Behavioral Health Services

Consent to Participate in Tele-Health Substance Use or Mental Health Services

I voluntarily give my consent for DCCCA, Inc. to facilitate mental health or substance use assessment and treatment services with to myself, my child, my family or other (specify) _____.

I understand and acknowledge that Tele-Health is defined as services conducted via internet-based videoconference or by telephone.

I voluntarily give my consent for DCCCA, Inc. to contact me by phone, text, videoconference or email.

I understand and acknowledge that federal, state and other regulatory guidelines may, in certain circumstances allow verbal consent to participate in treatment and to authorize release of information.[1]

I understand and acknowledge that DCCCA staff will not communicate with me via social media platforms including but not limited to Facebook, Twitter, Instagram, Facebook Messenger

I understand and consent to the need and right of DCCCA, Inc. to summon emergency medical service or transportation and to release appropriate information for such service or billing purposes.

I understand that this consent is voluntary and that I can withdraw my consent for treatment at any time.

_____

Client Name/Guardian (and relationship to client)

_____ _____

Client/Guardian Signature Date

[1] Federal and state regulations currently allow for verbal consent, in lieu of written consent, during the COVID-19 period.

DCCCA Behavioral Health Services
Notice of Privacy Practices

DCCCA Behavioral Health Services maintains client records consisting of personal, financial, social, and medical information. This information is used for diagnosis and treatment and also for contacting, scheduling, and determining financial ability, claims for third-party payers. Non-identifiable source information may also be used for reporting required by the state licensing agencies, need verification to county boards, and medical education. The Healthcare Portability and Accountability Act (HIPAA) establishes Privacy Rules that govern the uses and disclosures of this information. **We will not use or disclose your health information without your consent or authorization**, except as described in this notice or otherwise required by law.

This notice describes how your information may be used and disclosed and how you can get access to this information. Please review carefully.

USES AND DISCLOSURES OF HEALTH INFORMATION

(* Notes Authorization for DCCCA Behavioral Health Services to release PHI is signed by client/legal representative prior to release.)
Routine Types of Disclosures

- Treatment of client: for use by a physician, nurse or other member of your healthcare team to determine the best course of treatment for you.*
- Third party payers (insurance companies and governmental funding agencies): for use in payment collection and may include the diagnosis, treatment received, and date of treatment. (K.S.A. 65-5603)*
- Health professionals or subsequent healthcare provider: to assist in your care after you are no longer being treated by this facility or in addition to this facility.*
- Officers of the court: When treatment is a requirement of the court, health information will be disclosed to the appropriate agencies as required by law.*
- To medical personnel when a medical condition poses an immediate threat to the health of the client and/or emergency medical intervention is warranted.

Non-Routine Types of Disclosures

- Communications with family/significant others: Using our best judgment, we may disclose to a family member, other relative, or to a close personal friend, health information relevant to that person's involvement in your care or payment related to your care.*
- Schools: In a collaborative effort to provide treatment to a minor, testing results and information gathered in therapeutic assessments may be disclosed.*
- Public health agency: We may disclose (if required by law) to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- Suspected child or dependent adult abuse.
- Law enforcement: Health information may be disclosed in response to a valid court order.
- Employee Assistance Program/Employer: Limited health information may be disclosed to the extent necessary to comply with applicable laws when treatment is at the request or referral of an employer.*
- Workers compensation: We may disclose health information to the extent authorized and to the extent necessary to comply with laws relating to workers compensation.*
- Certain qualified individuals or organizations may have access to client records for audit or evaluations for them to determine our compliance with state and federal regulations.
- Business associates: We provide some services through collaboration with other human service agencies. We also have Business Associate Contracts or Chain of Trust Partner Agreements with other organizations to provide safeguards for protected health information disclosures, required to conduct DCCCA Behavioral Health Services' operations in providing client care and services.

This is an example of Uses and Disclosures and not a complete list. If you have a question concerning disclosure, please contact the Executive Director.

