HOPE

Treatment & Counseling Center

a partnership of Endeavor Health Services & Inspired Health Group

First Contact Form

Today's Date: _____

Patient Name: _____ Date of Birth: ___/___/____
Gender: _____

Home Address: _____ City: _____ State: NY
Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Preferred Phone for Contact: _____ Primary Language: _____

Any Special Calling Restrictions: _____

Agreed To Be Contacted By Hope Center: _____

Primary Doctor: _____ phone number _____

Ever Served In The Military? _____
Currently On Active Duty? _____

Substance Use: (current, history, under the influence, none) _____

Health Insurance Company Name: _____
Policy Number: _____

Reason For Visit: _____

Name of Person Referring: _____

Client Fee Agreement / Assignment of Benefits

Endeavor Health Services

PLEASE COPY FRONT & BACK OF INSURANCE CARD AND ATTACH

PLEASE READ THIS FORM CAREFULLY:

Copays or fees Due at Time of Visit

☐ UPDATED FEE AGREEMENT

Date Entered: _____ Initials: _____

PROGRAM: _____ COUNSELOR: _____ INITIAL VISIT DATE: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION REQUESTED BELOW:

CLIENT NAME: _____ CLIENT ID: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ Can we call you at this number? YES_____ NO_____

Can we identify ourselves as Mid Erie? Yes_____ or No _____

Is there an alternate phone number? Yes_____ or No_____ Special instructions? _____

_____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

GENDER: MALE☐ FEMALE☐ MARITAL STATUS: SINGLE☐ MARRIED☐ DIVORCED ☐ OTHER ☐

Complete the following if the financially responsible party is different than the client.

NAME: _____ PHONE #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

RELATIONSHIP: _____

PLEASE CHECK PRIMARY INSURANCE, SECONDARY AND OTHER, IF APPLICABLE:

MEDICAID: Yes_____ No_____ Have Applied_____ Recertification Date_____

☐

ID #:_____ SEQ: _____

IF MEDICAID PENDING, DO YOU HAVE PROOF: Yes _____ No _____

(Example: Pending Form from Medicaid office.) If no, did client fill out Medicaid application? Date _____

MEDICARE PRIMARY: Yes ____ No ____ Effective Date: _____

☐

ID #:_____ Type: _____ **SSI** ○ **SSD** ○

OTHER HEALTH INSURANCE (MEDICAID MANAGED CARE OR COMMERCIAL):

☐ Insurance Co._____ Insurance ID#: _____ Effective Date: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Policy Holder's Last Name: _____ First Name_____

PLEASE PROVIDE THE FOLLOWING IF NO INSURANCE (complete the Sliding Fee Worksheet):

Gross Household Income: _____ Household Size_____ Other Income (child support):_____

% allowed: _____ Established Fee per type of service/hour of service: _____

Copay or fees Due at Time of Visit

Endeavor Health Services

CLIENT FEE AGREEMENT / INSURANCE ASSIGNMENT OF BENEFITS

I understand that my signature indicates that I agree to the following:

1. I agree to the release of all assessment and treatment related information requested by my insurance company or its agent for billing, authorization, and/or payment purposes. Release is subject to CFR 42-Part II, and CFR 45-Parts 160 & 164 of the Code of Federal Regulations and Mental Hygiene Law 33.13 prohibiting unauthorized disclosure. I understand my Alcohol and Drug Abuse Patient treatment records cannot be re-disclosed without my written consent unless otherwise provided for in the regulations under 42 CFR –Part II.
2. I understand I may revoke my consent for release of information in writing at any time except to the extent that action has been taken in reliance upon it. I further understand that this release covers any referral of my account to a collection agency if I default on my account. This consent expires upon termination from treatment and agency receipt of reimbursement for all services performed.
3. I agree to pay the full cost of service at each visit, unless all of my insurance payments are assigned to Endeavor Health Services. This includes securing any necessary referrals and presenting a valid insurance card at each visit.
4. I agree to pay any insurance deductibles and/or the difference between what the insurance company may pay and the per session charge unless prohibited by regulations submitted by insurance contracts.
5. Endeavor Health Services makes no expression of implicit guarantee of insurance coverage for any of its services.
6. I have been informed of the fee for the initial and subsequent services I may receive. Lists of Agency rates are available upon request.
7. I authorize Endeavor Health Services to obtain any information that is required from any source to verify the information provided on this financial statement is accurate.
8. I authorize Endeavor Health Services to communicate, verbally and in writing,, to any source for the purpose of obtaining necessary billing information.
9. I will be responsible for the full cost of any treatment service rendered to me until I have provided the income information required to process any assistance for which I may be eligible.
10. I understand that the sliding fee discount program is available for those eligible (uninsured, underinsured) and that eligibility is based on income and family size.
11. I understand that copayment or fees for services are due at the time of service regardless of who is present for the service or financial responsibility.
12. If I do not make payment as service is rendered, my current session may be cancelled or rescheduled. This release is valid until my account has been satisfied or current insurance information is received with an updated release. This release is to be done annually.
13. I agree to pay all bank charges if a check is returned for insufficient funds.
14. These conditions have been explained to me. I have read these conditions; I understand and agree to them. I have been provided a copy upon request.

