VCS MENTAL HEALTH CLINIC
COUNSELING INTAKE

How did you hear about VCS Mental Health Clinic? _____

CLIENT DATA: (All information is confidential) Please print clearly

Name: _____

Address (Street & Number): _____

Address (City, State, Zip): _____

County of Residence: _____ Date of Birth: _____

Citizenship Status: ☐ US Citizen ☐ Green Card Holder ☐ Refugee
☐ Undocumented ☐ Prefer Not to Answer

Telephone Contact:	Telephone Number	May we call you here?	May we leave a message?
Home		☐ Yes ☐ No	☐ Yes ☐ No
Cell		☐ Yes ☐ No	☐ Yes ☐ No
Work		☐ Yes ☐ No	☐ Yes ☐ No

Which number above would you like appointment reminders sent to? ☐ Home ☐ Cell ☐ Work

Email address: _____ (please print clearly)

Do you have reliable transportation to get to/from appointments? ☐ Yes ☐ No

Emergency Contact: _____ Phone Number: _____

Ethnicity:
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer Not to Answer

Race:
☐ White ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander
☐ American Indian or Alaskan Native ☐ Asian ☐ Other ☐ Unknown
☐ Prefer Not to Answer

Are you part of a faith community? ☐ Yes ☐ No ☐ Prefer Not to Answer

If yes, which one? _____

Current Relationship Status:

☐ Single ☐ Married ☐ Couple Relationship ☐ Separated ☐ Divorced ☐ Widowed

How long: _____

Are you currently in counseling or therapy? ☐ Yes ☐ No

Other Medical/Mental Health Providers:

Name	Specialty	Address	Telephone

If you need additional room, please list on back.

Are you taking any medication: ☐ Yes ☐ No If yes, please list below

Medication	Dosage/Frequency	Name of Prescriber

If you need additional room, please list on back.

Name and Phone Number of Pharmacy: _____

Do you currently smoke? ☐ Yes ☐ No How much? _____

If yes, are you interested in quitting or reducing smoking? ☐ Yes ☐ No

VCS Mental Health Clinic Client Responsibilities

1. All counseling sessions are confidential.
   However, by law, VCS Mental Health Clinic has a legally mandated duty to warn if you are a danger to yourself or someone else.

2. If you need to cancel an appointment, VCS Mental Health Clinic must be notified at least 24 hours in advance. There may be a fee for late cancellations or no-shows.

3. If you miss an appointment, we will try to help you resolve any issues that are making it difficult to attend. If, despite this, you miss another consecutive appointment without good reason you may lose your recurring appointment. If you subsequently do not make and show for an appointment within two weeks, you may be discharged from the clinic.

4. There are NO weapons allowed on the premises of VCS. That includes anything that may be considered a weapon such as a pocket or utility knife. If you have a weapon, you will be asked to leave and your appointment will be rescheduled.

5. VCS Mental Health Clinic clients sometimes ask for referrals to other service providers and/or agencies. If we provide a list of suggestions, please use it as a guide. Any such referrals are not to be taken as endorsements.

I CERTIFY THAT I HAVE READ AND UNDERSTOOD THE ABOVE. I AGREE TO ABIDE BY THESE TERMS.

_____

PRINT NAME

_____ _____

SIGNATURE **DATE**

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
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?	☐	☐

Permission for use granted by Richard Brown, MD.

Rapid Opioid Dependence Screen (RODS)

Do not complete for children aged 11 or under

The following questions are about your prior use of drugs. For each question, please indicate "yes" or "no" as it applies to your drug use during the last 12 months.

