THE THERAPY CENTER AT DCCH

Client Registration Form

CLIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Address: _____

City/State/Zip: _____

Date of Birth: _____ Home Phone #: _____

Cell Phone #: _____ Email Address: _____

EMERGENCY CONTACT: Name: _____ Phone #: _____

RESPONSIBLE PARTY/GUARDIAN INFORMATION

Last Name: _____ First Name: _____ MI: _____

Address: _____

City/State/Zip: _____

Relationship to Client: _____

Date of Birth: _____ Social Security Number: XXX-XX-_____

Home Phone #: _____ Cell Phone #: _____

Email Address _____

INSURANCE INFORMATION:

Primary Insurance Company: _____ Member ID#: _____ Group #: _____

Name of Primary Individual on Insurance Policy: _____

Primary Insured's Date of Birth : _____

I, _____, am hereby providing authorization for The Therapy Center at DCCH to release any required information to the designated insurance company. I understand that I am responsible for any costs not covered by the insurance for the services provided at The Therapy Center at DCCH.

_____ _____

Signature of Responsible Party Date

Rev.11/18

THE THERAPY CENTER AT DCCH

Consents and Service Expectations

_____ _____

Client Name Date of Birth

Welcome to the Therapy Center at DCCH. We hope you find the atmosphere comfortable and the services helpful.

CONSENT TO TREATMENT

_____ By initialing here, I give consent to The Therapy Center to provide services to me or my dependent.

CONSENT TO PHONE/EMAIL COMMUNICATION

_____ By initialing here, I give consent to receiving reminder messages regarding appointment and payment issues. By providing my phone number and/or email address, I am giving my consent to use this method of communication. (Please check all that apply)

_____ Phone number(s) _____.

_____ Voicemails _____ A message can be left with the person answering. _____ Only speak with me.

_____ Email Address _____

_____ You may contact me by either phone or email.

Payment

Co-pays and deductibles must be paid at the time of service. Additional services (such as letters, school meetings, reports, court testimony, or depositions) beyond therapy are not billable to insurance and will require additional payment. These service fees must be paid at the time of service.

Hours of Operation

The Therapy Center office hours are Monday Thursday 8:00- 8:00PM. If you have an afterhours emergency please call 911 or go directly to your nearest emergency room for immediate assistance.

Confidentiality

All of your medical records are protected under HIPAA regulations. We do our best to protect your confidentiality during your office visit. Our office staff is trained to respect your privacy. If you wish to enter or exit a private entrance to avoid the lobby then please notify us of this. We will not leave information on your voice mail unless you have given us permission to do this. We may ask you to sign a release of information so we can exchange information and work together with other providers in providing you services. You have the right to refuse this. There are limits to this. If you provide us with information which suggests there is some abuse, neglect, or risk of serious harm then we have a legal duty to report this information to the State Social Services.

THE THERAPY CENTER AT DCCH

Consents and Service Expectations

Release of Protected Health Information (PHI)

We can provide basic treatment information regarding your/your dependent's treatment to the Primary Care Physician (PCP). You will need to sign a release of information for that purpose.

____ Yes, I request that you share information with the Primary Care Physician.

____ No, I do not want information shared with the Primary Care Physician at this time. I understand that I can request this at a later date, if I choose to.

Therapist

We provide trained professional therapists who are bound by a professional code of ethics. The client therapist relationship is a professional helping relationship with professional boundaries. It is important that you feel comfortable with your therapist. If after a session or two you feel your therapist is not a good fit for you then you have the right to ask your therapist to refer you to another therapist in the group or outside of the group if you wish.

Appointments

All appointments are scheduled for a specified amount of time. Please respect these time limits. If you arrive late, the appointment does not extend beyond the scheduled time. If an appointment is missed, we expect a 24 hour notice. Some exceptions will be allowed depending on the circumstances. If notice is not given, then depending on your payment arrangement, you may be charged for the session. Other appointments may not be scheduled until this fee is paid. If multiple sessions are missed without notice, then future appointment scheduling will be at the therapist's discretion. Only two future appointments may be scheduled at a time, unless your therapist approves more.

