

THE COMMUNITY YMCA NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

This Notice is being provided to you on behalf of **The Community YMCA** with respect to services provided at our various program sites (collectively referred to herein as “We” or “Our”). We understand that your treatment information is private and confidential. Further, we are required by law to maintain the privacy of “protected treatment information.” “Protected health information” includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care. **The Community YMCA** will share protected health information with one another, as necessary, to carry out treatment, payment or health care operations relating to the services to be rendered at **The Community YMCA** programs.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a written copy of our most current privacy notice from your program.

PERMITTED USES AND DISCLOSURES WITH CONSENT

We can use or disclose your protected health information for purposes of *treatment and payment*. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

- *Treatment* means the provision, coordination or management of your health care, including consultations between health care providers relating to your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to contact a physical therapist to create the exercise regimen appropriate for your treatment.
- *Payment* means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage and other utilization review activities. For example, prior to providing health care services, we may need to provide information to your Third Party Payor about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the Third Party Payor for the services rendered to you, we can provide the Third Party Payor with information regarding your care if necessary to obtain payment. Federal or State law may require us to obtain a written release from you prior to disclosing certain specially protected health information for payment purposes, and we will ask you to sign a release when necessary under applicable law.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

In addition to using and disclosing your information for treatment and payment, we may use your protected health information in the following ways:

- We may contact you to provide appointment reminders for treatment.
- We may contact you to tell you about or recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you.
- We may use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. If you are not present or otherwise available, we will determine whether a disclosure to identified party is in your best interest, taking into account the circumstances and based upon our professional judgment.
- We may contact you as part of our fund-raising and marketing efforts as permitted by applicable law.
- We will use or disclose protected health information about you when required to do so by applicable law.

SPECIAL SITUATIONS

Subject to the requirements of applicable law, we will make the following uses and disclosures of your protected health information:

- Information may be shared with another mental health agency in accordance with HIPAA [10:37-6.79(a)]
- If a consumer is psychiatrically evaluated by a psychiatric screening center, information may be released to the screening center staff to facilitate the evaluation [10:37-6.79(a)3]
- To comply with any Federal or State law requiring State law requiring the release of information [10:37-6.79(a)3]
- If officials within the offices of the State Medical Examiner or a County Medical Examiner making investigations and conducting autopsies request the information [10:37-6.79(b)4]
- Non-specific information may be provided to a family member or friend if the consumer does not object [N.J.A.C. 10:37-6.79(e)]; To a consumer’s personal physician to benefit the consumer {N.J.A.C. 10:37-6.79(f)}
- Medication information may be released to the consumer’s pharmacy, and
- Release of information about any consumer under the age of 14 requiring authorization will be determined by the consumer’s parent or guardian [N.J.A.C. 10:37-6.79(a)1-3]
- Public Health Activities. We may disclose health information about you for public health activities, including disclosures:
 - If a consumer reveals that child abuse may have taken place, the NJ Division of Child Permanency and Protection must be notified [10:37-108(b)]

- If the consumer is a minor suspected of being abused, the record may be released to DCPD [10:37-6.79(c)]
- If a consumer reveals abuse or exploitation in a rooming/boarded/nursing home, this shall be reported to the County Welfare Agency [10:37-108(b)]
- to report births and deaths to the Division of Mental Health and Addictions services;
- to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if the patient agrees or when required by law.
- Health Oversight Activities.
 - When the Office of Licensing or Medicaid conducts a review, a consumer's clinical record may be reviewed [10:37-6.79(b)2]
 - An accreditation reviewer may look at a consumer's record [10:37-6.79(b)3]
- Lawsuits and Disputes.
 - If a judge orders the release of information to a court [10:37-6.79(a)2]
- Serious Threats.
 - If a consumer voices a threat against a specific individual or group, that individual or person responsible for the group (e.g. school principal if the threat was made against a school) must be notified. Police may be notified if the intended victim cannot be contacted. [practitioners have a duty to warn]

Note: HIV-related information, genetic information, alcohol and/or substance abuse records, and other specially protected health information may enjoy certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections.