Signature of Client: _____ Date: _____

Signature of Parent/Guardian (if applicable) _____ Date: _____

Witness: _____ Date: _____

ENDEAVOR
HEALTH SERVICES

INFORMED CONSENT FOR TREATMENT

Welcome to Endeavor Health Services. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. Your primary counselor has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things discussed outside of sessions.

The first 2-3 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, we will be able to offer you some initial impressions of what your treatment might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with your counselor. If you have questions about our procedures, these should be discussed whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

PROFESSIONAL RECORDS

We are required to keep appropriate records of the services provided. Your records are maintained in a secure location in the office. We keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records received from other providers, copies of records sent to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, we recommend that you initially review them with a member of the clinical staff, or

have them forwarded to another mental health professional to discuss the contents. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

If you are unhappy with what is happening in therapy, we hope you will talk with your counselor so that these concerns will be addressed. Such comments will be taken seriously and handled with care and respect. You may also request that you be referred to another counselor and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience.

CONSENT TO PSYCHOTHERAPY

- I give consent for evaluation and treatment to be provided for myself or my child.
- 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.
- 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 client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.)

_____ _____

Signature of Patient or Parent/Guardian or Representative Date

_____

Patient's Printed Name

_____

Relationship to Patient (if applicable)

_____ _____

Witness Signature Date

ENDEAVOR HEALTH SERVICES

Acknowledgement of Receipt of Notice of Privacy Practices and Consumer (Client) Rights

Endeavor Health Services reserves the right to modify the privacy practices outlined in the notice.

Signature
I have received a copy of the Notice of Privacy Practices and Consumer (Client) Rights for Endeavor Health Services.

_____
Name of Client (Print or Type)

_____
Signature of Client

_____
Date

_____
Signature of Client Representative
(Required if the client is a minor or an adult who is unable to sign this form)

_____
Relationship of Client Representative to Client

ENDEAVOR HEALTH SERVICES

Consent To Use and Disclose Protected Health Information For Treatment, Payment and Health Care Operations

Section A:

Client Name:_____ Client's Date of Birth:_____

I authorize the use and disclosure of my Protected Health Information by Endeavor Health Services located at Hope Center and by Endeavor Health Services' workforce, health care professionals and vendors providing services or supplies to me for purposes of treatment, payment and health care operations.

Section B. **Important Information Regarding this Consent:**

1. I understand that state law requires my consent in some instances before Endeavor Health Services may use or disclose my Protected Health Information for treatment, payment or health care operations.

2. I understand that this information may be used or disclosed by Endeavor Health Services to:
   - plan my care and treatment;
   - communicate among various health care professionals who are involved in my care or treatment;
   - obtain payment for care provided by Endeavor Health Services or for the payment activities of another health care provider or entity;
   - provide information to my health insurance company or plan;
   - assess and review the quality of my care; and
   - conduct its business and health care operations.

3. I understand that Endeavor Health Services' Notice of Privacy Practices provides further information on its uses and disclosures of my Protected Health Information.

SIGNATURE

I have read and understand the terms of this consent. I have had an opportunity to ask questions about the use or disclosure of my Protected Health Information.

