Ur Space
at VCS

Forms for you to bring to your first visit

In this packet you will find some forms for you to fill out. You can do this by yourself or with the support of your parent or guardian. You should bring these to your first visit, or complete them now if you are getting these while waiting for your visit today.

If there is anything you are unsure about you can leave those questions blank and ask the clinician for help when you first meet. The clinician will have some other brief forms that they will explain to you and ask you to fill out at your first visit.

Here is the list of attached forms and what to do with them:

- Fill out the **Child / Adolescent Intake Form**
- Read and sign the **VCS Client Responsibilities** form
- Complete the **SBQ-R** questionnaire
- Complete the **CRAFFT** questionnaire
- Complete the **RODS** questionnaire

Here is the list of attached forms that are just for your information for you to keep:

- **Please Keep This Page for your Information**
- **Notice of Privacy Practices**

Ur Space at VCS

What to Expect

Hi and welcome to Ur Space.

If this is your first time in counseling, or even if you have been in counseling in the past, you probably have a bunch of questions about what it is and how it works at Ur Space. We hope to answer some of your questions here, but feel free to ask the clinician you meet at your first visit. We're always happy to help.

What is counseling?

Many things that happen to us can be hard to talk about with other people. Or sometimes even if we can talk about them, it's hard to know what to do about it.

Counseling is about having a relationship with someone who will help build a space with you where it is safe to talk about anything you want. Where you will never be judged or criticized. Where the counselor will help you to talk about what has happened, understand what you are feeling, and help find ways to get through it so you can get back to focusing on the things you want.

What kinds of things do people bring to counseling and how is counseling helpful?

People bring all kinds of things into counseling. Sometimes people have gone through an experience that has been very upsetting such as an unexpected death, parental divorce, a serious accident, or some kind of abuse. Sometimes people are feeling sad or anxious in a way that is making it hard to focus on school or friends and want help understanding why that is happening and what to do about it. Sometimes people feel badly about themselves or their bodies and want help with feeling better. Sometimes people are having a hard time making friends, dealing with bullying, or focusing on school. People bring in questions about sex and sexuality, such as wondering about being gay, lesbian, bisexual or transgender.

You can bring in anything you want to discuss and we will do our best to help.

What do I do in counseling? Is it just talking?

Basically, counseling is firstly about making a space where you can feel comfortable talking through the things you want to discuss. Then, if the problems are confusing, we try to make sense of how they came about or what caused them. Once we are able to make sense of them, then we work together to solve, overcome or learn ways to cope with them. It's a bit like if you go to the doctor, they first try to diagnose the problem and then work out how to cure it or help with the symptoms.

We like to be creative in how we help, so often that is in talking together, but we can also try things like meditation or relaxation skills, or use workbooks, or sometimes art. We will try to figure out together what works best for you and then do that.

How involved will my parents or guardians be?

This is also up to you. Counseling usually works best when parents or guardians are involved in some way since eventually the counseling will end and your parents or guardians may need to have been involved so they understand what you are experiencing and how to continue to help.

But there are situations where a person understandably may not wish to involve their parents or guardians, so the decision is up to you.

Is what I say in counseling kept private?

You are the person who gets to decide what you want to keep private and what you might want to share with other people, like your parents or guardians, or perhaps your teachers or school counselor.

Except in cases where we are concerned about you or someone else being in imminent danger or an adult causing serious harm to you, we will never tell anyone about anything you talk about in counseling without your permission and that decision is always up to you. As much as possible, when you want us to talk to another person, we will make sure you are there when we do so.

How often does counseling take place and when does it end?

This is also your decision. Typically people come to counseling about once per week for about 45 minutes each time, and counseling lasts around three months to a year. But you can come less or more frequently, and do less than three months or more than a year depending on your needs. You can also stop for a while and start back up again.

Can I say no to counseling?

Absolutely. Whether or not you decide to come to counseling is your choice.

We understand that you may have some mixed feelings about coming to counseling, especially if someone else is making you come. If this is you then we would encourage you to try it out for a month before making a decision – in other words know what you are saying no to or "try before you buy". We are very supportive of that and will always respect your decision to say no.