OTHER USES OF YOUR HEALTH INFORMATION

Other uses and disclosures of protected health information not covered by this notice or the laws that apply to us will be made only with your permission in a written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment and payment. However, we are not required to agree to your request. To request a restriction, you must make your request in writing to Program Supervisor at the program serving you.
2. You have the right to reasonably request to receive confidential communications of protected health information by alternative means or at alternative locations. To make such a request, you must submit your request in writing to the Program Supervisor at the program serving you.
3. You have the right to inspect and copy the protected health information contained in your medical and billing records and in any other clinical records used by us to make decisions about you, except:
 - (i) for psychotherapy notes, which are notes that have been recorded by a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record;
 - (ii) for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
 - (iii) for protected health information involving laboratory tests when your access is restricted by law;
 - (iv) if you are a prison inmate, obtaining a copy of your information may be restricted if it would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you;
 - (v) for protected health information contained in records kept by a Federal or State agency or contractor when your access is restricted by law; and
 - (vi) for protected health information obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information.
4. In order to inspect and copy your health information, you must submit your request in writing to the Program Supervisor at the program serving you. If you request a copy of your health information, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.
5. We may also deny access to protected health information if:
 - (i) a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person;
 - (ii) the protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
 - (iii) the request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person.

(iv) If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law.
6. You have the right to request an amendment to your protected health information, but we may deny your request for amendment, if we determine that the protected health information or record that is the subject of the request:
 - (i) was not created by us, unless you provide a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment;
 - (ii) is not part of your medical or billing records or other records used to make decisions about you;
 - (iii) is not available for inspection as set forth above; or
 - (iv) is accurate and complete.
7. In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records. In order to request an amendment to your health information, you must submit your request in writing to the Program Supervisor of the program servicing you, along with a description of the reason for your request.

8. You have the right to receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you for the six years prior to your request, except for disclosures:
- (i) to carry out treatment, payment and health care operations as provided above;
 - (ii) incident to a use or disclosure otherwise permitted or required by applicable law;
 - (iii) pursuant to a written authorization obtained from you;
 - (iv) to persons involved in your care or for other notification purposes as provided by law;
 - (v) for national security or intelligence purposes as provided by law;
 - (vi) to correctional institutions or law enforcement officials as provided by law;
 - (vii) as part of a limited data set as provided by law; or

To request an accounting of disclosures of your health information, you must submit your request in writing to the Program Supervisor for the program servicing you. Your request must state a specific time period for the accounting (e.g., the past three months). The first accounting you request within a twelve (12) month period will be free. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

COMPLAINTS

If you believe that your privacy rights have been violated, you should immediately contact the Program Supervisor of the program servicing you. We will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

CONTACT PERSON

If you have any questions or would like further information about this notice, please contact the Program Supervisor of the program servicing you at 732-290-9040.

The Community YMCA Counseling & Social Services

HIPAA ACKNOWLEDGMENT

I, _____, acknowledge that I have been provided with a copy of the
The Community YMCA's HIPAA privacy notice.

Client Signature

Date

Staff Signature

Date

The Community YMCA Counseling & Social Services

COUNSELOR CREDENTIAL DISCLOSURE FORM

This disclosure form is to verify awareness that clinical services are being provided by a qualified clinician, who may be in the process of obtaining credentials toward licensure or certification in the Mental Health and/or Substance Abuse field.

I, the undersigned, have been informed that the services, I am currently receiving at The Community YMCA Counseling & Social Services, may be provided by a Counselor with an Intern status under the direct supervision of a qualified Supervisor as defined by the licensing standards 13:34C-6.2c for LCADC, 13:34-13 for LAC / LPC, and 13:44G-7.3 for LSW / LCSW.

I, the undersigned, have been informed the counselor providing services may be receiving clinical supervision towards licensure as defined by the licensing standards 13:34C-6.2c for LCADC, 13:34-13 for LAC / LPC, and 13:44G-7.3 for LSW / LCSW from a qualified supervisor not employed by The Community YMCA.

This disclosure shall be kept as part of my clinical record.

Client Signature: _____

Date: _____

Parent Signature (required under 18): _____

Date: _____

Counselor Signature: _____

Date: _____

The Community YMCA Counseling & Social Services

Records Release Authorization

I, _____, hereby consent to the release of information between

The CYMCA Counseling & Social Services & _____
(Name of Individual(s) / Agency making the disclosure)

Permission is granted to release the following information from the records of:

(Client Name)

(Client Date of Birth)

___ Pertinent DCP&P Information
___ Progress/Disposition of Treatment
___ Psychological Tests
___ Psychiatric Evaluation

___ Final Summary
___ Treatment and Discharge Plans

___ Educational Progress/CST Records
___ Drug/Alcohol Evaluation
___ CCIS Discharge Summary
___ Legal Disposition: Courts,
Probation/Parole Records
___ Other: _____

The purpose or need for such disclosure is: _____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2 and the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR, Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent *in writing* at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows on:

(Expiration occurs upon termination of services, specified date, event or condition and no more than 12 months with the exception of the FPS program where follow up occurs 3, 6 and 12 months post discharge. Client Initial _____)

I understand that generally The Community YMCA Counseling & Social Services may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Signature of Client or Person Authorized by Law to Give Consent

Date

Signature of Minor (13 years of age and over)

Date

Signature of Witness

Date

The Community YMCA Counseling & Social Services

We build strong kids, strong families, strong communities.