Signature of Client or Parent/Representative/Legal Guardian:_____

Print Name of Client or Parent/Representative/Legal Guardian:_____

Description of Representative/Legal Guardian's Authority:_____

Date:_____

CONTACT INFORMATION

Contact information of the parent/representative/legal guardian who signed this form:

Address:_____

Telephone: _____(Daytime) _____(Evening)

FOR ENDEAVOR HEALTH SERVICES USE ONLY

Date Endeavor Health Services Obtained Consent:_____

Name and Title of Person Obtaining Consent:_____

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

Consent Form

MID-ERIE MENTAL HEALTH SERVICES, INC. DBA EHS

Provider/Facility Name

About PSYCKES

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

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

This data includes:

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

What You Need to Do

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

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

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

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

Your Choice. *Please check 1 box only.*

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

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

Print Name of Patient

Patient's Date of Birth

Patient's Medicaid ID Number

Signature of Patient or Patient's Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative Patient (if applicable)

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

NEW YORK STATE
OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES
OFFICE OF MENTAL HEALTH

CONSENT TO RELEASE INFORMATION
Certified Community Behavioral Health Clinic
Alcoholism/Substance Use or Mental Health Patient

Revoked On:_____ Staff Initials:_____

Patient's Last Name	First	M.I.
Case Number		
CCBHC Facility	Unit	

INSTRUCTIONS: **GIVE A COPY OF THIS FORM TO PATIENT!** Prepare one (1) copy for the patient's case record. If this form is to be sent to another agency with a request for information, prepare an additional copy for the patient's case record.

PATIENT'S CONSENT TO DISCLOSE AND OBTAIN PERSONAL IDENTIFYING INFORMATION

EXTENT OF NATURE OF INFORMATION TO BE DISCLOSED OR OBTAINED

Information to be exchanged among and between my Certified Community Behavioral Health Clinic (CCBHC), as named above, my Designated Collaborating Organization(s) (DCOs) _____ _____ (if applicable) and my Managed Care Organization (MCO) _____, which might include, (if applicable) information related to crisis intervention/stabilization; outpatient mental health and/or substance use services; HIV/AIDS status and treatment; screening, assessment and diagnosis; treatment planning; physical health screening; care management; psychiatric rehabilitation services; peer and family support; community based mental health care for veterans and members of the armed forces.

PURPOSE OR NATURE FOR DISCLOSURE/RELEASE AND NAME OF ORGANIZATIONS DISCLOSING AND OBTAINING PERSONAL IDENTIFYING INFORMATION.

Information may be exchanged among my CCBHC, DCOs and MCO for the purpose of treatment, payment and care coordination.

Information will be disclosed to NYS Department of Health (DOH), Office of Alcoholism and Substance Abuse Services (OASAS) and Office of Mental Health (OMH) for purposes of payment and statistical reporting requirements.

I, the undersigned, have read the above and authorize my CCBHC, DCO and MCO named above to disclose and obtain such information as herein specified.

I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire within twelve (12) months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I also understand that any disclosure of any identifying information is bound by Title 42 of the Code of Federal Regulations (C.F.R.) Part 2, governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. §§160 &164 and New York mental Hygiene Law § 33.13 ; and that redisclosure of this information to a party other than those designated above is forbidden without additional written authorization on my part.

NOTE: Any information released through this form **MUST** be accompanied by the form **Prohibition on Redisclosure of Information Concerning Alcoholism / Drug Abuse Patient** (TRS-1)

I understand that generally the program may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form. I have received a copy of this form.

_____ (Signature of Patient)

_____ (Print Name of Patient)

_____ (Date)

_____ (Signature of Parent/Guardian)

_____ (Print Name of Parent/Guardian)

_____ (Date)

HEALTHeLINK **Authorization for Access to Patient Information Through HEALTHeLINK**

Patient First Name

Patient Last Name

Date of Birth M M / D D / Y Y Y Y

Patient Address

Street _____ Apartment _____

City _____ State _____ Postal Code _____

Gender

☐ Male

☐ Female

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Participating HEALTHeLINK Providers and Payers ("Participants") who are involved in my care to obtain access to my medical records through the health information exchange organization called HEALTHeLINK. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HEALTHeLINK is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HEALTHeLINK's website at www.wnyhealthelink.com.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

SELECT ONLY ONE

My Consent Choice. Only ONE box is checked to the left of my choice. I can fill out this form now or in the future. I can also change my decision at any time by completing a new form.

☐ **1. YES** — **I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK.

☐ **2. YES, EXCEPT SPECIFIC PARTICIPANT(S)** — **I GIVE CONSENT** to all current and future Participants, who are involved in my care, to access ALL of my electronic health information through HEALTHeLINK, **EXCEPT** the Participant(s) listed below.