Therapy Center Lobby

In order to maintain a comfortable and professional environment for everyone, we ask for your cooperation with the following.

- Check in and out with the Receptionist at each visit. When possible, schedule future appointments at this time.
- Respect others privacy.
- Help maintain a clean environment by discarding any trash that you my have.
- Please supervise all minors.
- No smoking is permitted in this area.

Your Rights

You have the right to be treated with respect and dignity free of any discrimination. You have a right to your treatment records. You have a right to be satisfied with your services. If you want to provide us feedback you can request a client survey or you may submit a grievance to jross@dcchome.org. Please try to resolve all complaints with your therapist prior to filing a grievance.

_____ _____

Client/Guardian Signature Date

_____

Printed Name

rev. 12-18

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIAN

Patient Name: _____ DOB:_____

I, hereby authorize **The Therapy Center at DCCH** to disclose to my Primary Care Physician,

_____

(Physician's/Practice Name and Contact Information)

All clinical information about me as may be necessary to permit my Primary Care Physician to monitor the continuity of my care and to inform my Primary Care Physician of my health status.

This authorization becomes effective _____, and may be revoked by me in writing at any time, with the exception of any actions already taken to coordinate my care. Unless previously revoked by me, this authorization automatically terminates twelve (12) months from the effective date. I understand that this authorization does not extend to the release of any AIDS/HIV information unless I also place my initials here _____. I further understand that the information authorized by this release will be released to the authorized representative only, for the purpose noted above. I understand that I (or my legal representative) am entitled to a copy of this authorization form for my records.

_____

Legal Signature of Patient or Legal Guardian Date

_____

Printed name of Patient Witness Signature

Notice to Recipient: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and/or State law. In accordance with Federal and State law requirements, this information received pursuant to this document is confidential and the recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patients.

The Therapy Center at DCCH
75 Orphanage Road
Fort Mitchell, KY 41017
859-331-0821

DCCH Center for Children and Families

Notice of Privacy Practices

Effective June 14, 2015

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.

This Notice of Privacy Practices describes how DCCH may use and disclose your *Protected Health Information* to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your *Protected Health Information*.

Protected Health Information (PHI) is information about you, including your medical information and demographic information that may identify you. DCCH is required to abide by the terms of this *Notice of Privacy Practices*, but may change the terms at any time. The new Notice will be effective for all PHI maintained by DCCH at that time. DCCH will provide a paper copy of the Notice to you. On request, DCCH will provide another copy of the Notice to you through email or by accessing our web site (dcchcenter.org), by mail, or in person when you are in the building.

Our pledge to you

We understand that your PHI is personal. We are committed to protecting your PHI. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of your care records that we maintain, whether created by facility staff or your personal doctor. Your personal doctor may have different policies or notices regarding the use and disclosure of your medical information created in the doctor's office.

Purpose

We are required by law to keep PHI private, to give you this notice of our legal duties and privacy practices with respect to your PHI, and to follow the terms of the notice that is currently in effect.

Changes to this Notice

We may change our policies at any time. Changes will apply to information we already hold, as well as new information after the change occurs. If we make a material change in our policies that affects this notice, we will change our notice and post the new notice in our facility and on our web site at www.dcchome.org. You may receive a copy of the current notice at any time. The effective and revised dates are listed just below the title. You will be offered a copy of the current notice at intake and at each annual meeting. You will also be asked to acknowledge in writing that you were offered the notice.

How we may use and disclose your PHI

Under certain circumstances, we are entitled to use or disclose your PHI <u>without obtaining your written authorization</u>. Some examples of when we are permitted to do this are presented below:

Treatment: DCCH is permitted to use and disclose your PHI in accordance with the Authorization for Services/Emergency Consents release form that you signed and provided to us for treatment, managing your health care, and related services including, but not limited to, evaluation, intervention, coordinating, consulting, referring, maintaining a waiting list, and similar activities, under the following circumstances:

- Wherever DCCH provides services to you.
- To other health care, educational, childcare, or vocational providers who are or will provide services to you.
- To equipment vendors, residential facilities, transportation providers, and other organizations who have a relationship with you, or who will be providing services to you.
- To designated personal representatives or family members involved in or responsible for your care. If you do not want DCCH to make these disclosures, you shall notify the Privacy Officer in writing.
- For emergency treatment or transport to a medical center or other facility to assure your safety and well-being.
- To determine and recommend alternative treatments, therapies, health care providers or settings, or products or services to best meet your treatment needs.
- For other forms of treatment, health care management, or related services provided to you by DCCH.

