Hudson Valley Region
155 Washington Ave., Suite 300, Albany, NY 12210 518-432-7861

_____ _____

Print Patient Name Parent/Guardian Signature

Date: _____ **For Office Use:** Account # _____

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(518) 622-9163 -- Fax: (518) 621-4228

CONSUMER INFORMED CONSENT & SERVICE AGREEMENT

Welcome to Greene County Mental Health Center/Community Services Board. As we begin our work together, there are a few things you should know that will help you best use our services. Please direct any questions about this service agreement to your intake worker.

GCMH/CSB's Responsibility to You:

- We will provide you with mental health treatment for you specific condition. We are licensed to provide individual, group and family outpatient treatment. We will coordinate our treatment with any other providers involved with your care.
- We will inform you if we believe that your need for treatment exceeds our abilities or if we believe that you are not in need of our services. We will also make the appropriate referrals whenever possible and assist you in getting the correct level of care.
- We will supply you with a treatment that assists you in your efforts to help yourself. On that order, the clinic's staff will be timely for you appointments, respect your privacy, make reasonable accommodations if you have a disability that makes engaging our service difficult, respect your decision to stop treatment, and provide you with recourse if you have a complaint about our service without fear of reprisal.
- We follow the New York State Office of Mental Health Rights of Outpatients that is posted at every licensed site. It contains your rights as a consumer and whom you can contact if you feel you are not being treated fairly
- **If you have any after-hours emergencies that cannot wait until the next business day, you can reach our on-call clinician at 518-622-3344**

Your Responsibility to GCMH/CSB:

- While in treatment you will be expected to participate in planning your treatment and following through. You may be asked to do homework, participate in groups, or sign releases of information, if indicated for your treatment.
- While in treatment you will be expected to communicate to your clinician any changes you experience that directly affect your treatment. For example, if you are in treatment for depression and you start to have suicidal thoughts, we expect you to notify your clinician or other staff of that development. Another example would be if you are getting substance abuse treatment and you relapse. Your clinician needs to know so that we can help you.
- While in treatment you are expected to pay any fees or make arrangements to have the fees paid by a third party. You will be expected to work with our clinic on questions regarding your insurance or managed-care comp
- While in treatment you are expected to cancel appointments 24 hours in advance. Failing to do so is considered a "Missed Appointment." If you fail to cancel 24 hours in advance or miss any appointments without notice, the clinic reserves the right to charge you for such missed appointments. Failure to attend scheduled appointments could result in you termination from the clinic. It is your responsibility to obtain a follow-up appointment from your clinician if you cancel or miss an appointment.

GCMH/CSB Limits of Confidentiality:

Greene County Mental Health/Greene County Community Services Board closely adheres to New York State Mental Hygiene Law and to Federal Guidelines regarding confidentiality of mental health, substance abuse, and HIV information.

All information about your treatment is confidential as defined by the above laws.

Most disclosures occur only when you sign an authorization form allowing us to release information about you and your treatment. This is the primary method that GCMH/GCCSB uses to release information to anyone, including a family member. Please note that any information that is disclosed will be limited to what you and your clinician decide to be appropriate for the situation. There are, however, the following exceptions to confidentiality that are important to be aware of:

- We are ethically and legally obligated to disclose relevant information in the event of various emergency situations, such as if we believe that you or another person in the community may be at risk of serious harm. At those times we are obligated to inform authorities and/or the person targeted for harm. There are also other emergency situations in which the Mental Health Association of Columbia & Greene Counties' Mobile Crisis Assessment Team (MCAT) may be notified to intervene in an emergency situation in order to ensure your well being.

- We are not permitted to contact family members in the event of an emergency. You, however, can authorize Greene County Mental Health Center to do so by filling out the attached emergency form. We will only use this in the event of an emergency.

- We are allowed, and at times required, to disclose information under various legal compulsions such as: when child abuse or neglect is suspected or has occurred, when New York State Mental Hygiene Legal Services request information, to attorneys challenging involuntary hospitalization, to the NYS Justice Center or its representatives, to NYS Board for Professional Medical Conduct, to the local director of mental hygiene, or when we receive an authorizing court order from a judge. All of these situations tend to be very rare.