NOTICE TO ALL CLIENTS

Due to the scheduling restrictions of our clinicians and staff Psychiatrist, appointments may only be cancelled when an emergency situation exists.

In the event that an appointment needs to be cancelled you are required to provide 24 hours notice that you are cancelling an appointment with your Counselor or Psychiatrist. Failure to do so will result in being charged a fee of \$25, regardless of whether you are covered by insurance or another source of payment.

With the proper notice, clinical counseling and psychiatric openings may be rescheduled.

Appointments that are repeatedly missed may result in the termination of clinical counseling or psychiatric services with this agency.

The Community YMCA Counseling & Social Services

CLIENT BILL OF RIGHTS

(N.J.A.C. 10:161B-16.2 & N.J.A.C. 10:37-4.5)

1. The right to be informed of these rights, as evidenced by the client's written acknowledgment or by documentation by staff in the clinical record that the client was offered a written copy of these rights and given a written or verbal explanation of these rights in terms the client could understand.
2. The right to be notified of any rules and policies the program has established governing client conduct in the facility.
3. The right to be informed of services available in the program, the names and professional status of the staff providing and/or responsible for the client's care, and fees and related charges, including the payment, fee, deposit, and refund policy of the program and any charges for services not covered by sources of third-party payment or the program's basic rate.
4. The right to be informed if the program has authorized other health care and educational institutions to participate in his or her treatment, the identity and function of these institutions, and to refuse to allow their participation in his or her treatment.
5. The right to receive from his or her physicians or clinical practitioner(s) an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risks(s) of treatment, and expected result(s), in terms that he or she understands.
 - a. If, in the opinion of the medical director or director of substance abuse counseling, this information would be detrimental to the client's health, or if the client is not capable of understanding the information, the explanation shall be provided to a family member, legal guardian or significant other, as available.
 - b. Release of information to a family member, legal guardian or significant other, along with the reason for not informing the client directly, shall be documented in the client's clinical record.
 - c. All consents to release information shall be signed by client or their parent, guardian or legally authorized representative.
6. The right to participate in the planning of his or her care and treatment, and to refuse medication and treatment. A client's refusal of medication or treatment shall be documented in the client's clinical record.
7. The right to participate in experimental research only when the client gives informed, written consent to such participation, or when a guardian or legally authorized representative gives such consent for an incompetent client in accordance with law, rule and regulation.
8. The right to voice grievances or recommend changes in policies and services to program staff, the governing authority, and/or outside representatives of his or her choice either individually or as group, free from restraint, interference, coercion, discrimination, or reprisal.
9. The right to be free from mental and physical abuse, exploitation, and from use of restraints.
10. A client's ordered medications shall not be withheld for failure to comply with facility rules or procedures, unless the decision is made to terminate the client in accordance with this chapter; medications may only be withheld when the facility medical staff determines that such action is medically indicated.
11. The right to confidential treatment of information about the client. Information in the client's clinical record shall not be released to anyone outside the program without the client's written approval to release the information in accordance with Federal statutes and rules for the Confidentiality of Alcohol and Drug Abuse Client Records at 42 U.S.C. §§290dd-2, and 290ee-2, and 42 CFR Part 2 §§2.1 et seq., and the provisions of the Health Insurance Portability and Accountability Act (HIPAA) at 45 CFR Parts 160 and 164, unless the release of the information is required and permitted by law, a third-party payment contract, a peer review, or the information is needed by DAS for statutorily authorized purposes. The program may release data about the client for studies containing aggregated statistics only when the client's identity is protected and masked.
12. The right to be treated with courtesy, consideration, respect, and with recognition of his or her dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The client's privacy also shall be respected when program staff are discussing the client with others.
13. The right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any client.
14. The right to not be discriminated against because of age, race, religion, sex, nationality, sexual orientation, disability (including, but not limited to, blind, deaf, hard of hearing), or ability to pay; or to be deprived of any constitutional, civil, and/or legal rights. Programs shall not discriminate against clients taking medications as prescribed.
15. The right to be transferred or discharged only for medical reasons, for the client's welfare, that of other clients or staff upon the written order of a physician or other licensed clinician, or for failure to pay required fees as agreed at time of admission (except as prohibited by sources of third-party payment). Transfers and discharges, and the reasons therefore, shall be documented in the client's clinical record. If a transfer or discharge on a non-emergency basis is planned by the outpatient substance abuse treatment program, the client and his or her family shall be given at least 10