1. Have you taken any of the following drugs?
    a. Heroin ○ Yes ○ No
    b. Methadone ○ Yes ○ No
    c. Buprenorphine ○ Yes ○ No
    d. Morphine ○ Yes ○ No
    e. MS CONTIN ○ Yes ○ No
    f. Oxycontin ○ Yes ○ No
    g. Oxycodone ○ Yes ○ No
    h. Other opioid analgesics (e.g., Vicodin, Darvocet, etc.) ○ Yes ○ No

If you answered yes to any of the above please proceed to the following questions:

2. Did you ever need to use more opioids to get the same high as when you first started using opioids?

○ Yes ○ No

3. Did the idea of missing a fix (or dose) ever make you anxious or worried?

○ Yes ○ No

4. In the morning, did you ever use opioids to keep from feeling "dope sick" or did you ever feel "dope sick"?

○ Yes ○ No

5. Did you worry about your use of opioids?

○ Yes ○ No

6. Did you find it difficult to stop or not use opioids?

○ Yes ○ No

7. Did you ever need to spend a lot of time/energy on finding opioids or recovering from feeling high?

○ Yes ○ No

8. Did you ever miss important things like doctor's appointments, family/friend activities, or other things because of opioids?

○ Yes ○ No

Created by Sandra A. Springer, MD

SBQ-R Suicide Behaviors Questionnaire-Revised

Patient Name _____ Date of Visit _____

Instructions: Please check the number beside the statement or phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself? (check one only)

- ☐ 1. Never
- ☐ 2. It was just a brief passing thought
- ☐ 3a. I have had a plan at least once to kill myself but did not try to do it
- ☐ 3b. I have had a plan at least once to kill myself and really wanted to die
- ☐ 4a. I have attempted to kill myself, but did not want to die
- ☐ 4b. I have attempted to kill myself, and really hoped to die

2. How often have you thought about killing yourself in the past year? (check one only)

- ☐ 1. Never
- ☐ 2. Rarely (1 time)
- ☐ 3. Sometimes (2 times)
- ☐ 4. Often (3-4 times)
- ☐ 5. Very Often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it? (check one only)

- ☐ 1. No
- ☐ 2a. Yes, at one time, but did not really want to die
- ☐ 2b. Yes, at one time, and really wanted to die
- ☐ 3a. Yes, more than once, but did not want to do it
- ☐ 3b. Yes, more than once, and really wanted to do it

4. How likely is it that you will attempt suicide someday? (check one only)

- ☐ 0. Never
- ☐ 1. No chance at all
- ☐ 2. Rather unlikely
- ☐ 3. Unlikely
- ☐ 4. Likely
- ☐ 5. Rather likely
- ☐ 6. Very likely

Informed Consent

CLINICIAN-CLIENT SERVICE AGREEMENT

Welcome to the VCS Mental Health Clinic. 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. It also includes an agreement and information regarding billing your insurance provider, if you have one. 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.

MENTAL HEALTH SERVICES

As a client in our clinic, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights of which you should be aware. Our clinic has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Mental health treatment 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 treatment often requires discussing the unpleasant aspects of your life. However, mental health treatment has been shown to have benefits for individuals. Treatment 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. Treatment requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The beginning of treatment 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 our work 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 us. If you have questions about our procedures, we should discuss them 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.

APPOINTMENTS

Appointments will ordinarily be 30-45 minutes in duration at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a

session, we ask that you provide us with 24 hours' notice. If it is possible, we will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL RECORDS

We are required to keep appropriate records of the mental health treatment services that we provide. Your records are maintained in a secure off-site database. We keep brief records noting that you were here, your reasons for seeking treatment, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records we receive from other providers, copies of records we send to others, and your billing records. These records are accessible by any of our clinic staff to ensure coordination of services (for example, if you see another clinician when your primary clinician is away, they will need to be able to access your records to review your treatment history and plan). 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 your clinician, or have them forwarded to another mental health professional to discuss the contents. If we refuse your request for access to your records, you have a right to have our decision reviewed by another mental health professional, which we will discuss with you upon your request. 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.

CONFIDENTIALITY

Our policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

PARENTS & MINORS

The clinic works with adults aged 18 and over, and with children and adolescents aged 10-17. For children and adolescents, the consent of a parent or guardian is required for outpatient mental health treatment unless other circumstance dictate otherwise. As much as possible, the clinic involves parents and guardians in the course of treatment of their child, noting that the decision as to how much to involve parents or guardians belongs to the child or adolescent client. While parents understandably want to be informed about what is being discussed in treatment, our experience is that children and adolescents usually need to maintain some privacy during the beginning of treatment in order to feel safe disclosing their concerns to the therapist. The objective of the clinic is to help as much as possible with the child eventually communicating these concerns to their parent or guardian.