- Protected Health Information (PHI) will be sent to the Regional Health Information Organization operated by HIXNY, which is part of a statewide computer network; however, your consent is needed in writing in order for any other medical providers to retrieve any of your medical information.

- We are allowed to disclose information if a crime has been committed on the premises or against clinic personnel. We will only disclose to the authorities the minimal amount of information necessary for law enforcement to conduct their duties.

- We are allowed to disclose information with other providers who are involved or are planning to be involved in your care. This may include your primary care physician or other agencies, such as Twin County Recovery Services, Mental Health Association (MHA) of Columbia and Greene Counties, MHA's Mobile Crisis Team, and Columbia Memorial Hospital. While we have the right to disclose certain pertinent information to coordinate care and/or an emergency response, whenever possible we will ask for your permission to do so prior to any release of information.

- We will not re-disclose any information that we receive from other treatment providers.

Please know that regardless of the circumstances, it is always our ethical and legal obligation to disclose only the minimal amount of information relevant to the particular situation. It is also our ethical obligation to discuss with you any information that is shared with other professionals, except in emergencies where we are unable to do so.

_____ _____

Print Patient Name Parent/Guardian Signature

Date: _____ **For Office Use:** Account #: _____

GREENE COUNTY MENTAL HEALTH CENTER
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Cairo, NY 12413-2868

Phone: 518-622-9163 Fax: 518-621-4228

Disclosure Statement, Services Agreement, Privacy Notice, and Consent Form FOR

_____ **For Office Use:** Account # _____

(Print Patient Name)

I have received and read the *Disclosure Statement, Services Agreement, and Privacy Notice* from GREENE COUNTY MENTAL HEALTH CENTER.

I agree to participate in assessment and treatment services while abiding by the terms and conditions described in the Services Agreement and Privacy Notice.

I understand that I can revoke this Agreement in writing at any time.

ADDITIONAL CONFIDENTIALITY AGREEMENT FOR ADOLESCENT PATIENTS:
In the interest of promoting privacy and efficacy for my child in psychotherapy, I consent to waive my rights to access to my child's Clinical Record, except for summary information. I have discussed this with my child's clinician and agree to treatment in accordance with the policy described in the *Minors and Parents* section of the Services Agreement.

_____ _____ _____
Signature of Parent/Guardian Relation to Patient Date

_____ _____
Signature of Patient (14 years and older) Date

POLICY ON FAMILY INVOLVEMENT and MISSED APPOINTMENTS

Print Patient Name: _____ **For Office Use:** Account # _____

Family Involvement

- Family involvement is a mandatory part of your child's treatment.

- You must make a commitment to face-to-face contact and/or telephone communications with the therapist to keep your child's case open. Your child's therapist will discuss this with you during the assessment process.

- Family involvement is important because:
- It provides feedback on your child's behavior and mood at home.
- It assists the therapist in determining if there are ways your family can help your child meet his/her goals in therapy.

- At least one parent/legal guardian must accompany the child to medication management appointments.

Making Your Appointments

- Therapy is most successful when patients attend their sessions regularly.

- If your scheduled appointment must be canceled, please do so 48 hours prior to appointment time.

- If you fail to make your appointment or cancel on the same day of the scheduled appointment, this will be considered a "no-show/missed appointment."

- After two or more "no-show/missed appointments" for therapy or medication, your case may be closed.

- When your case is closed, all clinic-related services are terminated, including both verbal therapy and medication management.

Please indicate that you have read and agree to this policy.

_____ _____

Parent/Legal Guardian's Signature Date

_____ _____

Therapist's Signature Date

Greene County Mental Health Center

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518-622-9163 -- Fax: 518-621-4228

I, (Print Parent/Guardian Name) _____ give permission for (Print Patient Name) _____, to receive mental health services from Greene County Mental Health Center/Community Services Board.