Payment: DCCH is permitted to use and disclose your PHI in accordance with the Authorization for Services/Emergency Consents release form that you signed and provided to us. For instance, we may forward information regarding services planned or provided to you to your insurance company, Medicaid, or other funding source to determine eligibility and/or arrange payment; or, we may use your information to prepare a bill to send to you or the person responsible for your payment. We may use and disclose your medical information to another entity or health care provider for payment of the entity that receives the information. For instance, we may forward information to the emergency responders to allow them to obtain payment or reimbursement for serves provided to you or to

business associates who perform billing or collection activities for DCCH. A written contract between DCCH and business associates will contain terms to protect the privacy of you medical information.

Health Care Operations: We may use and disclose PHI to support our health care operations. For example, we may use or disclose your medical information to review the quality of our services and to evaluate our staff's performance. Unless you tell us otherwise we may use or disclose your PHI to support our health care operations for some of the following reasons:

- To provide you with information about treatment alternatives, health care providers or settings, products, or other health-related services that may be of interest or benefit to you. You may submit a request in writing, to the privacy officer, if you do not want these materials sent to you.
- To the DCCH Board of Trustees and Overseers, board committees, or councils, for case review to assess the quality of treatment, health care, and related services.
- To a volunteer or business associate assisting with adaptation of curriculum, materials, software, equipment, and classroom/training/work environments to best meet your treatment and payment needs at DCCH.
- To post specific care instructions for you on the wall in your program area so all providers can provide appropriate care for you according to your treatment plan.
- To effectively conduct programs (e.g. names on cubbies, personal items, etc.) and to celebrate client achievements or activities (names on art work or pictures of children/adults posted in or around the program area, etc.)
- To students, who are completing a professional training experience at DCCH, for the purposes of treatment, health care management, or related services.
- To business associates who assist with DCCH's health care operations. DCCH will maintain a written contract with business associates that contain terms to protect the privacy of your PHI.
- To send you notice of meetings, events, agency newsletters, annual reports, requests for volunteer or financial support or notice of other public awareness and fundraising efforts of DCCH. You may contact the Privacy Officer, in writing, to request these materials not be sent to you.
- To maintain waiting list and enrollment data by program and for other DCCH directories.
- To other health care providers and organizations assisting in a disaster relief effort, to coordinate care for you.
- To any other organization as necessary to assure DCCH's effectiveness in health care operations.

Other Permitted or Required Uses and Disclosures

Subject to certain requirements, DCCH is **permitted or required by law** to use or disclose your protected health information in the following situations without your express permission or authorization. Disclosures will be limited to the relevant requirements of the law. Examples of instances where the law permits or requires disclosure include the following:

- **Public Health**: To public health authorities for the purpose of controlling disease, injury or disability.
- **Communicable Diseases**: To a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Health Oversight**: To health oversight and government agencies for activities authorized by law: investigations, audits, and inspections relating to the health care system, governmental benefits, regulatory compliance, civil rights.
- **Abuse or Neglect**: To a public health authority authorized by law to receive reports of child abuse or neglect; and, if we believe you have been a victim of abuse, neglect or domestic violence.
- **Food and Drug Administration (FDA)**: To a person or company required by FDA to report adverse events, product defects or problems, biologic product deviations, track products; and, to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance.
- **Legal Proceedings**: During the course of any judicial or administrative proceeding, in response to a court order or administrative tribunal, and to respond to a subpoena, discovery request or other lawful process.
- **Law Enforcement**: For law enforcement purposes, such as: (1) legal processes, (2) requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion of death as a result of criminal conduct, (5) a crime on DCCH's premises, and (6) medical emergency, not at DCCH, where it is likely a crime occurred.
- **Coroners and Funeral Directors**: To a coroner or medical examiner for identification purposes, determining cause of death or to perform other duties authorized by law, and, to a funeral director, as authorized by law, to permit the funeral director to carry out duties.
- **Criminal Activity**: To law enforcement authorities to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and, if necessary for them to identify or apprehend an individual.
- **Military Activity and National Security**: To Armed Forces personnel as deemed necessary by appropriate military command authorities; to the Department of Veteran Affairs to determine you eligibility for benefits; and, for national security and intelligence activities including protective services to the President.
- **Workers' Compensation**: To comply with workers' compensation laws and similar programs.