If you have any other questions, feel free to ask your counselor or call us at 845-634-5729

CHILD / ADOLESCENT INTAKE FORM

How did you hear about VCS? _____

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

Birth Name: _____

Chosen Name: _____

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Another_____

Address (Street & Number): _____

Address (City, State, Zip): _____

Safe to send mail to the above address? ☐ Yes ☐ No

County of Residence: _____ Date of Birth: _____

Citizenship: ☐ US Citizen ☐ Green Card ☐ 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

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

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: _____

Language spoken in your home:_____

School and grade: _____

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

Does anyone in the house vape or smoke cigarettes / tobacco products? □ Yes □ No

If yes, who? _____

FAMILY

Please list all the people who **live** in your house with you

NAME	RELATIONSHIP	GENDER	AGE

Please list all parents and siblings **not** living with you.

NAME	RELATIONSHIP	GENDER	AGE

Are all your parents/guardians living? ☐ Yes ☐ No

If no, who is not living and how old were you when they died? _____

_____

SELF-ASSESSMENT

If you are not comfortable answering some of these questions, feel free to leave them blank

General

1. What are your main concerns? _____

_____

2. What do you wish you could change in your life? (Check all that apply)

☐ Parents ☐ School ☐ Friends ☐ Myself ☐ Alcohol use
☐ Drug use ☐ Feeling I don't fit in ☐ Weight ☐ Other: _____

3. What are your hobbies? _____

_____

4. What jobs or careers are you interested in for the future? _____

Weight, Eating and Hunger

5. Do you deliberately limit how much you eat, or not eat for long periods of time, in order to affect your weight or appearance? ☐ Yes ☐ No

6. Does thinking about your weight or appearance make it difficult to concentrate on things you are interested in (e.g. conversations, school work)? ☐ Yes ☐ No

7. Do you sometimes purposefully throw up after eating? ☐ Yes ☐ No

8. Do you often feel hungry or not have enough food to eat? ☐ Yes ☐ No

Social & School

9. Are you satisfied with the quality of your friendships and the number of friends you have? ☐ Yes ☐ No

   What do you like to do with your friends? _____

   _____

10. Are you in a special program at school? ☐ Yes ☐ No

    If yes what program? _____

11. Do you have problems with teachers at school? ☐ Yes ☐ No

    If yes, what kinds of problems? _____

12. Do you get into fights at school or in the community? ☐ Yes ☐ No

13. Have you ever had problems with other students teasing, hitting, bullying (including online) or saying mean things to you? ☐ Yes ☐ No

14. Do you have connections to, or have had any problems with a gang? ☐ Yes ☐ No

15. Does using social media ever cause any problems for you (e.g. other people tell you they think it's a problem, or it gets in the way of schoolwork, or causes worry)? ☐ Yes ☐ No

Self-Injury

16. Have you ever cut or physically hurt yourself (e.g. bruising, scratching, burning, pinching, biting etc.) on purpose? ☐ Yes ☐ No

    If yes: When was last time? _____

    Does anyone know about it? ☐ Yes ☐ No

    If yes, who? _____

Sex & Gender

17. Do you think of yourself as:

☐ Straight or heterosexual ☐ Lesbian, gay, or homosexual

☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose

18. What is your current gender identity? (Check one):

☐ Male ☐ Female ☐ Intersex

☐ Transgender Male / Trans Man / Female-to-Male (FTM)

☐ Transgender Female / Trans Woman / Male-to-Female (MTF)

☐ Genderqueer, neither exclusively male nor female

☐ Additional Gender Category / (or Other), please specify: _____

☐ Choose not to disclose

19. What sex were you assigned at birth on your original birth certificate? (Check one):

☐ Male ☐ Female ☐Choose not to disclose

20. Would you like help with any issues related to your sexual orientation or gender identity?

☐ Yes ☐ No ☐ Unsure

21. Are you currently sexually active? ☐ Yes ☐ No

22. Have you had sex in the past? ☐ Yes ☐ No

23. Have you ever been pregnant or gotten someone pregnant? ☐ Yes ☐ No

24. Have you ever experienced any kind of sexual contact that you didn't want or which felt upsetting at the time or later?
☐ Yes ☐ No

25. Has anyone ever asked you to have sex in exchange for money or something else?
☐ Yes ☐ No

Trauma

26. Have you experienced any of the following events (check all that apply):

☐ Car accident

☐ Alcoholism or drug use in the home by a family member

☐ Sudden death of a family member or close friend

☐ Serious injury or life-threatening event

☐ Major medical operation or event

☐ Witnessing a violent upsetting event

☐ Physical, emotional, verbal or sexual abuse

☐ Bullying at school

☐ Incarceration of a parent or caregiver

☐ Major medical or mental health illness of a family member in the home'

☐ Separation or divorce of parents or caregivers

☐ Other event that is difficult to get out of your mind

VCS Client Responsibilities

1. All counseling sessions are confidential.
   However, by law, we have a legally mandated duty to warn if you are a danger to yourself or someone else.