YOUR RIGHTS UNDER THE FEDERAL PRIVACY STANDARD
Although your health records are the physical property of DCCCA Behavioral Health Services, you have certain rights with regard to the information contained therein.

- **You have the right to obtain a copy of this Notice of Information Practices.** The Notice is available to you in paper form.

- **You have the right to inspect and obtain a copy of your health information upon written request.** This right is not absolute and in certain situations, we can deny access, if access might cause harm to the client or another individual. You do not have a right to access information generated by an entity other than DCCCA Behavioral Health Services. Psychotherapy notes, separated from the medical record or information that was obtained from someone other than a healthcare provider under a promise of confidentiality are not covered by this right to access.

  In other situations, when access to treatment information is denied, DCCCA Behavioral Health Services will inform you of the reason for denying access and how to seek a review of that decision. The reviewable grounds for denial include but are not limited to:

  a) The access is reasonably likely to endanger the life or physical safety of the individual or another person, as determined by a qualified mental health professional.

Notice of Privacy Practices

b) The health information makes reference to another person and such information is likely to cause substantial harm to the other person, as determined by a qualified mental health professional.
c) The request is made by the individual's designee and providing the information to the designee is likely to cause substantial harm to the individual or another person, as determined by a qualified mental health professional.

For these reviewable grounds, the Executive Director will review the decision of the provider denying access and provide the client a written explanation of the reason for denial within 60 days

- **You have the right to request a correction or amendment to your health information.** We do not have to grant the request if the record was not created by our agency. In such instances, you must seek correction or amendment from the agency creating the record. If they correct or amend the information, we will file the change in our record. We do not have to grant the request if the record is accurate and complete or if the record is not available to you as described immediately above. If your request for correction or amendment is denied, DCCCA Behavioral Health Services will inform you of the reason for denying access.
  If the request for correction or amendment to the record is granted, the change will be made to your medical record and the correction/amendment distributed to those you identify to us as needing the information. When appropriate, the correction or amendment may be distributed to other entities, as defined in the Uses and Disclosures section of this Notice.

- **You have the right to request restriction on uses and disclosures of your health information for treatment, payment, and health care operations.** "Health care operations" consist of activities that are necessary to carry out the operations of DCCCA Behavioral Health Services, such as quality assurance and peer review. The right to request restriction does not extend to uses or disclosures permitted or required under 164.502(a)(2)(i) (disclosures to you), 164.510(a) (for facility directories, but note that you have the right to object to such uses), or 164.512 (uses and disclosures not requiring a consent or an authorization). The latter uses and disclosures include, for example, those required by law like mandatory reporting of child and adult abuse, and in those cases, you do not have a right to request restriction. The Consent to use and disclose your individually identifiable health information provides the ability to request restriction. We do not, however, have to agree to the restriction. If the restriction is granted, we will adhere to it unless you request otherwise or we give you advance notice. You may also ask us to communicate with you by alternate means and, if the method of communication is reasonable, we must grant the alternate communication request. Refer to the consent form.

- **You have the right to obtain an accounting of "non-routine" uses and disclosures, other than those for treatment, payment, and health care operations.** We do not need to provide an accounting of uses and disclosures for:
  a) The facility directory or to persons involved in the individual's care as provided in 164.510 (uses and disclosures requiring an opportunity for the individual to agree or object, including notification to family members, personal representatives, or others responsible for the care of the individual).
  b) National security or intelligence purposes under 164.512(k)(2) (disclosures not requiring consent, authorization, or an opportunity to object, see chapter 16).
  c) Those made to correctional institutions or law enforcement officials under 164.512(k)(5) (disclosures not requiring consent, authorization, or an opportunity to object).
  d) Those made prior to April 14, 2003.

  After receipt of a valid, written request for non-routine accounting, we will provide the accounting within 60 days. The accounting will include the date of each disclosure, the name and address of the entity who received the health information, a brief description of the information disclosed, and a brief statement of the purpose of the disclosure that informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization, or a copy of a written request for disclosure.