I understand that proper treatment of my child's psychiatric condition may require medication.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Therapist Date

For Office Use: Account # _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

Print Patient Name: _____ **For Office Use:** Account # _____

Facility: Greene County Mental Health/Community Services Board

I have received a copy of the GCMH & CGGSB Notice of Privacy Practices (**Effective Date** 6/25/2018)

_____ _____

Parent/Guardian Signature Date

Individual or Personal Representative with legal authority to make health care decisions

If signed by a Personal Representative:

Name: _____

Role: _____

_____

If the individual has a personal representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to and acknowledgement obtained from the personal representative.

If the individual or Personal Representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices given to the individual on _____ by:

- ☐ Face to face meeting
- ☐ Mailing
- ☐ Other: _____.

Reason Individual or Personal Representative did not sign this form:

- ☐ Individual or Personal Representative chose not to sign.
- ☐ Individual or Personal Representative did not respond after more than **one** attempt.
- ☐ Other:_____.

Good Faith Efforts: the following good faith efforts were made to obtain the individual or Personal Representative's, if applicable, signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than **one** attempt must have been made.

- ☐ Face to face presentations(s):
- ☐ Telephone contact(s):
- ☐ Mailing(s):
- ☐ Other:

Staff Signature: _____ Title: _____

Print Name: _____ Date: _____

This form must be retained for a period of at least six (6) years in the appropriate record in accordance with the GCMH & GCCSB Privacy Policy Manual.

Consent for Telemental Health Treatment at Greene County Mental Health

AUTHORIZATION FOR RELEASE OF INFORMATION BY THE GREENE COUNTY MENTAL HEALTH CENTER/GREENE COUNTY COMMUNITY SERVICES BOARD:

I hereby authorize and direct the Greene County Mental Health Center/Greene County Community Services Board, to provide treatment via telephonic or video conferencing, to release to government agencies, insurance carriers, or others who might be financially liable for my medical care, all information needed to substantiate payment for such medical care. Patient may withdraw this consent at any time and will not impact the patient ability to receive care by Greene County Mental Health however treatment providers may be changed if the client decides to opt out of Telemental Treatment. Please choose one:

☐ Patient Consents to Treatment via telephonic or video conferencing.

☐ Patient Denies to Treatment via telephonic or video conferencing

_____ _____

Print Patient Name Parent/Guardian Signature

Date: _____ **For Office Use:** Account # _____

HIXNY ELECTRONIC DATA ACCESS CONSENT FORM

Greene County Mental Health Center

In this Consent Form, you can choose whether to allow Greene County Mental Health Center 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 Greene County Mental Health Center 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, Greene County Mental Health Center '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, Greene County Mental Health Center 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.

Please carefully read the information on both pages of this form before making your decision. You have two choices.

☐ **I GIVE CONSENT for Greene County Mental Health Center 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 to Greene County Mental Health Center to access** my electronic health information through Hixny for any purpose, *even in a medical emergency*.

_____	_____	_____
Print Name of Patient	Patient Date of Birth	Account #
_____	_____	
Signature of Patient or Patient's Legal Representative	Date	
_____	_____	
Print Name of Legal Representative (if applicable):	Relationship of Legal Representative to Patient (if applicable)	

Details about patient information in Hixny and the consent process:

How Your Information Will be Used.
Your electronic health information will be used by Greene County Mental Health Center **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 or 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, Greene County Mental Health Center 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 if 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 diagnosis, 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 Greene County Mental Health Center 's medical staff who are involved in your medical care; health care providers who are covering or on call for Greene County Mental Health Center'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 Greene County Mental Health Center at 518-622-9163; 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 Greene County Mental Health Center 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 Greene County Mental Health Center. 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.

Date: _____ **For Office Use**: _____

☐ Consent given for patient by Parent/Guardian or Representative to retrieve and use medication history from Surescripts

☐ Consent denied for patient by Parent/Guardian or Representative to retrieve and use medication history from Surescripts.

_____ _____

Print Child's Name Child's Date of Birth

_____ _____

Print Parent/Guardian or Representative Name Signature of Parent/Guardian or Representative