Child

Saratoga Center for the Family
Client Information Sheet

1. Child's preferred name: _____ Birthdate: _____ Age: _____

Child's Legal name: _____

Gender: _____ Ethnicity: _____ County of Residence: _____

Address: _____

Person(s) completing this form: _____ Relationship to Client: _____

2. Mother's name: _____ Birthdate: _____

Home phone: _____ Cell phone: _____

Address: _____

Currently employed: ❑ No ❑ Yes, as: _____ Work phone: _____

3. Father's name: _____ Birthdate: _____

Home phone: _____ Cell phone: _____

Address: _____

Currently employed: ❑No ❑Yes, as: _____ Work phone: _____

4. Parents are currently ❑ Married ❑ Divorced ❑ Remarried ❑ Never married ❑ Other_____

Child's custodian/guardian is: _____

*Please be prepared to provide legal documentation of current custody arrangements

5. Emergency contact name: _____ Phone: _____

Address: _____

Relationship to Client: _____

6. Primary Care Doctor: _____ Phone: _____

7. School: _____ Teacher: _____

8. Grade or highest education level completed: _____

9. Ethnicity: ❑ Caucasian/White ❑ African-American ❑ Asian
❑ Hispanic/Latino ❑ Native American ❑ Other: _____

10. Yearly Household Income:
❑ $0-9,999 ❑ $10,000-14,999 ❑ $15,000-24,999
❑ $25,000-34,999 ❑ $35,000-49,999 ❑ $50,000 and up

11. Who referred you/how did you find out about us?
❑ Social Services ❑ Court ❑ School ❑ Saratoga County Mental Health
❑ Other: _____

Office Use Only
❑ PA ❑ SA ❑ DV
❑ BEH ❑ Other

Client's Name_____ Date of Birth _____

HAS THE CLIENT HAD? (Mark Y/N)	Yes	NO	HAS THE CLIENT HAD? (Mark Y/N)	Yes	NO
Recurrent Headache			Epilepsy		
Eye Problem			Seizures		
Ear Problem			Dizziness		
Nose Problem			Fainting with exercise		
Throat Problem			Head Injury		
Thyroid Disorder			Concussion		
Heart Murmur			Bone Injuries		
Heart Disease			Joint Injuries		
Heart Palpitations			Stomach Problems		
High Blood Pressure			Intestinal Problems		
Low Blood Pressure			Diabetes		
Anemia			Eating Disorder		
Sickle Cell			ADD		
Bleeding Disorders: Hemophilia/Other			ADHD		
Hepatitis			Chicken Pox Vaccine		
Kidney Disorders			Chicken Pox Illness		
Bladder Disorders			Mononucleosis		
Pneumonia			Alcohol Abuse		
Bronchitis			Drug Abuse		
Tuberculosis			Sexual Assault		
Seasonal Allergies/Hay Fever			Victim of Violence		
Asthma			Emotional Problems-Specify below:		
Surgeries:					
Hospitalizations:					

If you wish to provide further details about any of the above, please use this space: _____

List any medications to which the client is allergic:

In general, would you say the client's health is: ____ Excellent ____ Very Good ____ Good ____ Fair ____ Poor

Does the client get 20 to 30 minutes of exercise at least three times a week? ____ Yes ____ No

Is the client at a healthy weight as recommended by his/her physician? ____ Yes ____ No

You may be answering the following for yourself or, if your child is the client, completing this on his/her behalf. Please base the answers upon what has been experienced in the past month:

	STRONGLY AGREE	*AGREE*	*DISAGREE*	*STRONGLY DISAGREE*
1. The client feels good about him/herself.	___	___	___	___
2. The client can deal with his/her problems.	___	___	___	___
3. The client accomplishes the things he/she wants.	___	___	___	___
4. The client has friends or family that he/she can count on.	___	___	___	___

If an Adult client, please complete the following section. Again, please base the answers upon what has been experienced in the past month:

How much did the following problems bother you?	*Not at All*	*A Little*	*Somewhat*	*A Lot*
1. Nervousness or shakiness				
2. Feeling sad or blue				
3. Feeling hopeless about the future				
4. Feeling everything is an effort				
5. Feeling no interest in things				
6. Your heart pounding or racing				
7. Trouble sleeping				
8. Feeling fearful or afraid				
9. Difficulty at home				
10. Difficulty socially				
11. Difficulty at work or school				

If the client is a Child (under age 18), the parent or guardian completes this section about the child. Again, please base the answers upon what has been experienced in the past month:

What best describes the child?	*Never*	*Sometimes*	*Often*
1. Destroyed property			
2. Was unhappy or sad			
3. Behavior caused school problems			
4. Had temper outbursts			
5. Worrying prevented him/her from doing things			
6. Felt worthless or inferior			
7. Had trouble sleeping			
8. Changed moods quickly			
9. Used alcohol or drugs			
10. Was restless, trouble staying seated			
11. Engaged in repetitious behavior			
12. Needed constant attention			