- days advance notice of such transfer or discharge, except as otherwise provided for in N.J.A.C. 10:161B-6.4(c).
16. The right to be notified in writing, and to have the opportunity to appeal, an involuntary discharge.
 17. The right to have access to and obtain a copy of his or her clinical record, in accordance with the program's policies and procedures and applicable Federal and State laws and rules.
 18. Notice of the client's rights set forth in this chapter and any rules governing the conduct of clients with respect to an agency shall be given to each client within five days of admission. Such notice shall be in writing, and shall be supplemented by an offer to discuss or explain the written description. Explanations shall be in a language which the client understands. If the client cannot read the provisions of the notice, it shall be read to him/her. In the case of an adjudicated incompetent client, the above shall be followed for the client's guardian. Receipt of the written notice shall be documented in the client's file.
 19. If the client or guardian refuses to acknowledge receipt of the notice, the person delivering the notice shall document this in the client's file.
 20. Subject to any other provisions of law, no client shall be deprived of any civil right solely by reason of his/her receiving mental health services, nor shall such services modify or vary any legal or civil right of any client.
 21. No client may be presumed to be incompetent because she/he has been examined or treated for mental illness, regardless of whether such evaluation or treatment was voluntarily or involuntarily received.
 22. All funded mental health programs shall provide their clients with the following rights,
 - a. The right to be free from unnecessary or excessive medication. (See N.J.A.C. 10:37-6.54).
 - b. The right to not be subjected to non-standard treatment or procedures, experimental procedures or research, psycho-surgery, sterilization, electro-convulsive therapy or provider demonstration programs, without written informed consent, after consultation with counsel or interested party of the client's choice. (See N.J.A.C. 10:37-6, Article XV.) If a client has been adjudicated incompetent, authorization for such procedures may be obtained only pursuant to the requirements of N.J.S.A. 30:4-24.2d.
 - c. The right to treatment in the least restrictive setting, free from physical restraints and isolation (See N.J.A.C. 10:37-6, Article XV.)
 - d. The right to be free from corporal punishment.
 - e. The right to privacy and dignity.
 - f. The right to the least restrictive conditions necessary to achieve the goals of treatment/services.

CLIENT GRIEVANCE PROCEDURE

All clients have a right to have grievances reviewed in an impartial, non-judgmental manner. Grievances may be initially discussed between the client and staff member, or the client may go to any advocacy program listed below first. If no resolution is reached between the client and staff member, the client should submit a written grievance to the program Supervisor. The Supervisor will respond in writing or by phone within 5 working days. If these steps do not meet the client's needs, the client may request a meeting with the Vice President (within 60 days of the filed grievance). The Vice President will respond with the objective of resolving the problematic issue within 10 days of grievance receipt. If these efforts are not successful, the client will be referred to the appropriate advocacy program(s) listed below.

Complaints may be lodged with:

NJ Div. Mental Health & Addiction Services, PO Box 362, 5 Commerce Way, Hamilton, NJ 08691	877-712-1868
NJ Div. MH&AS Ombudsman, Diane Sharley, 222 S. Warren St., Trenton, NJ 08625	609-777-0717
NJ Div. Mental Health Advocacy, Justice Hughes Complex, 25 Market St, Trenton, 08625	877-285-2844
Disability Rights New Jersey, 210 S. Broad St. #3, Trenton, NJ 08608	609-292-9742
Comm. Mental Health Law project (Monmouth/Ocean), 1 Main Street, Eatontown, NJ 07724	732 380-1012
Mon. Cty / Mental.Health Svcs, Steve Horvath, 3000 Kosloski Rd, Freehold, NJ 07728	732-431-7200
Mon. Cty /Sub.Abuse Services, Gary Abraham, 3000 Kosloski Rd, Freehold, NJ 07728	732-308-3770
DCP&P (Div.of Child Protection & Permanency) 185 W. Route 36, West Long Branch, NJ 07764	732-229-2518
Fam & Children's Srvs (Adult Protective Services), 191Bath Ave, Long Branch	732-531-9191
Ocean Cty/Mental Health Administrator, 1027 Hooper Ave, PO Box 2191, Toms River, NJ 08754	732-506-5374
Ocean Cty Board of Social Services, 1027 Hooper Ave, PO Box 547 Toms River, NJ 08754	732-286-5933