2. If you need to cancel an appointment, please notify us 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 in session. 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. If you would like referrals to other service providers and/or agencies we are happy to help. 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 **DATE**

_____ _____

SIGNATURE **DATE**

The Suicide Behaviors Questionnaire-Revised (SBQ-R) - Overview

The SBQ-R has 4 items, each tapping a different dimension of suicidality:[1]

- Item 1 taps into lifetime suicide ideation and/or suicide attempt.
- Item 2 assesses the frequency of suicidal ideation over the past twelve months.
- Item 3 assesses the threat of suicide attempt.
- Item 4 evaluates self-reported likelihood of suicidal behavior in the future.

Clinical Utility

Due to the wording of the four SBQ-R items, a broad range of information is obtained in a very brief administration. Responses can be used to identify at-risk individuals and specific risk behaviors.

Scoring

See scoring guideline on following page.

Psychometric Properties[1]

	Cutoff score	Sensitivity	Specificity
Adult General Population	≥7	93%	95%
Adult Psychiatric Inpatients	≥8	80%	91%

1. Osman A, Bagge CL, Guitierrez PM, Konick LC, Kooper BA, Barrios FX., The Suicidal Behaviors Questionnaire-Revised (SBQ-R): Validation with clinical and nonclinical samples, Assessment, 2001, (5), 443-454.

SBQ-R - Scoring

Item 1: taps into *lifetime* suicide ideation and/or suicide attempts			
Selected response 1	Non-Suicidal subgroup	1 point	
Selected response 2	Suicide Risk Ideation subgroup	2 points	
Selected response 3a or 3b	Suicide Plan subgroup	3 points	_____
Selected response 4a or 4b	Suicide Attempt subgroup	4 points	**Total Points**

Item 2: assesses the *frequency* of suicidal *ideation* over the past 12 months			
Selected Response:	Never	1 point	
	Rarely (1 time)	2 points	
	Sometimes (2 times)	3 points	
	Often (3-4 times)	4 points	_____
	Very Often (5 or more times)	5 points	**Total Points**

Item 3: taps into the *threat of* suicide *attempt*		
Selected response 1	1 point	
Selected response 2a or 2b	2 points	_____
Selected response 3a or 3b	3 points	**Total Points**

Item 4: evaluates *self-reported likelihood* of suicidal behavior in the future			
Selected Response:	Never	0 points	
	No chance at all	1 point	
	Rather unlikely	2 points	
	Unlikely	3 points	
	Likely	4 points	
	Rather Likely	5 points	_____
	Very Likely	6 points	**Total Points**

Sum all the scores circled/checked by the respondents.
The total score should range from 3-18.

_____
Total Score

AUC = Area Under the Receiver Operating Characteristic Curve; the area measures discrimination, that is, the ability of the test to correctly classify those with and without the risk. [.90-1.0 = Excellent; .80-.90 = Good; .70-.80 = Fair; .60-.70 = Poor]

	Sensitivity	Specificity	PPV	AUC
Item 1: a cutoff score of ≥ 2				
• Validation Reference: Adult Inpatient	0.80	0.97	.95	0.92
• Validation Reference: Undergraduate College	1.00	1.00	1.00	1.00
Total SBQ-R : a cutoff score of ≥7				
• Validation Reference: Undergraduate College	0.93	0.95	0.70	0.96
Total SBQ-R: a cutoff score of ≥ 8				
• Validation Reference: Adult Inpatient	0.80	0.91	0.87	0.89

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

The CRAFFT Questionnaire (version 2.1)

To be completed by patient

Please answer all questions **honestly**; your answers will be kept **confidential**.