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

Other uses and disclosures of your PHI will be made **only with your written authorization**, unless otherwise permitted or required by law. You may revoke an authorization, at any time, in writing, except to the extent that DCCH has already taken an action in reliance on the use or disclosure indicated in the authorization. DCCH will not condition any aspect of your treatment on whether you provide authorization for the requested use or disclosure. For example in the following cases we will never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Your rights regarding your medical information

You have the following rights regarding PHI we maintain about you:

- **Right to Inspect and Copy** – In most cases, you have the right to receive a copy and/or inspect the PHI we retain about you, upon written request. This includes a right to an electronic copy if the PHI is maintained in an electronic format. After the first request for copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request, you may submit a written request for a review of that decision. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. However, in some circumstances, our denial of a request by you to inspect and/or receive copies of your information is not subject to review.
- **Right to Amend** - If you feel medical information about you is incorrect or incomplete; you may ask DCCH to amend the information. An amendment shall be in writing and submitted to the Privacy Officer. The request shall identify the information to be amended and provide a reason to support the request. Your request may be denied if you ask for an amendment of information that was not created by DCCH; is no longer available; is not part of the information you would be permitted to inspect and copy; or, is already accurate and complete.
- **Right to an Accounting of Disclosures** – you have a right to a list of those instances where we have disclosed your PHI when you submit a written request. This list will not include disclosures made for treatment, payment, healthcare operations or for activities you authorized. Submit your request in writing to the Privacy Officer. Your request shall state a time period no longer than 6 years, and not before April 14, 2003. The first list you request in a 12 month period will be free. DCCH will notify you of any costs involved for subsequent lists within the same 12 month period; and, you may choose to withdraw or modify your request before any costs are incurred.
- **Right to Request Restrictions** - You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. You are entitled to a restriction to not disclose information to your health plan for health care services that we provided for which you paid us directly in full when the purpose of the disclosure is for the health plan's payment or health care operations. We are not required to agree to other types of requests. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
- **Right to Request Confidential Communications** - To request communication about PHI matters in a certain way or at a certain location (mailing address), submit your request in writing specifying how or where you wish to be contacted. DCCH will not ask the reason for request and will accommodate all reasonable requests.
- **Right to a Paper Copy of This Notice** - You have the right to a paper copy of this notice if this notice was sent to you electronically. You may ask for a copy of this Notice on paper at any time. You may obtain a copy of this Notice at our web site (www.dcchome.org) or by calling DCCH's receptionist to ask for a paper copy to be mailed to you.

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again

All written requests or appeals should be submitted to the HIPAA Privacy Officer at DCCH, attention HIPAA Privacy Officer, 75 Orphanage Road, Ft. Mitchell, KY 41017.

Complaints

If you are concerned that your privacy rights may have been violated, or if you disagree with a decision we made about access to your records, you may lodge a written complaint with our Privacy Officer (listed below). Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office for Civil Rights. Our Privacy Officer can provide you with the address. Under no circumstance will you be penalized or retaliated against for filing a complaint.

Privacy Officer

If you have questions or need further assistance regarding this Notice, please contact the HIPAA Privacy Officer at DCCH, 75 Orphanage Road, Ft. Mitchell, KY 41017, or by calling (859) 331-2040.

Confirmation of Receipt

I confirm that I received a copy of DCCH's Center for Children and Families **Notice of Privacy Practices** put into place 6-14-2015.

In cases where a client does not want to sign this form please indicate the reason why below

_____

_____

_____ _____

(Print Name) (Signature)

_____

(Date)