How much have your child's problems caused...?	*Not at All*	*A Little*	*Somewhat*	*A Lot*
1. Interruption of personal time				
2. Disruption of family routines				
3. Less attention paid to any family member				
4. Disruption or upset of relationships within the family				
5. Disruption or upset of family's social activities				

Were there any concerns during the mother's pregnancy or the delivery? If "YES", please explain: _____

Were developmental milestones met on time? If "NO", please explain: _____

Saratoga Center for the Family
359 Ballston Avenue
Saratoga Springs, NY 12866

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" handout and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment no less than 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

I am aware that non-identifying information about me may be used for quality assurance, treatment evaluation, and other service monitoring and/or research purposes.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

☐ Copy accepted by client ☐ Copy kept by therapist

WARNING: This is privileged and confidential client information. Any unauthorized disclosure is a federal offense. Not to be duplicated. Please handle, store, and dispose of properly. Permission to send these records to you has been given to the Center in writing by the concerned client or his or her guardian. You do not have the legal right to share these records with any other person, agency, organization, or program unless you first obtain written permission to do so from the subject of these records or his or her guardian.

(Rev. 11/20/14 KD)

Saratoga Center for the Family
Insurance/Payment Information

Client name: _____ Date: _____

Client date of birth: _____

Primary care physician: _____ Phone: _____

Does the client have health insurance? ___ yes ___ no. *If yes*, complete below. *If no*, speak to the receptionist about our Financial Assistance Program.

Insurance company: _____

Insurance member number: _____

Group number: _____

Name of policy holder: _____ Relationship: _____

Policy holder date of birth: _____

Policy holder place of employment: _____

I authorize release of any medical or other information to my insurance company as necessary to obtain payment in compliance with the Health Insurance Privacy and Portability Act (1996). I also authorize payment of benefits directly to Saratoga Center for the Family.

Signature: _____ Date: _____

Relationship to insured: _____

Please notify us and complete a new form if your insurance changes in any way.

Office use only:
Above insurance changed on date: _____
New form completed on date: _____

Authorization to Release Information

Saratoga Center for the Family 359 Ballston Avenue Saratoga Springs, NY 12866 518-587-8008 (phone) 518-587-8241 (fax)

A. Identifying information about me/the client:
Client Name: _____
Client Address: _____ Client DOB: _____
Parent/guardian of Client (if applicable): _____ Client Phone: _____

B. Primary Care Doctor Name: _____
Doctor's Address: _____
Doctor's Phone: _____ Doctor's Fax: _____

C. I hereby authorize the source named above to exchange information as indicated in the marked boxes below:

- ☐ Inpatient or outpatient treatment records, evaluations for physical, psychological, psychiatric illness or substance abuse
- ☐ Court orders and legal status reports
- ☐ Treatment plans, recovery plans, aftercare plans, admission and discharge summaries.
- ☐ Academic or educational records.
- ☐ Do not release HIV-related information
- ☐ Do not release drug and alcohol information
- ☐ Information relevant to treatment planning
- ☐ Other _____

D. I authorize the source named above to speak by telephone with the therapist identified in part L, below, about information that can assist with me/the client receiving treatment or being evaluated or referred elsewhere. I give my permission to release/obtain information from any staff member at the aforementioned listed agency as necessary to coordinate services.

E. I understand that no services will be denied me/the client solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan for me/the client. The information disclosed may be used in connection with my/the client's treatment.

F. *This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502); and pursuant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization). This form is to serve as both a general authorization, and a special authorization to release information under the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (Public Law 93-282), the Veterans Omnibus Health Care Act of 1976 (Public Law 94-581), and the Veterans Benefit and Services Act of 1988 (Public Law 100-322). It is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191.It is also in compliance with 42 C.F.R. Part 2 (Public Law 93-282), which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations.*

G. In consideration of this consent, I hereby release the source of the records from any and all liability arising there-from.

H. Authorization is in effect until revoked in writing, unless otherwise specified: _____

I. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

J. I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon my request.

K. Signatures:

_____ _____ _____
___ client ___parent ___guardian ___representative Printed name Date

_____ _____ _____
Clients under age 18 offered opportunity to sign Printed name Date

L. I have discussed the issues above with the client and/or his or her parent or guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____ _____
Signature of professional Printed name Date

(Please Check One): ☐ Copy given for client or parent/guardian ☐ Client or parent/guardian refused copy *(revised 11/1/12 CJD)*

Saratoga Center for the Family
359 Ballston Avenue
Saratoga Springs, NY 12866

Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____ and Saratoga Center for the Family. When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here:_____.