CONTACTING US

Your clinician may not be able to answer the phone when they are with another client or otherwise unavailable. However, you can normally contact a receptionist during office hours and leave a message for your clinician or other staff. We will try to return your call as soon as possible, but it may take a day or two for non-urgent matters. If you do not hear from your clinician or your clinician is unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) contact your Local Hospital Emergency Room, or 2) call 911 and ask to speak to the mental health worker on call, or 3) call the Rockland County Behavioral Health Response Team at (845) 517-0400. We will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering in your clinician's absence.

OTHER RIGHTS

If you are unhappy with what is happening in treatment, please talk with your clinician so that they can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that we refer you to another clinician and are free to end treatment 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, or national origin. You have the right to ask questions about any aspects of treatment and about your clinician's specific training and experience. You have the right to expect that we will not have social or sexual relationships with current or former clients.

CONSENT TO TREATMENT

Your signature below indicates that you have read this Agreement and received the Notice of Privacy Practices and agree to their terms.

_____

Print Name

_____ _____

Signature Date

Insurance Assignment Form

INSURANCE AND FEES

Insurance is a contract between you and your insurance company. We file insurance claims and accept insurance assignment as a service to our clients. You are responsible for deductible and co-pays at the time of service. When payment is received from your insurance company, any differences will be settled. Payments may be made with cash, credit card, debit card, check, or money order. If your check is returned a $15 returned check fee will be assessed.

DISPUTES

You are ultimately responsible for payment of all fees. If, for any reason, your insurance claim is denied, you are responsible for the full amount of the bill. We will continue to assist you in receiving payment from your insurance company. We will work with the insurance company to sort out any confusion or questions that may arise, but will not enter into a "dispute" with an insurance company regarding deductibles, co-payments, covered charges, "usual and customary charges" etc. It will be your responsibility to resolve any type of dispute over payment with your insurer.

INFORMATION PROVIDED TO INSURANCE COMPANIES

Your insurance provider may require us to provide them with a clinical diagnosis in order to bill for services Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-5. There is a copy in our office and we will be glad to let you see it to learn more about your diagnosis, if applicable. We will also have to develop a treatment plan outlining the goals for treatment. This information is stored securely in an off-site database. We can provide you with copies of any insurance-related records at your request.

ASSIGNMENT AND RELEASE

I understand I am financially responsible for all charges whether or not paid by insurance. This form is also considered the "Authorization to Pay the Clinic". I hereby authorize payment directly to VCS Inc. of the insurance benefits otherwise payable to me. I grant authorization for VCS Inc. to release all information necessary to third party payers to secure payment of benefits. This is my "signature on file".

_____

Print Name

_____ _____

Signature Date

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name (Last, First, M.I.) "C" No.

Sex . . . . . Date of Birth . . . . . .

Facility Name VCS Mental Health Clinic Unit/Ward/Residence No.

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed:

Name and status as a client in the VCS Mental Health Clinic

Purpose or Need for Information:

1. This information is being requested:
   - ❑ by the individual or his/her personal representative for release to a person or entity with a demonstrable need for the information; or
   - ☑ Other (please describe) By VCS Mental Health Clinic
2. The purpose of the disclosure is (please describe):

To coordinate services with the Rockland Behavioral Health Response Team only at times when the clinic determines that you are at heightened risk of harm to self or others

From: Name, Address, & Title of Person/ Organization/Facility/Program Disclosing Information

VCS Mental Health Clinic
77 S Main St, New City, NY 10956

To: Name, Address, & Title of Person/Organization/Facility/ Program to Which this Disclosure is to be Made

***NOTE:** If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.*

Rockland County Behavioral Health Response Team

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. I understand that:

1. Only the information described in this form may be used and/or disclosed as a result of this authorization.
2. This information is confidential and is protected under federal privacy regulations (HIPAA) and the NYS Mental Hygiene Law and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with HIPAA, then it could be redisclosed and would no longer be protected by HIPAA. However, this information will still be protected under the NYS Mental Hygiene law, which prohibits this information from being redisclosed by anyone who receives it unless the redisclosure is permitted by the NYS law (Mental Hygiene Law §33.13).
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by *(insert name of facility/program)* VCS Mental Health Clinic . I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524 and NYS Mental Hygiene Law §33.16.