Participant's Name (Provider Office):	Participant's address or phone number:

☐ **3. YES, ONLY SPECIFIC PARTICIPANT(S)** — **I GIVE CONSENT ONLY** to the specific Participant(s) listed below to access ALL of my electronic health information through HEALTHeLINK.

Participant's Name (Provider Office):	Participant's address or phone number:

☐ **4. NO, EXCEPT IN AN EMERGENCY** — **I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for current and future Participants to access my electronic health information through HEALTHeLINK.

☐ **5. NO, EVEN IN AN EMERGENCY** — **I DENY CONSENT** for current and future Participants to access my electronic health information through HEALTHeLINK for any purpose, ***even*** in a medical emergency.

I understand that my information may be accessed in the event of an emergency, unless I complete this form and check box #5, which states that I deny consent *even* in a medical emergency.

I understand that upon my request, HEALTHeLINK is required to provide me with a list of disclosures of my electronic health information under the terms of this form.

My questions about this form have been answered and I have been provided a copy of this form if I request it.

Signature of Patient or Patient's Legal Representative

X _____

Date of Signature M M / D D / Y Y Y Y

Print Name of Patient's Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

☐ Parent ☐ Healthcare agent/proxy

☐ Guardian ☐ Other _____

This Box To Be Filled Out Only By The Provider

Mid-Erie Counseling and Treatment Services

Entity Consent Received By

Witness*

*Required if NOT completing this form in a Participant's office.

Print Name of Witness _____ Signature of Witness _____

Relationship of Witness to Patient (ex., spouse, son, neighbor, etc.)

Details about patient information in HEALTHeLINK and the consent process:

1. **How Your Information May Be Used.** With limited exceptions, if you give consent, the Participant(s) you approve may use your electronic health information **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information About You Are Included.** If you give consent, the Participants you approve may access ALL of your electronic health information available through HEALTHeLINK. 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
   - HIV/AIDS
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - 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, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **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 HEALTHeLINK at www.wnyhealthelink.com or by calling 716- 206-0993 ext. 311.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Participant(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. Your information may also be accessed without your consent by Public Health Agencies if permitted by State and/or Federal Law. Any data received from a 42 C.F.R. Part 2 designated facility (certain providers of alcohol or drug abuse care) may only be accessed where there is a treating provider relationship. A complete list of Participants is available from HEALTHeLINK at www.wnyhealthelink.com/PhysiciansandStaff/CurrentParticipants/ParticipatingHEALTHeLINKProviders or by calling 716-206-0993 ext. 311 if you want a hard copy which will be provided at no charge within 5 business days of the request.

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 one of the Participants you have approved to access our records; or visit HEALTHeLINK's website at www.wnyhealthelink.com; or call HEALTHeLINK at 716- 206-0993 ext. 311; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

6. **Re-disclosure of Information.** Any Participant(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

7. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice or until such time as HEALTHeLINK ceases operation ***(or until 50 years after your death whichever occurs first)***. If HEALTHeLINK merges with another Qualified Entity our consent choices will remain effective with the newly merged entity.

8. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Participant(s) that access your health information through HEALTHeLINK while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

Name _____

Date _____

Patient Health Questionnaire-9

(PHQ-9)

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not At All**	**Several Days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble failing or staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

Not difficult at all ☐ Some what difficult ☐ Very difficult ☐ Extremely difficult ☐

Name _____

Date _____

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not At All**	**Several Days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

NAME_____ DATE:_____

The CAGE-AID Questionnaire

1. Have you felt you ought to cut down on your drinking or drug use?

☐ Yes ☐ No

2. Have people annoyed you by criticizing your drinking or drug use?

☐ Yes ☐ No

3. Have you felt bad or guilty about your drinking or drug use?

☐ Yes ☐ No

4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

☐ Yes ☐ No

Source: Reprinted with permission from the *Wisconsin Medical Journal.* Brown, R.L., and Rounds, L.A. Conjoint screening questionnaires for alcohol and drug abuse. *Wisconsin Medical Journal* 94:135-140, 1995.