Client Signature _____ Witness _____ Date _____

The Community YMCA Counseling & Social Services

CONSENT FOR SERVICES

I, _____, hereby give my consent for _____ (self/son/daughter/grandchild/foster child) to participate in services provided by The Community YMCA Counseling and Social Services branch.

I acknowledge that this is a voluntary program and that *services are by appointment only*.

I have the option to terminate services at any time for any reason. Also, I am aware that upon completion of services, a follow-up survey may be conducted for assessment purposes only.

I also agree to hold The Community YMCA Counseling & Social Services and its staff harmless from any and all judgments, damages, and/or lawsuits of whatever nature arising from, or in connection with my participation in this program. I do so without promise of reward or coercion of any kind.

CONFIDENTIALITY

I have participated in a discussion regarding Federal Confidentiality Laws (CFR-42), its limitations and exceptions. These include:

- Risk to self and /or others
- The physical and/or sexual abuse of a child
- A medical emergency
- Court mandate, (i.e., a court order/subpoena)
- Neglect of a child including, substance abuse of a caretaker or exposure to domestic violence.

I understand that my treatment provider has a “*duty to warn*” appropriate individuals, institutions and/or agencies in these instances. I further understand that if I present for treatment *under the influence* of alcohol or illegal drugs and I intend to drive a vehicle, the staff at this agency may notify local law enforcement, if I refuse alternate transportation options.

EMERGENCY/CRISIS DURING NON-BUSINESS HOURS

In the event of an emergency, I understand that during non-working hours I may reach the answering service through the agency voice mail system (732-290-9040) for assistance.

Signature of Client or Person Authorized by Law to Give Consent

Date

Signature of Parent/Legal Guardian

Date

Signature of Witness

Date

The Community YMCA Counseling & Social Services

OUTPATIENT SERVICES AGREEMENT

In order to obtain OUTPATIENT SERVICES from this program, I understand that I MUST COMPLY WITH THE FOLLOWING:

1. Appointment attendance is a high priority. I agree to keep my appointments as scheduled and understand counseling services are available by appointment only.
2. Three (3) missed appointments will result in termination of services. I understand there is a waiting list and that my Counselor has designated my scheduled appointment time specifically for me or my child.
3. I understand that if services are for my child, I must be involved in treatment by participating in family sessions and/or parent consultations. I further understand that if services for my child are provided in an outpatient office setting, I will remain on the premises for the duration of my child's appointment.
4. I understand if I have to reschedule my session **24-hour notice is required**. Failure to do so will result in a \$25 fee*
5. A "No Show" for any appointment is unacceptable and will result in a \$25 fee*, as well as placing services in jeopardy of termination.
6. Payment* is expected prior to each session.
7. Three (3) unpaid* sessions will result in termination of services, unless arrangements are made with the agency billing staff.
8. I agree that ***I am not seeking services to obtain testimony in court*** from my Primary Counselor or other agency staff. If services are desired for court testimony and/or custodial purposes, then the services of a treatment provider outside of The Community YMCA Counseling & Social Services must be enlisted. I understand the reason for this requirement is to prevent the therapeutic relationship from being compromised.
9. I understand that services start with a four (4) week evaluation period during which it may be necessary for my therapist to recommend clinical procedures which may include individual, group and/or family counseling, HIV testing, a psychiatric examination, and/or urine monitoring.
10. I agree to adhere to the clinical recommendations of my treatment provider and to participate fully in this program toward my successful completion of treatment.
11. I agree to provide the name of each physician from whom I am receiving medication and I give my permission to consult with each physician to avoid a harmful medication interaction.

*This does not apply to Medicaid clients, unless there is a co-pay.

By signing this document, I, _____, agree to abide by the expectations outlined in this agreement. I understand that failing to comply with these terms may lead to the termination of services.