B-1. One-Time Use/Disclosure: I hereby permit the one-time use or disclosure of the information described above to the person/ organization/facility/program identified above.

My authorization will expire:

❑ When acted upon; ❑ 90 Days from this Date; ❑ Other _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

State of New York
OFFICE OF MENTAL HEALTH

Facility/Agency Name	Patient's Name (Last, First, M.I.)	"C"/Id. No.
VCS Mental Health Clinic		

B-2. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the person/organization/facility/program identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:

- ☑ When I am no longer receiving services from *(insert name of facility/program)* VCS Mental Health Clinic ;
- ❑ One year from this date;
- ❑ Other _____

C. Patient Signature: I certify that I authorize the use of my health information as set forth in this document.

_____ _____
Signature of Patient or Personal Representative Date

_____
Patient's Name (Printed)

_____
Personal Representative's Name (Printed)

_____
Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Authorization)*

D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

WITNESSED BY: _____
Staff person's name and title

Authorization Provided To: _____

Date: _____

To be Completed by Facility:

_____
Signature of Staff Person Using/Disclosing Information

_____
Title

_____
Date Released

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part I, to the Person/Organization/Facility/Program whose name and address is:

_____

_____

_____

I hereby refuse to authorize the use/disclosure indicated in Part I, to the Person/Organization/Facility/Program whose name and address is:

_____

_____

_____

_____ _____
Signature of Patient or Personal Representative Date

_____
Patient's Name (Printed)

_____
Personal Representative's Name (Printed)

_____
Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Revocation of Authorization)*

PLEASE KEEP THIS PAGE FOR YOUR INFORMATION

Clinic Hours: Monday-Friday 8:00AM-5:00PM (evenings by appointment)

To **CANCEL** an appointment, call VCS Mental Health Clinic at 845-634-5729. If you receive the voicemail, please speak slowly and clearly and leave the following information.

Your first & last name
Your phone number
Counselor name
Day and time of your appointment

Please note: Any calls made after 5pm will not be received until the following day.

If VCS Mental Health Clinic is closed and you are in crisis, you may call any of the following:

911: Fire/Police/Ambulance
(845) 517-0400: Rockland County Mobile Mental Health Crisis Unit
(845) 348-2345: Nyack Hospital Emergency Room
(845)368-5029: Good Samaritan Hospital Emergency Room (Suffern)
1-800-273-8355: The National Suicide Hotline

IF THE AGENCY IS CLOSED DUE TO WEATHER, THERE WILL BE A MESSAGE ON THE GENERAL PHONE NUMBER.

If you have any concerns regarding agency policies or procedures while in counseling at VCS Mental Health Clinic, please feel free to discuss them with your counselor or any member of the clinical staff.

Rockland County has two excellent information referral lines if you need help with food stamps, healthcare, housing, transportation, other programs in the county, discrimination assistance, criminal justice and legal services, etc. If you cannot find the help you need through these numbers you can speak to your counselor.

COMMUNITY SERVICE INFORMATION LINE – Dial 211

Hudson Valley Region 2-1-1
Get Connected. Get Answers.
Dutchess • Orange • Putnam
Rockland • Sullivan • Ulster • Westchester
United Way

VCS Inc.

Notice of Privacy Practices

Your Information.
Your Rights.
Our Responsibilities.

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.**

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

Our Uses and Disclosures

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

VCS Inc.
77 S Main St
New City, NY 10956

Tel: (845) 634-5729
Email: info@vcs-inc.org
Web: www.vcs-inc.org

For questions regarding any information in this pamphlet please contact VCS Executive Director Sarah Goforth at (845) 634-5729 ext 321

Effective 2/18/2015