- **You have the right to revoke your consent or authorization to use or disclose health information, except to the extent that we have already taken action in reliance on the consent or authorization.**

If you believe your privacy rights have been violated, you can file a complaint with DCCCA Behavioral Health Services Executive Director or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION WE MAINTAIN. SHOULD WE CHANGE OUR INFORMATION PRACTICES, YOU HAVE THE RIGHT TO REQUEST A COPY OF THE NEW NOTICE.

HOW TO CONTACT US: If you have questions about this policy, please write or call:
Director of Behavioral Health Services
DCCCA
3312 Clinton Parkway
Lawrence, KS 66047
1.785.841.4138

DCCCA
IMPROVING LIVES

Notice adopted April 14, 2003.

Revised December, 2016

Behavioral Health Services

Consent to Treatment and for Use and Disclosure of Individually Identifiable Health Information

Client Name: _____ Client ID: _____

I consent to treatment and services delivered by the clinical staff of DCCCA Behavioral Health Services. I also understand that treatment and services are not an exact science and may involve risks. I understand there is no guarantee that the outcome of my treatment may be what I want it to be.

I understand that as a part of my healthcare, DCCCA Behavioral Health Services receives, originates, maintains, discloses, and uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. I understand that DCCCA Behavioral Health Services and its physicians, other health care professionals, and staff may use this information to perform the following tasks:

- Diagnose my medical/psychiatric/psychological condition
- Plan my care and treatment
- Communicate with other health professionals within DCCCA Behavioral Health Services concerning my care
- Disclose Protected Health Information (PHI) to insurance companies and other party payors or agents, to the extent necessary to collect payment for treatment and services rendered by DCCCA Behavioral Health Services
- Conduct routine health care operations, such as quality assurance, utilization review (the process of monitoring the necessity for, the appropriateness of, and the quality of care provided) and peer review (the process of monitoring the effectiveness of health care personnel)

I have received a copy of the **DCCCA Behavioral Health Services'** ***Notice of Information Practices*** that explains the uses and disclosures that DCCCA Behavioral Health Services may make with respect to my individually identifiable health information. I understand that I have the right to review the Notice before signing this consent. DCCCA Behavioral Health Services has afforded me sufficient time to review this Notice and has answered any questions that I have to my satisfaction. I also understand that DCCCA Behavioral Health Services cannot use or disclose my individually identifiable health information other than as specified on the Notice. I also understand, however, that DCCCA Behavioral Health Services reserves the right to change its notice and the practices detailed therein prospectively.

I understand that I do not have to consent to the use or disclosure of my individually identifiable health information for treatment, payment, and health care operations, but that if I do not consent, DCCCA Behavioral Health Services may refuse to provide me health care services unless applicable state or federal law requires DCCCA Behavioral Health Services to provide such services.

I understand that I have the right to request restrictions/objections on the use or disclosure of my individually identifiable health information to carry out treatment, payment or health care operations. I further understand that DCCCA Behavioral Health Services is not required to agree to the requested restriction but that, if it does agree, it must honor the restriction unless I request that it stop doing so or DCCCA Behavioral Health Services notifies me that it is no longer going to honor the request.

I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that DCCCA Behavioral Health Services has already taken action in reliance on my earlier effective consent. I have been informed if I have concerns about the protection of my rights, including my privacy rights, I may contact DCCCA Behavioral Health Services Director or the regional consultant with the Kansas Department of Aging and Disability Services.