Client/Caregiver Signature: _____

Date: _____

Witness Signature: _____

Date: _____

The Community YMCA Counseling & Social Services

FINANCIAL AGREEMENT

Non-refundable \$150.00 Admission Fee to be paid in full at the initial visit, unless other arrangements are approved by the Director of Outpatient Services or your insurance carrier can be billed for the service.

Proof of income will be submitted through pay stub, W-2, Medicaid card, etc. If I do not provide proof of income, I will be charged at the cost of \$125.00 per hour.

I understand that I am required to pay a fee of \$ _____ per one hour counseling session.

I understand that I am required to provide 24 hours notice that I am *canceling an appointment* with my Counselor or Psychiatrist. Failure to do so will result in being charged a fee of \$25, regardless of whether I am covered by insurance or another source of payment.

The cost of urine assays, if applicable, will be absorbed by me.

I give permission to The Community YMCA Counseling & Social Services to contact my insurance carrier and/or Medicaid to verify coverage and provide necessary reimbursement information.

I understand it is my responsibility to inform The Community YMCA Counseling & Social Services of any changes in my Medicaid coverage. Failure to provide coverage termination information could result in being personally billed for the balance not covered by Medicaid/Insurance Carrier.

I understand in the event my Medicaid/Insurance coverage lapses, The Community YMCA we will continue to provide therapeutic services, and I will be responsible for payment for the unreimbursed services rendered.

I understand that The Community YMCA Counseling & Social Services will attempt to obtain reimbursement directly from my insurance carrier/Medicaid for the difference between my assessed fee and the actual cost of the service (\$125.00).

When it is the policy of the insurance carrier to reimburse directly to the client:

1. I will be expected to pay the assessed fee at each session.
2. I will *immediately* send any insurance reimbursement monies I receive from my insurance carrier to The Community YMCA Counseling & Social Services.
3. ***I understand that failure to submit any payment received from my insurance carrier will result in legal action by The Community YMCA Counseling & Social Services.***

I understand that I may not receive future services, if my balance exceeds an acceptable level or I leave the agency without making payment arrangements on fees I owe. Failure to remit my outstanding balance when billed could result in collection or legal proceedings.

I have read, understand and agree to the terms stated above.

DATE

CLIENT SIGNATURE

The Community YMCA Counseling & Social Services

HIV TESTING

In accordance with the N.J. Department of Human Services, Division of Addiction Services, please be advised that The Community YMCA Counseling & Social Services recommends that you receive the HIV rapid test, which may be obtained at the *Jersey Shore Monmouth Regional Screening Center*.

No Needles. No Names. No Doubts. Located at 71 Davis Avenue *behind Jersey Shore University Medical Center* in Neptune, call 732-774-0151 for testing appointments. Testing is free and you never have to give your name. Help protect yourself and others by getting a confidential routine screening.

By Appointment:

Monday thru Friday
9 a.m. to 5 p.m.

Walk In:

Tuesdays from 2:00 p.m. to 4:30 p.m.
Thursdays from 4:00 p.m. to 6:30 p.m.

For your assistance, our agency offers pre and post test counseling, which would be provided by your Primary Counselor. This test is not mandatory and your standing in the agency will in no way be affected should you refuse it.

TB TESTING

Any individual who has come in contact with someone who has TB, should be tested as soon as possible. And as a precautionary measure, it is recommended that anyone seeking treatment for substance abuse services also consider obtaining a test for tuberculosis.

TB testing is available @ The TB Clinic, 3435 Rte 9 North, Freehold. For more information, call 732-308-3750.

ADVANCED DIRECTIVES

Advanced Directives for mental health consists of directions which state specifically what plan you want those responsible for your care to follow in the event that you are rendered unable to make decisions due to a severe mental health crisis. **For more information**, please call 609 292 9742 or 1 800 922 7233 or go to www.state.nj.us/health/advanceddirective/

Your signature is required as a record that you have been offered this information.

Signature _____

Date _____

The Community YMCA Counseling & Social Services

ACKNOWLEDGEMENT OF TREATMENT PLANNING PROCESS

AS THE UNDERSIGNED PARENT/GUARDIAN OF A CLIENT WHO IS UNDER THE AGE OF 18, I HEREBY ACKNOWLEDGE THAT THE FOLLOWING HAS BEEN REVIEWED IN RELATION TO MY CHILD'S **TREATMENT PLAN**:

- THE PROBLEMS TO BE ADDRESSED
- THE GOALS OF THE TREATMENT PROCESS
- THE OBJECTIVES OF THE TREATMENT PROCESS
- THE INTERVENTION STRATEGIES THAT WILL BE EMPLOYED
- ANY OBSTACLES TO THE THERAPEUTIC PROCESS

I ACKNOWLEDGE THAT THE SAME PROCESS WILL BE FOLLOWED EVERY 90 DAYS.