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from our website, http://www.saratogacff.org, or by calling us at 518-587-8008, or from our privacy officer, Kelly Daugherty, LCSW-R, GC-C.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____ _____

Signature of client or his or her personal representative Date

_____ _____

Printed name of client or personal representative Representative's relationship to the client

_____ _____

Therapists Signature Date

Date of NPP: _____ ☐ Copy given to the client/parent/personal representative

WARNING: This is privileged and confidential client information. Any unauthorized disclosure is a federal offense. Not to be duplicated. Please handle, store, and dispose of properly. Permission to send these records to you has been given to the Center in writing by the concerned client or his or her guardian. You do not have the legal right to share these records with any other person, agency, organization, or program unless you first obtain written permission to do so from the subject of these records or his or her guardian.

(Rev. 12/17/14 KD)

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ☐ Male ☐ Female **Date:** _____

Relationship with the child: _____

Instructions *(to the parent or guardian of child)*: The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		* Only complete if your child is between 6 to 17yrs old * During the past TWO (2) WEEKS, how much (or how often) has your child...	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past TWO (2) WEEKS, has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past TWO (2) WEEKS, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

Child's Name _____
Today's Date _____
Date of Birth _____

Record Number _____
Filled out by _____

Pediatric Symptom Checklist

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

			Never (0)	Sometimes (1)	Often (2)
1.	Complains of aches/pains	1			
2.	Spends more time alone	2			
3.	Tires easily, has little energy	3			
4.	Fidgety, unable to sit still	4			
5.	Has trouble with a teacher	5			
6.	Less interested in school	6			
7.	Acts as if driven by a motor	7			
8.	Daydreams too much	8			
9.	Distracted easily	9			
10.	Is afraid of new situations	10			
11.	Feels sad, unhappy	11			
12.	Is irritable, angry	12			
13.	Feels hopeless	13			
14.	Has trouble concentrating	14			
15.	Less interest in friends	15			
16.	Fights with others	16			
17.	Absent from school	17			
18.	School grades dropping	18			
19.	Is down on him or herself	19			
20.	Visits doctor with doctor finding nothing wrong	20			
21.	Has trouble sleeping	21			
22.	Worries a lot	22			
23.	Wants to be with you more than before	23			
24.	Feels he or she is bad	24			
25.	Takes unnecessary risks	25			
26.	Gets hurt frequently	26			
27.	Seems to be having less fun	27			
28.	Acts younger than children his or her age	28			
29.	Does not listen to rules	29			
30.	Does not show feelings	30			
31.	Does not understand other people's feelings	31			
32.	Teases others	32			
33.	Blames others for his or her troubles	33			
34.	Takes things that do not belong to him or her	34			
35.	Refuses to share	35			

Total score _____

Does your child have any emotional or behavioral problems for which she/he needs help? ( ) N ( ) Y
Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services? _____

SARATOGA CENTER FOR THE FAMILY
Building stronger families throughout Saratoga County

INFORMATION FOR CLIENTS

What you should know before entering treatment

Saratoga Center for the Family (SCF) is a private, not-for-profit agency serving Saratoga County and surrounding communities. SCF is committed to strengthening, empowering and improving the emotional wellbeing of children, families and the community, and to reduce the incidence and effects of child abuse and neglect.

Individual/Family Counseling:

Counseling at our center includes meeting with a therapist at predetermined intervals of time (e.g., weekly, bi-weekly). Therapy can cover a range of topics depending on the purpose for seeking treatment. There are no physical risks associated with therapy, although in the beginning an increase in emotional distress can occur as issues and topics are being brought up. Please speak to your therapist if you have any concerns. Therapists at Saratoga Center for the Family are professionals holding masters or doctoral degrees in social work, marriage and family therapy, mental health counseling or psychology. The Center also sometimes acts as a training site for interns who are pursuing licensure in their field. All interns are supervised by licensed staff.

Custody:

- The therapists at SCF are not trained in custody evaluation. You must seek outside providers for this service. If called to appear in court, we will not speak to custody issues.

Court Appearances:

- If we appear in court at your request and on your behalf, you are responsible for our fee of $150.00 an hour.

Ending Services:

- No-show and Late Cancellation Policy: The staff at SCF strives to provide the best services possible. Therefore, your appointment time is reserved especially for you. If you have to cancel your appointment, please call us at 587-8008 no less than 24 hours before your appointment. *If you miss two appointments without notifying us, we will discharge you as a client and if you have 3 same day cancels the therapist may choose to discharge you from treatment and you will have to undergo the intake process again if you wish to return to care.*
- A client may be discharged if he/she exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic.
- A client may be discharged if he/she refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner.
- Clients will be notified of non-voluntary discharges by letter. The client may appeal this decision with the Clinical Director or request to reapply for services at a later date.
- A client may end services at any time. Clients are strongly encouraged to discuss this decision with their therapist.