_____ _____

Client/Guardian Signature Date

_____ _____

Witness Signature Date

DCCCA, INC

Authorization for Requesting and Disclosing Protected Health Information

Name:	Date of Birth:	DCCCA#:

I hereby authorize _____, an employee of DCCCA, Inc. to:

☐ Disclose information to ☐ Request information from ☐ Exchange information with

Name:
Address:
City: State: Zip Code:
Phone (optional): Fax (optional):

Check and initial type of information authorized to be requested or disclosed:

- ☐ Admission Intake
- ☐ Discharge Summary
- ☐ Psychological Evaluation Report
- ☐ Psychiatric Evaluation Report
- ☐ Substance Abuse Evaluation Report
- ☐ Presence in Program
- ☐ School Progress Reports/Records
- ☐ Other, specify:
- ☐ Other, specify:
- ☐ Medical History, Lab results
- ☐ Diagnosis
- ☐ Treatment Plan
- ☐ Summary of Treatment
- ☐ Progress Notes
- ☐ Verbal or written Progress Reports/Consultations
- ☐ HIV/AIDS Information
- ☐ Child Respite Information

All of the records authorized above may be requested or disclosed unless restrictions are specified here:

I understand that this information will be used for the purpose of:

☐ Assessment ☐ Treatment ☐ Case Coordination ☐ Follow-up Care

☐ Other (specify): Case Management

This authorization shall remain in effect, as of _____ (date of customer/legal guardian signature) until _____ (date). **If this item is left blank, the authorization shall remain effective for 365 days after the signature date listed below.**

I, the undersigned, have read the above and authorized the request or disclosure of Protected Health Information (PHI) as described.
I understand that services are not conditioned upon the execution of this authorization.
I understand that DCCCA cannot assure that the recipient will maintain confidentiality of the information authorized to be released.
I understand that I may revoke this authorization at any time by providing written notice to my treatment provider except to the extent that action has been taken in reliance on the authorization.

Signature of Customer/Legal Guardian	Signature of Witness
Printed Name of Legal Guardian and Relationship	Date

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR, Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

DCCCA

Behavioral Health Services

Authorization of Disclosure and Consent for Release of Confidential Information

I, (client name) _____ DOB: _____

Client ID: _____ SSN: _____

authorize **DCCCA Behavioral Health Services**, located at _____, to release information and obtain information contained in my records to/from the following individual or organization and only under the conditions listed below:

Name of **EMERGENCY CONTACT** to whom disclosure is to be made: _____

_____

Address and phone number of emergency contact to whom disclosure is to be made:

_____

_____

Specific information to be disclosed: Information pertaining to emergency episode/event

The purpose and need for such disclosure: In the event that an emergency occurs and communication between parties is necessary

This consent to disclose may be revoked by me at any time EXCEPT: to the extent that action has been taken in reliance thereon. This release (unless expressly revoked earlier) expires upon: 90 days from the signature date.

Signature of client: _____ Date: _____

Signature of witness: _____ Date: _____

If applicable, signature of parent, guardian or legal representative:

Signature of representative: _____ Date: _____

Relationship: _____

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR, Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Behavioral Health Services

Fee Agreement

Client Legal First Name:

Client Legal Last Name:

Client Legal Middle Initial:

Address

Street 1:

Street 2:

APT/Suite:

City:

State/Province:

Zip:

DCCCA uses your past 90 days of financial information and the agency's sliding fee scale to determine fee information. Insurance co-pays and deductibles are your responsibility as required by your insurance company. DCCCA staff will inform you of those amounts once verified by the insurance company. If your insurance company denies reimbursement or you choose to pay out of pocket for your services, your fee(s) per session are:

Current verified income: $

Verified income is per: [X] Month [ ] Year

Number of persons dependent upon this income:

Primary Service/Modality:

Based on verified income shown above

Fee Per Session:

Secondary Service/Modality:

Based on verified income shown above

Fee Per Session:

Comments:

Fee Waived: [ ] No [ ] Yes

Fee Waiver Explanation:

If the fee has been waived, Program Coordinator must approve this form.

Customer Agreement

I understand that DCCCA will exhaust all efforts to bill third party funders. However, I may be responsible for deductible and co-pay amounts for which reimbursement is denied. I understand that DCCCA will bill me for charges identified as my responsibility on my insurance company's Explanation of Benefits. There charges may be in addition to the established co-pay.