Parent/Guardian Signature _____ Date _____

THE COMMUNITY YMCA COUNSELING & SOCIAL SERVICES
Client and Family Information

This form is required to be filled out completely by the client prior to the onset of treatment. If there is information you do not know, or cannot obtain, write in the word "unknown." The information will be reviewed by the professional person assigned to your case and will be treated in a strictly confidential manner.

Date application was completed: _____

PLEASE PRINT

1. Name: _____
2. Parent/Guardian's names: _____
3. Name, age & relationship of all living with this child _____

4. Address: _____
5. Length of time at present address: _____ 6. Telephone No.: _____
7. Date of birth: _____ 8. Place of birth: _____
7. Marital Status: _____
9. Living arrangements: With whom? _____
10. Religion affiliation: _____ 11. Valid N.J. driver's license: _____
12. Military status: Were you ever a member of the Armed Forces? _____
13. Previous contact with this Agency? When? _____ Counselor: _____
14. Referral source: Name of Agency & Contact Person _____

15. Referral source's perception of problem: _____

16. What is your opinion of why you are applying for services? _____

17. What are your expectations of receiving services at the Agency? _____

18. What is the highest educational level you have completed? (i.e. college, technical school, etc.) _____

19. What is your current occupation? _____

20. Annual income: _____ Number of dependents: _____
21. How long have you worked at your current place of business? _____
22. Are you satisfied with your current employment? _____ If not, can you state why? _____

- If currently unemployed:
- a. Do you want employment? _____ Yes _____ No
- b. What area? _____
- c. What are your vocational skills, training, interests? _____

23. Have you ever been convicted of any criminal offense? _____
Identify any arrests and the date of each occurrence, including DWI/DUI: _____

24. Do you have any particular hobbies or interests? _____

25. Do you belong to any civic/social organizations? _____
What are they? _____
26. How would you describe yourself as a person? (outgoing, loner, etc.) _____

27. Do you anticipate any transportation problems in coming to the Agency for
services? _____ If yes, reason: _____
28. Would other family members be willing to be involved in counseling sessions if it would be beneficial
to work with you? _____
29. How many times in the last 30 to 60 days have you had problems related to your family?
_____ What kind of problems? _____

30. Have you ever been abused? _____
If yes, circle type of abuse: _____ physical _____ emotional _____ sexual
Comments: _____

The Community YMCA Counseling & Social Services

MONTHLY EXPENSES

This information is utilized in determining self-pay fees in the event there is a lapse in insurance.

Name: _____ Date _____ Monthly net income: \$ _____

<u>Expense</u>	<u>Amount</u>
Mortgage / Rent	\$ _____
Auto payments	\$ _____
Insurance	
Auto	\$ _____
Health	\$ _____
Other (_____)	\$ _____
Gas / Electric	\$ _____
Credit Cards	\$ _____
Other loans (_____)	\$ _____
Telephone	\$ _____
Child support / Alimony	\$ _____
Childcare / Tuition	\$ _____
Medical / Dental	\$ _____
Food / Related necessities	\$ _____
Clothing	\$ _____
Commutation / Work related expenses	\$ _____
Miscellaneous	\$ _____
Total	\$ _____

PROOF OF INCOME IS REQUIRED WITHIN 30 DAYS

MEDICAL HISTORY

Name: _____ Age: _____ Date: _____

Emergency Contact (state relationship): _____ Phone: _____

Date Last Seen by Doctor: _____ Date of Last Physical Examination: _____

Reason for Visit: _____

Name of Your Current Physician: _____ Phone: _____

Address: _____

Are immunizations up to date? No Yes

Please identify any major health problems you experienced in the past and specify any current medical conditions, including Tuberculosis:

Past: _____

Present:

If you are taking any prescribed medication, please complete the information below:			
Medication	Dosage	How Long Have You Been Taking	Prescribing Physician

Have you ever experienced any surgeries, serious injuries or hospitalizations? No Yes