Rev 9/1/2013

Fagerstrom Test For Nicotine Dependence

Date: _____

Client Name: _____

Client Signature: _____

Do you smoke, chew tobacco, or vape with nicotine-containing products? _____ Yes _____ No

Please check ☑ one box per question			
How soon after waking do you smoke your first cigarette?	Within 5 minutes 5-30 minutes 31-60 minutes	☐ ☐ ☐ ☐	3 2 1 0
Do you find it difficult to refrain from smoking in places where it is forbidden? e.g. Church, Library, etc.	Yes No	☐ ☐	1 0
Which cigarette would you hate to give up?	The first thing in the morning Any other	☐ ☐	1 0
How many cigarettes do you smoke?	10 or less 11-20 21-30 31 or more	☐ ☐ ☐ ☐	0 1 2 3
Do you smoke more frequently in the morning?	Yes No	☐ ☐	1 0
Do you smoke even if you are sick in bed most of the day?	Yes No	☐ ☐	1 0
	Total Score		
SCORE	1-2=low dependence 3-4=low to mod dependence	5-7=moderate dependence 8 +=high dependence	

Are you interested in quitting smoking? _____ Yes ____ No-not at this time

Does anyone in the household smoke? If yes, who? _____

_____

Are they interested in quitting? _____ Yes _____ No

ENDEAVOR HEALTH SERVICES

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 READ IT CAREFULLY.

Purpose of this Notice

This Notice provides information about the way in which your medical information may be used or disclosed by Endeavor Health Services.

Participating Organizations

Along with this Notice, you may be given a list of organizations that work together in the operation of a number of mental health services programs for residents of Erie County. This list may change from time to time.

The important thing for you to know is that each of these organizations has agreed to a common set of policies for protection of the privacy of the people they serve. The organizations that work together are referred to as the "participating organizations".

Our Obligation to You

The participating organizations respect your privacy. This is part of our code of ethics. We are required by law to maintain the privacy of "protected health information" about you, to notify you of our legal duties and your legal rights, and to follow the privacy policies described in this notice. "Protected Health Information" means any information that we create or receive that identifies you and relates to your health or payment for services to you.

Use and Disclosure of Information about You

Use and disclosure for treatment, payment and health care operations.

We will use your protected health information and disclose it to others as necessary to provide treatment to you. Here are some examples:

- We may share information about you in order to evaluate whether you are eligible to participate in a program of services.
- We may provide information to your health plan or a treatment provider in order to arrange for a referral or clinical consultation.
- Various members of our staff may see your clinical record in the course of our care for you. This includes counselors, case managers, nurses, physicians and other staff.
- It may be necessary to send urine samples to a laboratory for analysis to help us evaluate your medical condition.

- We may contact you to remind you of appointments.
- We may contact you to tell you about treatment services that we offer that might be of benefit to you.

We will use or disclose your protected health information as needed to arrange for payment for service to you. For example, information about your diagnosis and the service we render is included in the bills that we submit to your health insurance plan. Your health plan may require health information in order to confirm that the service rendered is covered by your benefit program and medically necessary. A health care provider that delivers service to you, such as a clinical laboratory, may need information about you in order to arrange for payment for its services.

It may also be necessary to use or disclose protected health information for our health care operations including our vendors and agents who help us to carry out our business functions or those of another organization that has a relationship with you. For example, our quality assurance staff reviews records to be sure that we deliver appropriate treatment of high quality. Your health plan may wish to review your records to be sure that we meet national standards for quality of care.

It is our policy to obtain your written permission to use and disclose your protected health information for treatment, payment or health care operations purposes. You will be asked to sign a consent form to permit all such uses and disclosures of your information. Please understand, however, that if you participate in our programs, we may use and disclose protected health information for treatment, payment or health care operations even if we do not have your permission or even if you revoke your permission. However, if you choose to pay for services directly (out of pocket), you have a right to restrict disclosures of PHI to your Health Care Plan with respect to healthcare.

Unless you provide us with alternative instructions, we may contact you about reminders for treatment, medical care, or health check-ups. We may also contact you to tell you about health related benefits or services that may be of interest to you or to give you information about your health care choices.

Emergencies. If there is an emergency, we will disclose your protected health information as needed to enable people to care for you.

Disclosure to your family and friends. If you are over 18 years of age, an emancipated minor or a minor in certain other situations, you have the right to control disclosure of information about you to any other person, including family members or friends. If you ask us to keep your information confidential, we will respect your wishes. However, if you don't object, we will share information with family members or friends involved in your care as needed to enable them to help you.

Disclosure to health oversight agencies. We are legally obligated to disclose protected health information to certain government agencies, including the Erie County Department of Mental Health, the New York State Office of Mental Health, and the federal Department of Health and Human Services
Disclosures to child protection agencies. We will disclose protected health information as needed to comply with state law requiring reports of suspected incidents of child abuse or neglect.