During the PAST 12 MONTHS, on how many days did you:

1.	Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Put "0" if none.	☐ # of days
2.	Use any **marijuana** (weed, oil, or hash by smoking, vaping, or in food) or "**synthetic marijuana**" (like "K2," "Spice")? Put "0" if none.	☐ # of days
3.	Use **anything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Put "0" if none.	☐ # of days

READ THESE INSTRUCTIONS BEFORE CONTINUING:

- **If you put "0" in ALL of the boxes above, ANSWER QUESTION 4, THEN STOP.**
- **If you put "1" or higher in ANY of the boxes above, ANSWER QUESTIONS 4-9.**

		No	Yes
4.	Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
5.	Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
6.	Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
7.	Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
8.	Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
9.	Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:
The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

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

PLEASE KEEP THIS PAGE FOR YOUR INFORMATION

Clinic Hours: Monday-Friday 8:00AM - 4:00PM (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

Ur Space at VCS

Forms to give to your parent or guardian

Please give these forms to your parent or guardian to fill out and bring them to your first visit. If there is a reason that you do not wish to involve your parent or guardian then please contact us prior to your first visit to discuss this.

Here is the list of attached forms for your parent or guardian to complete and what to do with them:

- Complete the **Parent / Guardian Intake Form**
- Sign the **Informed Consent** form
- Sign the **Insurance Assignment** Form
- Complete and sign the **Health-e-Connections** consent form
- Complete the **Health Screening** form
- Sign the **Telehealth Informed Consent** form
- Complete the **Authorization for Release of Information** form for any people or agencies you would like VCS to communicate with

PARENT / GUARDIAN INTAKE FORM

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

Adolescent/Child Name: _____

Address (Street & Number): _____

Address (City, State, Zip): _____

Safe to send mail to the above address? ☐ Yes ☐ No

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

Email address: _____ (please print clearly)

I am the child / adolescent's: ☐ Father ☐ Mother ☐ Legal guardian ☐ Other_____

Parent/Legal Guardian's Name:_____

In the case of divorced parents or legal guardianship for this child: By signing below, you acknowledge that as a Legal Custodian you have authority to consent to treatment for the above named adolescent/child.

Signature_____

Has your child received any previous mental health services? ☐ YES ☐ NO

With whom? _____

Who is your child's doctor or health care provider? _____

Please list any medications your child is taking: _____

Was your child ever hospitalized or in residential care? ☐ YES ☐ NO

Where & when? _____

Check any areas in which your child/teen is having problems:

☐ Weight	☐ Sexual Acting Out	☐ Mood	☐ Nightmares
☐ Health	☐ Language Skills	☐ School	☐ Self-Harm
☐ Nervous Habits	☐ Suicidal Thoughts	☐ Depression	☐ Drug Use
☐ Diet and Eating	☐ Friends/Getting Along with others	☐ Isolation	☐ Anxiety
☐ Anger	☐ Sleeping	☐ Social Media	☐ Hygiene
☐ Gender Identity/Sexual Orientation			

Briefly explain the items you checked:

_____

_____

_____

_____

_____

_____

Has your child been assessed for special needs services at their school? ☐ YES ☐ NO

If yes, are they currently in a special needs program? ☐ YES ☐ NO

Does anyone in the house vape or smoke cigarettes / tobacco products? ☐ YES ☐ NO

If yes, who? _____

Does anyone in the house use any of the following:

Illegal drugs? ☐ YES ☐ NO

Use of prescription drugs other than prescribed? ☐ YES ☐ NO

Alcohol to the extent that anyone considers it to be a problem? ☐ YES ☐ NO

If yes to any of the above, who? _____

VCS Mental Health Clinic
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 you and your child's 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

You and your child 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 and your child. 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 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 the part of the person receiving treatment. Success often means continuing to work on treatment issues outside of sessions.

The beginning of treatment will involve a comprehensive evaluation of your child's needs. By the end of the evaluation, we will offer your child some initial impressions of what our work might include. At that point, we will discuss their treatment goals and create an initial treatment plan. You child will need to evaluate this information and make their own assessment about whether they feel comfortable working with us. If you or your child have questions, we can discuss them whenever they arise. If doubts persist, we will be happy to help 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 your child and to them alone. If your child needs to cancel or reschedule a session, we ask for 24 hours' notice. If it is possible, we will try to find another time to reschedule the appointment. In addition, your child is responsible for coming to their session on time. If they are late, their appointment will still need to end on time.