If yes, please explain: _____ Have you

ever had a seizure? No Yes Describe and indicate when: _____ Have you

ever had a head injury? No Yes Describe and indicate when: _____ Have you been in

contact with anyone who has TB? No Yes Describe and indicate when: _____

Have you ever been tested for Tuberculosis? No Yes When/Results: _____

Have you ever been tested for Hepatitis B or C? No Yes When/Results: _____

Are you allergic to any medication or drugs? No Yes Describe: _____

Do you have any **allergies**? No Yes Describe: _____

Prior Treatment/Counseling History

Type	No	Yes	When	Provider & Location	Was it Helpful?
Psychological/Psychiatric Treatment					<input type="checkbox"/> No <input type="checkbox"/> Yes
Drug/Alcohol/Gambling					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes

Do you have any of the following difficulties with sleep: Falling asleep No Yes

Staying asleep No Yes Early morning awakening No Yes

Daytime drowsiness No Yes Other: _____

Do you exercise? No Yes What is your exercise routine: _____

Do you drink caffeinated drinks? No Yes How much daily? _____ Other caffeine products: _____

Substance Use History

Drug	First Use	Last Use	Current Frequency and Amount

Have you ever lost consciousness while under the influence of alcohol/drugs? No Yes

How many time? _____ What drugs were used? _____

Has anyone ever expressed concern regarding your use of drugs and/alcohol? No Yes

How many time? _____ What drugs were used? _____

How many times a year do you get a hangover? _____

Do you binge on alcohol/drugs? No Yes How often? _____

Do you use alcohol to the point of intoxication? No Yes How often? _____

Have you ever felt guilty about using/abusing drugs and/or alcohol? No Yes

Have you ever used alcohol or illicit drugs to feel better or relieve a hangover? No Yes

Client and Family History

	Self	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
ALCOHOLISM							
DRUG ADDICTION							
MENTAL ILLNESS							
EATING DISORDER							
SEIZURE DISORDER							
THYROID DISORDER							
DIABETES							
HEART DISEASE							
HYPERTENSION							
HEPATITIS/LIVER DISEASE							
TUBERCULOSIS							
HIV/AIDS							
OTHER:							

Have you experienced any changes to your weight (gain or loss) in the last six months? No Yes

If yes, please indicate the amount of change: _____lbs. gained _____lbs. lost

Do you follow a special diet or have any food restrictions? No Yes

If yes, please indicate type of diet/restrictions and reason for following: _____

Do you have a history of, or a current eating disorder? No Yes If yes, please explain: _____

FOR FEMALES ONLY

Early onset menstruation: No Yes

Identify any problems related to menstrual cycle: _____

Please identify any problem areas identified below by marking each with a check mark:

Prenatal care/ Delivery	_____	Physical Health	_____	
Developmental milestones	_____	Dental Health	_____	
Previous Mental Health Tx	_____	Eating Habits	_____	Fears going to bed _____
Current Mental Health Tx.	_____	Suicidal Thoughts	_____	Homicidal thoughts _____
Prenatal Drugs/Alcohol	_____	Medications	_____	Tantrums _____
Verbally Aggressive	_____	Demanding/Argumentative	_____	Stealing _____
Physically Aggressive	_____	Destruction of property	_____	Lying _____
Cruelty towards animals	_____	Fire setting behaviors	_____	Running Away _____
Refuses to talk	_____	Sexually acting out	_____	Bedwetting _____
Disruptive in class	_____	School attendance	_____	Learning Delays _____
Fears going to school	_____	Repeated grades	_____	Head banging _____
Needs consistent routine	_____	Acts impulsively	_____	Rocking _____
Repeats acts over and over	_____	Short Attention Span	_____	

Client/Guardian Signature _____ Date _____

Witness Signature _____ Date _____

The Community YMCA Counseling & Social Services
We build strong kids, strong families, strong communities.

Records Release Authorization

I, _____, hereby give permission to
(Client Name) **(Date of Birth)**

The Community YMCA Counseling & Social Services
(Name of Individual and Agency which is to make the disclosure)

to release the following information from my records:

Necessary information and documentation required to obtain insurance coverage and reimbursement.
This information is to be released to:

Insurance / Managed Care Provider(s) / Medicaid / Medicare
(Name/Title of person or organization to which disclosure is to be made)

The purpose or need for such disclosure is: to obtain coverage and reimbursement for services

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2 and the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR, Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent *in writing* at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows on:

(Specification of the date, event or condition upon which consent expires)

I understand that generally The Community YMCA Counseling & Social Services may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Signature of Client or Person Authorized by Law to Give Consent

Date

Signature of Minor (13 years of age and over)

Date

Signature of Witness

Date