Disclosures to report abuse, neglect, or domestic violence. We may use your Protected Health Information to notify a government authority (NY State Justice Center for the Protection of People with Special Needs) if required or authorized by law or if you agree to the report, if we have reason to believe that you have been a victim of abuse, neglect or domestic violence.

Disclosures to avert a serious threat to health or safety. We may use and disclose your Protected Health Information when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person. However, any disclosure would be made only to someone able to prevent the threat and in accordance with the NYS SAFE Act 9.46 of the MHL.

Other disclosures without written permission. There are other circumstances in which we may be required by law to disclose protected health information without your permission. They include disclosures made:

- Pursuant to court order or as required for judicial and administrative proceedings;
- To public health authorities;
- To law enforcement officials in some circumstances;
- To correctional institutions regarding inmates;
- To federal officials for lawful military or intelligence activities;
- To coroners, medical examiners and funeral directors;
- To researchers involved in approved research projects; and
- As otherwise required by law.

Alcohol and Drug Abuse Programs. If you participate in an alcohol or drug abuse program, that program will follow the provisions of 42 CFR Part 2 governing disclosure of protected health information. Except for emergencies, alcohol/drug abuse programs will not disclose protected health information to a third party without your written permission or a court order. If a request for disclosure of your record is received, you will be contacted and asked whether you wish to authorize disclosure. If you refuse to authorize disclosure, or it is not possible for us to contact you in person, we will not disclose your information without a court order.

Confidential HIV Related Information. Under New York State Law, confidential HIV-related information (information concerning whether or not you have had an HIV-related test, or have HIV infection, HIV-related illness, or AIDS, or which could indicate that a person has been potentially exposed to HIV), cannot be disclosed except to those people you authorize in writing to have it.

Disclosures with your permission. No other disclosure of protected health information will be made unless you give written Authorization for the specific disclosure.

Breach Notification Policy. All of Endeavor's electronic information is secured, however it is the duty of this agency to notify individuals in the unlikely event of a breach of unsecured PHI.

Your Legal Rights

Right to review and copy record. You have the right to inspect and receive a copy of the records used to make decisions about you. Your request must be in writing. We will allow you to review your record unless a clinical professional determines that it is reasonably likely to endanger your life, or physical

safety or that of another person. If another person provided information about you to our clinical staff in confidence, that information may be removed from the record before it is shared with you. We will also delete any protected health information that refers to another person if access to this information is likely to cause substantial harm to that other person. At your request, we will make a copy of your record for you. (electronic or paper) We will charge a reasonable fee for this service.

Right to request confidential communications. You may request that communications to you, such as appointment reminders, bills, or explanations of health benefits be made in a confidential manner. We will accommodate any such request, as long as you provide a means for us to process payment transactions.

Right to request restrictions on use and disclosure of your information. You have the right to submit a written request for restrictions on our use and disclosure of your protected health information for treatment, payment or health care operations, or for disclosure of your health status to family or other person(s) involved in your care. We are not obligated to agree to a requested restriction, but we will consider your request.

Right to revoke a Consent or Authorization. You may revoke a written Consent or Authorization for us to use or disclose your protected health information. The revocation will not affect any previous use or disclosure of your information.

Right to "amend" record. If you believe your records contain an error, you may ask us to amend it. Your request must be in writing and must state a reason to support the requested amendment. If there is a mistake, a note will be entered in the record to correct the error. If not, you will be told and allowed the opportunity to add a short statement to the record explaining why you believe the record is inaccurate. This information will be included as part of the total record and shared with others if it might affect decisions they make about you.

Right to an accounting. You have the right to an accounting of certain disclosures of your protected health information. This does not include disclosures that you authorize, or disclosures that occur in the context of payment or health care operations. We will provide an accounting of other disclosures made in the preceding six years. If requested by law enforcement authorities that are conducting a criminal investigation, we will suspend accounting of disclosures made to them.

Right to a paper copy of this Notice. You have the right to receive a paper copy of our Notice of Privacy Practices posted at our site.

Changes to this Notice. Endeavor reserves the right to change this Notice and to make the revised or new Notice provisions effective for all Protected Health Information received and maintained by Endeavor Health Services as of the date of the revision. We will post a copy of the current Notice at our site and on our website and a copy of the revised Notice will be available to you if you request one.