PROFESSIONAL RECORDS

We are required to keep appropriate records of the services that we provide. The records are maintained in a secure off-site database. We keep brief records noting that your child was here, their reasons for seeking treatment, the goals and progress we set for treatment, their diagnosis, topics we discussed, their medical, social, and treatment history, records we receive from other providers, copies of records we send to others, and billing records. These records are accessible by any of our clinic staff to ensure coordination of services (for example, if your child sees another clinician when their primary clinician is away, they will need to be able to access the records to review the treatment history and plan). Except in unusual circumstances that involve danger to your child, your child has the right to a copy of their file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, we recommend that your child initially reviews them with their clinician, or has them forwarded to another mental health professional to discuss the contents. If we refuse a request for access records, your child has a right to have our decision reviewed by another mental health professional, which we will discuss with upon request. Your child also has the right to request that a copy of their file be made available to any other health care provider at their 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.

PARENT / CAREGIVER INVOLVEMENT IN TREATMENT

We welcome and encourage the involvement of parents and/or caregivers in treatment. Please first understand that the assurance of confidentiality of the information that your child shares in treatment is important to build a trusting relationship and to help them gradually open up about the issues they wish to discuss and about which they are seeking help. For this reason, we normally seek their consent before sharing any information with others, including parents and caregivers. Our experience is that an open consent under which we periodically or regularly disclose information to parents and caregivers without the permission of the child or adolescent in each instance tends to inhibit treatment and can make it harder for children and adolescents to open up and make progress. If there are issues about which you are concerned or you wish to know some specific information that

your child may be discussing in treatment, please let your child's clinician know and they will discuss your question with your child and then assist in arranging a conversation with you about that information with the participation of your child. We believe that the involvement of families in treatment and gradual building of trust and communication between families and the child or adolescent in treatment is usually essential to good outcomes, so our goal is to facilitate gradual sharing of information and the involvement of parents and caregivers in treatment wherever possible.

CONTACTING US

You child's 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 the 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 the clinician or the clinician is unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep your child 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 your child in advance of planned absences, and provide you and your child with the name and phone number of the mental health professional covering in a clinician's absence.

OTHER RIGHTS

If you or your child are unhappy with what is happening in treatment, please talk with the clinician so that they can respond to your concerns. Such comments will be taken seriously and handled with care and respect. Your child may also request that we refer them to another clinician and they are free to end treatment at any time. Your child has the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, or national origin. Your child has the right to ask questions about any aspects of treatment and about their clinician's specific training and experience. You child has 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, and consent to the treatment of your child in the clinic.

_____	_____	_____
Parent / Caregiver Printed Name	Signature	Date
_____	_____	_____
Child / Adolescent Printed Name	Signature	Date

VCS Mental Health Clinic
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".

_____

Insurance Policy-holder Printed Name

_____ _____

Insurance Policy-holder Signature Date

VCS Inc.

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

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 the Organization named above to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections 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 HealtheConnections website at http://healtheconnections.org/ .

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent *even* in a medical emergency.

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.

My Consent Choice. 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. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services

☐ **2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for the Organization named above to access my electronic health information through HealtheConnections.

☐ **3. I DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

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

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through HealtheConnections and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **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 Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through HealtheConnections. This includes information created before and after the date this form is signed. 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 include sensitive health conditions, including but not limited to:

Alcohol or drug use problems	HIV/AIDS
Birth control and abortion (family planning)	Mental Health conditions
Genetic (inherited) diseases or tests	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. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from HealtheConnections. You can obtain an updated list at any time by checking HealtheConnections website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through HealtheConnections for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **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 the Provider Organization directly by accessing their contact information on the HealtheConnections website at http://healtheconnections.org/; 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/.*

7. **Re-disclosure of Information.** Any organization(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.

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

9. **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. Organizations that access your health information through HealtheConnections 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.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form**.**

VCS MENTAL HEALTH CLINIC
Health Screening Form

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

Full Name (First MI Last): _____

Date of Birth: _____ Age: _____

Have you had any of the following symptoms in the last 12 months? Please Check.