I understand that I may not be eligible for other funding sources and all fees are ultimately my responsibility.

I agree to pay the fees documented above at the time of service and to pay for all charges billed to me as a result of my insurance company's Explanation of Benefits. I understand that DCCCA may refund payments I have made if the service is reimbursed by a third-party payer, or if I have paid for services in advance and cannot continue treatment for reasons beyond my control. I understand being asked to leave treatment for consistent non-compliance is not considered beyond my control.

I acknowledge that the fees and Customer Agreement were verbally explained to me by a DCCCA staff. I understand that failure to pay the agreed upon fees may result in DCCCA discharging me from treatment. I further understand that successful discharge may be delayed until services are paid in full.

Signature of Customer/Legal Guardian	Signature of Witness
Printed Name of Legal Guardian and Relationship	Date

Behavioral Health Services

Consent for Mental Health Treatment and Acknowledgement of Customer Rights and Responsibilities Receipt

I voluntarily give my consent for DCCCA, Inc. to provide intake/assessment and treatment services to myself, my child, my family or other (specify) _____.

I acknowledge that I have been given a copy of the DCCCA Customer Rights Statement and the Notice of Privacy Practices. I understand that I also have the Rights and Responsibilities afforded me by my insurance (KANCARE, private insurance) and that should I have further questions about this information, I may ask for assistance.

I understand that DCCCA will file claims with my insurance carrier, but that I am responsible for ensuring payment for services received at DCCCA.

I understand that as part of my healthcare, this organization originates and maintains health records and collects data that is used for Treatment, payment, Health Care Operations, Auditing and Research, and for reporting required intake/assessment data. These records may describe my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand and consent to the need and right of the organization to summon emergency medical service or transportation and to release appropriate information for such service or billing purposes.

I understand that I have the right to file a grievance if I am dissatisfied with the services I have received or if my legal rights have been infringed upon. I understand that a grievance should be reported in writing and that every grievance reported shall be thoroughly investigated.

I understand that this consent is voluntary and that I can withdraw my consent for treatment at any time.

_____

Client Name/Guardian (and relationship to client)

_____ _____

Client/Guardian Signature Date

_____ _____

Witness Signature Date

Behavioral Health Services

Customer Rights Statement

You have the right to:

- Receive quality care.
- Have service hours, service expectations, and service rules explained to you in a language that you can understand, and prior to services beginning.
- Be treated with courtesy, dignity, and respect including respect of ethnic, familial, and cultural diversity.
- Be informed about your service plan, the process by which it was developed, and participate in the development and modification of your service plan.
- Receive periodic review of your service plan.
- Ask and receive information regarding the name and qualifications of the DCCCA staff who are working with you.
- Have privacy during service sessions.
- Have all records kept confidential to the extent provided by law.
- Obtain or review your records by contacting your assigned DCCCA staff in writing thirty days (30) in advance (writing assistance will be provided if needed).
- Receive services in a place free of physical barriers and without regard to race, sex, religious affiliation, ethnicity, or sexual orientation.
- Have any fees for services fully explained, including the amount to be charged, when fees may be charged, changed, reduced, refunded or waived, schedules and manners of payment and the potential consequences for not paying fees.
- Make a formal complaint about a condition or incident which violates your rights as a DCCCA Customer. You have the right to have your complaint reviewed by someone other than the individual involved in your complaint, and to have your complaint responded to in writing, in a timely manner.

Making a Complaint:

Any customer has the right to make complaints, without interference or retaliation, about conditions or incidents that are dangerous, inhumane, illegal, or that violate his or her rights.

If you wish to make a complaint, you may file a written report with the on-site Program Coordinator.

If your situation requires additional assistance, please forward your written complaint to: Quality Improvement Director, 3312 Clinton Parkway, Lawrence, Kansas 66047