How to Exercise Your Rights

Questions about our policies and procedures, requests to exercise individual rights, and complaints should be directed to our Privacy Officer., through the agency's Administrative Assistant at 716-895-6700. Ext 4050. All telephone inquires will be screened by the agency's Administrative Assistant and directed to the appropriate individual. (Administrator and/or Privacy Officer).

Personal representatives. A "personal representative" of a patient may act on their behalf in exercising their privacy rights. This includes the parent or legal guardian of a minor. In some cases, adolescents who are "mature minors" may make their own decisions about receiving treatment and disclosure of protected health information about them. If an adult is incapable of acting on his or her own behalf, the personal representative would ordinarily be his or her spouse or another member of the immediate family. An individual can also grant another person the right to act as his or her personal representative in an advance directive or living will.

Disclosure of protected health information to personal representatives may be limited in certain cases such as in the case of domestic or child abuse.

Complaints

If you have any complaints or concerns about our privacy policies or practices, please submit a Complaint to our Contact Person. If you wish, the Contact Person will give you a form that you can use to submit a Complaint if you wish.

You can also submit a complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint. Send your complaint to:

Regional Manager
Region II, Office of Civil Rights
U.S. Department of Health and Human Services
Jacob Javits Federal Building
26 Federal Plaza, Suite 3312
New York, NY 10278
1-800-368-1019

Effective Date

These policies and procedures were approved on April 14, 2003 and revised on March 19, 2013

ENDEAVOR
HEALTH SERVICES

What To Expect At Endeavor Health Services

Your first counseling appointment is anticipated to be 60 minutes in length and visits after that will typically be 45-60 minutes in duration. The assessment process will typically take 2-3 sessions to complete. You will need to bring your insurance care and any applicable copays for services with you. We accept most insurances including Medicaid and Medicare. During your appointment with us, you will be given the opportunity to discuss any questions you have and options for your counseling treatment. For those with a history of use of alcohol or other substances, a toxicology sample will need to be provided as part of this appointment. You will be involved in making decisions about how often you will be seen and what you want to work on. At all times you and your information is treated with the utmost dignity and respect for your privacy.

Once admitted to the program, there will be the option for participation in many different session types. Based on what you need to work on, sessions may be provided in individual, family, group, or psychiatric sessions. This will be discussed with your counselor during the assessment process.

In each session you will have the opportunity to give feedback on how you feel treatment is unfolding and discuss if you would like any changes. We know that getting regular feedback from you will lead to a more successful outcome.

Please bring a list of any medications you may be on and the names of any other providers or people you work with.

To make the most of your appointment, please arrive on time. The counselors want to make sure there is plenty of time to discuss any issues or concerns. If you arrive more than 15 minutes late, we may have to reschedule your appointment. We also ask for 24 hour notice related to cancellation of appointments.

If you have any questions at any time, please contact your counselor. We look forward to working with you very soon!

ENDEAVOR
HEALTH SERVICES

RIGHTS OF OUTPATIENT PROGRAM CONSUMERS

As a consumer (client) of outpatient clinic services at Endeavor Health Services, you are entitled to the rights outlined below:

(1) to receive services that are responsive to individual needs in accord with an individualized treatment plan, which the patient helps develop and periodically update;

(2) to receive services from provider staff who are competent, respectful of patient dignity and personal integrity, and in sufficient numbers to deliver needed services consistent with regulatory requirements;

(3) to receive services in a therapeutic environment that is safe, sanitary, and free from the presence of alcohol or other drugs of abuse;

(4) to know the name, position, and function of any person providing treatment to the patient, and to communicate with the provider director, medical director, board of directors, other responsible staff or the Commissioner;

(5) to receive information concerning treatment, such as diagnosis, condition or prognosis in understandable terms, and to receive services requiring a medical order only after such order is executed by an appropriate medical professional;

(6) to receive information about provider services available on site or through referral, and how to access such services;

(7) to receive a prompt and reasonable response to requests for provider services , or a stated future time to receive such services in accordance with a individual treatment plan;

(8) to know the standards that apply to his or her conduct, to receive timely warnings for conduct that could lead to discharge and to receive incremental interventions for non-compliance with treatment plans;

(9) to receive in writing the reasons of a recommendation of discharge and information of appeal procedures;

(10) to voice a grievance, file a complaint, or recommend a change in procedure or service to provider staff and/or the Office, free from intimidation, reprisal or threat;

(11) to examine, obtain a receipt, and receive an explanation of provider bills, charges, and payments, regardless of payment source;

(12) to receive a copy of the patient's records for a reasonable fee;