☐ Ankle Swelling	☐ Coughing	☐ Hearing Loss	☐ Pulse Irregularity	☐ Vaginal Discharge
☐ Bed-wetting	☐ Cramp	☐ Memory Problems	☐ Seizures	☐ Vision Changes
☐ Blood in Stool	☐ Dark Urine	☐ Mole/Wart Changes	☐ Shakiness	☐ Vomiting
☐ Breathing Difficulty	☐ Diarrhea	☐ Muscle Weakness	☐ Sleep Problems	☐ Yellowing of the Eyes
☐ Chalky Stool	☐ Dizziness	☐ Nervousness	☐ Sweat (night)	☐ Other:
☐ Chest Pain	☐ Falling	☐ Nosebleeds	☐ Swollen Lymph Nodes	☐ Other:
☐ Confusion	☐ Gait Unsteadiness	☐ Numbness	☐ Tingling in Arms & Legs	☐ Other:
☐ Consciousness Loss	☐ Hair Change	☐ Panic Attacks	☐ Tremors	☐ Other:
☐ Constipation	☐ Lightheadedness	☐ Penile Discharge	☐ Urination Difficulty	☐ Other:

☐ Not Applicable **Immunizations** (required for individuals with Developmental Disability)

Immunizations – Has individual had or been immunized for the following diseases? Please check.

☐ Chicken Pox	☐ Diptheria	☐ German Measles	☐ Hepatitis B	☐ Measles
☐ Mumps	☐ Polio	☐ Small Pox	☐ Tetanus	☐ Other:

All Immunizations Up to Date? ☐ Yes ☐ No – Comments:

Family's perception of the individual's health problems

Have you / individual had any medical hospitalizations / surgical procedures in the last 3 years?

☐ No ☐ Yes If yes, complete information below.

Hospital	City	Date	Reason

VCS MENTAL HEALTH CLINIC
Health Screening Form

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

Full Name (First MI Last): _____

Date of Birth: _____ Age: _____

Have you/individual had any of the following health problems?

	Now	Past	Never	Family Hist	What Treatment Received and Date(s)
Abscesses	☐	☐	☐	☐	
Anemia	☐	☐	☐	☐	
Arthritis	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	
Bleeding Disorder	☐	☐	☐	☐	
Blood Pressure (high or low)	☐	☐	☐	☐	
Bone/Joint Problems	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	
Cirrhosis/Liver Disease	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	
Drug Overdose	☐	☐	☐	☐	
Endocarditis	☐	☐	☐	☐	
Epilepsy/Seizures	☐	☐	☐	☐	
Eye Disease/Difficulties	☐	☐	☐	☐	
Fibromyalgia/Muscle Pain	☐	☐	☐	☐	
Headaches	☐	☐	☐	☐	
Head Injury/Brain Tumor	☐	☐	☐	☐	
Hearing Problems/Deafness	☐	☐	☐	☐	
Heart Disease	☐	☐	☐	☐	
Hepatitis (specify type)	☐	☐	☐	☐	
Kidney Disease	☐	☐	☐	☐	
Lung Disease	☐	☐	☐	☐	
Menstrual Pain	☐	☐	☐	☐	
Oral Health/Dental	☐	☐	☐	☐	
Sickle Cell Anemia or Trait	☐	☐	☐	☐	
Stomach/Bowel Problems	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	
Thyroid	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	
AIDS/HIV	☐	☐	☐	☐	
Sexually Transmitted Disease	☐	☐	☐	☐	
Eating Disorder	☐	☐	☐	☐	
Sleep Difficulties	☐	☐	☐	☐	
Other	☐	☐	☐	☐	
Other	☐	☐	☐	☐	

Please note the family history details of any of the above conditions and individual's relationship to that family member:

VCS MENTAL HEALTH CLINIC
Health Screening Form

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

Full Name (First MI Last): _____

Date of Birth: _____ Age: _____

Allergies / Drug Sensitivities

☐ None
☐ Food (specify):
☐ Medicine (specify):
☐ Other (specify):

For Women Only

Currently pregnant? If yes, expected delivery date. ☐ No ☐ Yes -	**Receiving pre-natal healthcare? If yes, indicate provider.** ☐ No ☐ Yes -
Are you currently breastfeeding? ☐ No ☐ Yes	**Any significant pregnancy history?** ☐ No ☐ Yes – If yes, explain.
Last Menstrual Period Date:	