Fees:

- If you have health insurance that provides mental health coverage your insurance carrier will be billed for services.
- Your co-pay will be due at the time of service. If you do not have health insurance or have health insurance but no mental health coverage you can speak to the center's advocate about a financial assistance program. An affordable fee will be set for treatment, which will be due at the time of service.
- Payment for services is the responsibility of the client, or a person who has agreed to provide payment. When payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid, it may be reported to credit agencies, and the client's credit report may state the amount owed, the time frame, and the name of the clinic or collection source.

Your Rights as a Client:

- **Complaints**: We will investigate your complaints.
- You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.
- **Suggestions**: You are invited to suggest changes in any aspect of the services we provide.
- **Civil rights**: Your civil rights are protected by federal and state laws.

- **Cultural/spiritual/gender issues**: You may request services from someone with training or experiences from a specific cultural, spiritual, or gender orientation. If these services are not available, we will help you in the referral process.
- **Treatment**: You have the right to take part in formulating your treatment plan.
- **Denial of services**: You may refuse services offered to you and be informed of any potential consequences.
- **Medical/legal advice**: You may discuss your treatment with your doctor or attorney.
- **Disclosures**: You have the right to receive an accounting of disclosures of your protected health information that you have not authorized. Request this in writing.
- **Crisis Services**: The SCF does not provide crisis services. If someone is at risk for serious harm: CALL 911 OR GO OTHE NEAREST EMERGENCY ROOM.
- **After Hours Contact**: SCF's typical hours of operation are M-F from 8AM to 5PM. You may leave after hours voice mail messages for your therapist by calling the main number at 518-587-8008 and following the menu. Therapists are expected to check their voice mail messages once every 24 hours M-F.

Your rights to receive information:

- **Costs of services**: We will inform you of how much you will pay.
- **Termination of services**: You will be informed as to what behaviors or violations could lead to termination of services at our clinic.
- **Confidentiality**: You will be informed of the limits of confidentiality and how your protected health information will be used.
- **Policy changes**: We will do out best to immediately inform you of policy changes that may affect you.

Our Ethical Obligations:

- We dedicate ourselves to serving the best interest of each client.
- We are committed to providing care in a manner that supports and protects the personal dignity of each client.
- We are committed to providing care that reflects 'best practices' and evidence-based treatments.
- We will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.
- We maintain an objective and professional relationship with each client.
- We respect the rights and views of other mental health professionals.
- We will appropriately end services or refer clients to other programs when appropriate.
- We will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. We will continually attain further education and training.
- We respect various institutional and managerial policies but will help to improve such policies if the best interest of the client is served.
- We will provide ongoing discussions with you about how and with whom your information is shared.

Patient's responsibilities:

- You are responsible for your financial obligations to the clinic as outlined above.
- You are responsible for following the policies of the clinic.
- You are responsible to treat staff and fellow patients in a respectful, cordial manner in which their rights are not violated.
- You are responsible to provide accurate information about yourself.

What to do if you believe your rights have been violated:

- Express your concerns with your therapist. If this does not resolve the problem, then:

Contact our Executive Director, Ms. Rebecca Baldwin, at 518-587-8008, ext. 303. If she cannot help, then, share your concerns with the following agency:

NYS Office of Mental Health Commission o
Customer Relations Service: 1-800-597-8481 or En Espanol: 1-800-210-6456 TDD (for those who are deaf/hearing impaired): 1-800-597-9810
99 Washington Avenue, Suite 1002, Albany, NY 12210
General Phone: 518-473-4090 or 1-800-624-4143

SARATOGA CENTER FAMILY

NOTICE OF PRIVACY PRACTICES

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

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This handout is a shorter version of the full, legally required NPP and you may have a copy of this to read and refer to it for more information. However, we can't cover all possible situations so please talk to our Privacy Officer (see the end of this handout) about any questions or problems.

How we use and disclose your protected health information with your consent We will use the information we collect about you mainly to provide you with treatment, to arrange payment for our services, and for some other business activities that are called, in the law, health care operations. After you have read this notice we will ask you to sign a consent form to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.
Fundraising: We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Disclosing your health information without your consent:

There are some times when the laws require us to use or share your information. For example:

- When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
- When we are required to do so by lawsuits and other legal or court proceedings.
- If a law enforcement official requires us to do so.
- For workers' compensation and similar benefit programs.
- There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Your rights regarding your health information:

- You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
- You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
- You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our privacy officer to arrange how to see your records. See below.
- If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting area, and you can always get a copy of it from the privacy officer.
- You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please contact our privacy officer, who is Wende Tedesco , LCSW-R and can be reached by phone at 518-587-8008 or by e-mail at wtedesco@saratogacff.org.

The effective date of this notice is January 1, 2014