(13) to be free from physical, verbal or mental abuse;

(14) to be treated by provider staff who are free from alcohol or drug abuse;

(25) to be free from any staff or patient coercion, undue influence, intimate relationships, and personal financial transactions;

(16) to be free from performing labor or personal services solely for provider or staff benefit, that are not consistent with treatment goals, and to receive compensation for any labor or employment service in accord with applicable state and federal law; and

(17) the following rights apply to patients who reside in an inpatient/residential setting:

(i) to practice religion in a reasonable manner not inconsistent with treatment plans or goals and/or have access to spiritual counseling if available;

(ii) to communicate with outside persons in accord with the individualized treatment plan;

(iii) to freely communicate with the Office, public officials, clergy and attorneys;

(iv) to receive visitors at reasonable times in relative privacy in accord with the individualized treatment plan;

(v) to be free from restraint or seclusion.

(vi) to have a reasonable degree of privacy in living quarters and a reasonable amount of safe personal storage space;

(vii) to retain ownership of personal belongings, that are not contrary to treatment goals;

(viii) to have a balanced and nutritious diet.

(18) Participants referred to a faith based provider have the right to be given a referral to a non-faith based

Endeavor requests that you let us know of any concerns that you have about the treatment services you receive. Initially you should inform your primary counselor of your concern who will attempt to resolve the difficulty. If your concern is not answered to your satisfaction, you should request to speak with the program supervisor. If your concern remains unresolved, you may contact the Director of Clinical Services at 895-6700. You can also make a formal written grievance to the Executive Director of Endeavor. If your concern remains unresolved to your satisfaction, you have the option of contacting one or more of the following:

1. New York State Office of Mental Health
   Western New York Field Office
   737 Delaware Ave. Suite 200
   Buffalo, NY 14209
   (716) 533-4089

2. New *York* State Office of Alcoholism and Substance Abuse Services
   Western New York Regional Office
   295 Main Street Suite 577
   Buffalo, NY 14203
   (716) 847-3037

3. New York State Justice Center
   For the Protection of People with Special Needs
   1-855-373-2122

4. Erie County Department of Mental Health
   95 Franklin Street
   Buffalo, NY 14202
   (716) 858-8530

5. Alliance for the Mentally Ill of Erie County
   432 Amherst St.
   Buffalo, NY 14207
   (716) 877-9415

6. Protection and Advocacy for Mentally Ill Individuals
   Neighborhood Legal Services
   Ellicott Square Building
   295 Main Street, Room 495
   Buffalo, NY 14203
   (716) 847-0650

7. Mental Health Association
   Client Advocacy Services
   999 Delaware Ave.
   Buffalo, NY 14209
   (716) 886-1242

8. NYS OASAS
   Patient Advocacy
   1-800-553-5790

ENDEAVOR
HEALTH SERVICES

Consumer Responsibilities

(a) Participation in an outpatient clinic service presumes a consumer's continuing desire to change lifestyle habits and requires each consumer to act responsibly and cooperatively with provider staff, in accord with an individual treatment plan and reasonable provider procedures. Therefore, each consumer is expected to:

(1) work toward the goal of symptom management

(2) treat staff and other consumers with courtesy and respect;

(3) respect other consumers' right to confidentiality;

(4) participate in developing and following a treatment plan;

(5) become involved in productive activities according to ability;

(6) pay for services on a timely basis according to financial means;

(7) participate in individual counseling and/or group and or family counseling sessions as applicable;

(8) inform medical staff if receiving outside medical services;

(9) address all personal issues adversely affecting treatment; and

(10) act responsibly and observe all provider rules, regulations and policies;

(b) Consequences for consumer non-compliance.

(1) Provider policies and procedures to address consumer non-compliance shall be designed to support a consumer's positive response to treatment. Such policies and procedures must specify standards and expectations for consumer behavior, and any consequences of non-compliance, including behavior which may result in treatment termination.

(2) Providers shall address consumer non-compliance with timely and appropriate incremental interventions designed to assist consumers in responding positively to treatment. Such incremental interventions shall be incorporated in the consumer's treatment plan, be time-limited, and be documented in the consumer's record.

(3) No treatment intervention or action can include delay or denial of any clinical, medical, or other required service vital to the health or recovery of the consumer.

(4) Providers shall first warn consumers of any behavior that could result in a recommendation of discharge with continued non-compliance, and must document such warning(s) in the consumer's record.