Last Examination

Doctor's Name:	**Date:**	**Phone #:**
Dentist's Name:	**Date:**	**Phone #:**
Specialist's Name/Specialty:	**Date:**	**Phone #:**
Specialist's Name/Specialty:	**Date:**	**Phone #:**

Height:	**Weight:**

Nutritional Screening (please check)

☐ No Problem	**Eating** ☐ More ☐ Less ☐ Not Eating	**Drinking** ☐ More ☐ Less	**Appetite** ☐ Increased ☐ Decreased
☐ Nausea	☐ Vomiting	☐ Trouble Chewing or Swallowing	
Special Diet		**Other**	

Pain Screening

Does pain currently interfere with activities? ☐ No ☐ Yes – If yes, how much does it interfere with these activities (please check) ☐ Not at All ☐ Mildly ☐ Moderately ☐ Severely ☐ Extremely
Please indicate the source of the pain:
If completed by individual/family/guardian/staff, please sign and date below: **Completed By – Print Name:** **Signature:** **Date:**

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

VCS MENTAL HEALTH CLINIC
Health Screening Form

Full Name (First MI Last): _____

Date of Birth: _____ Age: _____

Actions, Recommendations and Referrals by Medical Reviewer

Was assessment completed face-to-face? ☐ No ☐ Yes

Specify Action(s) Taken:

Blood work ordered? (Complete Blood Count, Metabolic Panel, Lipids, Thyroid Function Test) ☐ No ☐ Yes
If no, why not? :

Other tests ordered? ☐ No ☐ Yes – If yes, specify tests:

Recommended For Clinic

Blood Pressure: **Abdominal girth:** **BMI:** **Temperature:** **Pulse:** **Respiration:**

Does individual have a health care proxy? : ☐ No ☐ Yes
Does individual have an advanced directive? : ☐ No ☐ Yes

Recommendations or referrals made:

☐ Primary Care Physician:
☐ Healthcare Agency:
☐ Specialty Care:
☐ Other (specify):
☐ No Referral Needed

Comments:

Recommendations shared with individual?
☐ No ☐ Yes If yes, individual's response:

If not, how will recommendations be shared with individual? :

Completed by:	**Date:**

VCS Informed Consent to Participate in Telemedicine Services

I, _____, have been asked to receive behavioral health services via telemedicine. I have been informed of my diagnosis and proposed telemedicine treatment plan. I understand that I will be receiving health care services through interactive videoconferencing equipment.

I understand that, at this time, there are no known risks involved with receiving my care in this way. Some of those risks may include but not limited to:

- Loss of transmission
- Crisis response times
- Confidentiality concerns

VCS policies and procedures regarding telehealth address many concerns and plan for contingencies but do not cover every scenario.

I understand that the equipment will be shown to me and I will see how it works before I receive any services. I understand that my participation in telemedicine is voluntary and I may refuse to participate or decide to stop participation at any time, verbally or in writing. I understand that my refusal to participate or decision to stop participation will be documented in my medical record. I have been informed of the potential consequences of my revocation of informed consent to treatment.

I understand that my privacy and confidentiality will be protected. I also understand that the likelihood of a videoconference being intercepted by an outsider is similar to the potential interception of a phone call. When I am receiving services via telemedicine, I will be notified as to who is in the room at the remote site. However, the services that we use, namely Clocktree, has been properly vetted, and meets all HIPAA and HITECH requirements pertaining to privacy and security.

I understand that the health care providers at both my location and the remote video site will have access to any relevant medical information about me including any psychiatric and/or psychological information, alcohol and/or drug abuse, and mental health records.

I have read this document and I hereby consent to participate in receiving behavioral health services via telemedicine under the terms described above. I understand this document will become a part of my medical record.

Please check the appropriate box below.

☐ I agree to participate in and receive behavioral health services via telemedicine.

☐ I have chosen not to participate in the telemedicine sessions.

_____ _____

Behavioral Health Recipient/Guardian Printed Name Signature

_____ _____

Witness Signature Date

AUTHORIZATION FOR RELEASE OF INFORMATION

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

Sex Date of Birth

Facility Name 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:

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) _____
2. The purpose of the disclosure is (please describe):

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

_____
_____
_____

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.*

_____
_____
_____

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)* _____ . 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_____

Continue on Next Page ➔

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.

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)* _____ ;
- ❑ 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)*