Southeast Kansas Mental Health Center

Face Sheet

ADAS __Yes __ No _____%
DX _____
For CA Staff Use Only

Date _____ E-mail _____ Case No. _____

Client Name _____ Preferred Name _____

Age _____ Date of Birth _____Client Social Security # _____ Military/Veteran Status ☐ Yes ☐ No

Females Only: Maiden name _____ Former married names _____

Client Address _____ City/State/Zip _____

Phone # _____ Work Phone # _____

Cell Phone # _____ County of residence _____
We may contact you and/or leave a message regarding your appointment times unless instructed otherwise _____

If less than 6 months in this county, please specify previous county of residence_____

Do you have a legal guardian? ☐ No ☐ Yes If Yes, please provide the following:

Legal Guardian _____ Phone # _____

Address _____

Client Legal Custody Status (check one) ☐ A. No JJA/DCF involvement ☐ D. Child in JJA Custody/out-of-home
☐ G. Child in JJA custody/lives at home ☐ J. Under supervision of JJA/not custody
☐M. Child in DCF custody/out-of-home ☐P. Child in DCF custody/lives-at-home
☐S. Under DCF supervision, not custody ☐ Other- Explain

Client Employment Status (check one) ☐ 2. Part-time (less than 35 hrs.) ☐ 3. Full-time (more than 35 hrs.)
☐ 4. Retired ☐ 5. Unemployed ☐ 6. Active Military Duty ☐ 7. Not in labor force

Client Marital Status (check one) ☐ 1. Never Married ☐ 2. Married ☐ 4. Divorced ☐ 5. Separated
☐ 6. Widowed ☐ 7. Common-law ☐ 00. Other

Client Student Status (check one) ☐ 1. Full Time Student ☐ 2. Part-time Student ☐ 3. Not a student
School _____

Race (check one) ☐ White ☐ Black or African American ☐ American Indian ☐ Alaskan Native
☐ Native Hawaiian ☐Pacific Islander ☐ Asian ☐ Other

Ethnicity ☐ Hispanic ☐ NOT Hispanic

Primary Language _____ Other languages spoken _____

Primary Care Provider _____ Primary Care Provider Telephone # _____ Referred By _____

Gender (check one) ☐ 1. Male ☐ 2. Female ☐ 3. Transgender male to female ☐ 4. Transgender female to male

Party responsible for account _____ Relationship _____

Social Security # _____ DOB: _____ Email _____

Has the client received previous mental health services? ☐ Yes or ☐ No If yes, please list:

Name of Facility	Address	Inpatient/Outpatient	Dates

Client Employment Information (if not employed, head of house employment information)

Employee Name _____

Employer _____ Occupation _____

Name (spouse) _____

Employer _____ Occupation _____

Address/City/State/Zip_____ Phone _____

List sources of household income*	Source	Gross Monthly Amount

* ***Proof of income must be attached for fee adjustment.***

List those dependent upon household income

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Emergency Contact Name _____ Telephone # _____

Address _____

You have the right to use Advance Directives. Please indicate below if you have written Advance Directives, if not, a form can be provided, but is not required for treatment. ☐ Yes or ☐ No (Advanced Directives are your written health care choices).

Reimbursement Information

PRIMARY INSURANCE (attach copy) _____

ID # _____ Group # _____

Address _____ City _____ State/ZIP _____

Insured's Name _____ DOB _____

Subscriber's Name _____

Benefit verification date _____ Pre-certification date & info. _____

SECONDARY INSURANCE (attach copy) _____

ID # _____ Group # _____

Address _____ City _____ State/ZIP _____

Insured's Name _____ DOB _____

Client's relationship to insured _____

Benefit verification date _____ Pre-certification date & info. _____

1. Is the patient a Veteran? ☐ Yes ☐ No
   a. Did the VA refer you here for treatment? ☐ Yes ☐ No
   b. Does the patient have a VA "fee basis ID card?" ☐ Yes ☐ No

   Veterans Administration Authorization: Does the patient authorize you to bill the VA? ☐ Yes ☐ No

2. Do you have a Federal Black Lung card? ☐ Yes ☐ No
   Are the services you are receiving today related to lung disease? ☐ Yes ☐ No
   If yes, submit claims to: Federal Black Lung Program, PO Box 740, Lanham, Maryland 20706

3. Is this medical condition due to an accident of any kind? ☐ Yes ☐ No
   If yes, was it: ☐ Work Related ☐ Auto ☐ Injured in own home ☐ Other

WORKER'S COMPENSATION INSURANCE INFORMATION

Date of accident _____ Employer Name and Address _____

Names of Workers Compensation Insurance_____

Name of Person or company Insured_____

Insurance company Claim or Policy #_____

Worker's compensation Claim #_____

Name of Worker's Compensation Agency where claim was filed_____

Address_____

Has the case been settled ☐ Yes Date_____ ☐ No

Name of Patient's Legal Representative in this case (if any) _____

Phone number of Legal Representative_____

AUTOMOBILE, NO-FAULT OR LIABILITY INSURANCE INFORMATION:

Date of Accident: _____ If other than auto, describe accident_____

Business /Property Owner_____Address: _____Telephone#: _____

Type of insurance: Premises Medical _____ Liability_____

Name of Policy holder_____ Address of Policyholder_____

Policy Number or Claim ID Number_____ Insurance Company_____

Address of Insurance company_____

Legal Representative& Phone number for this case (if any) _____

Southeast Kansas Mental Health Center

Agreement for Financial Responsibility

Client _____ Case # _____

** - A unit is 15 minutes. ** - Proof of income must be attached before fee is adjusted. ***-No fee adjustment.*

		Fees are subject to change without notice	
Type of Service		Unadjusted Fee	Adjusted Fee**
Assessment (Counselor or QMHP)	90791	$ 200.00 per hour	$
Assessment (Psychiatrist)	90792	$ 210.00 per hour	$
Individual/Family Therapy (Counselor or QMHP)	90837	$ 210.00 per hour	$
Group Therapy	25000	$ 90.00 per hour	$
Community Psychiatric Support	31000	$ 140.00	$
Medication Review	99213	$ 130.00 per hour	$
Injections	96372	$ 40.00 per appointment	$
Targeted Case Management	34000	$ 25.00 per unit*	$
Attendant Care	33000	$ 10.00 per unit*	$
Psychosocial Group	32000	$ 10.00 per unit*	$
Peer Support (Individual)	35000	$ 15.00 per unit*	$
Outpatient Treatment Program Chemical Abuse Services	90837	$ 210.00*	$
ADSAP Evaluations	14000	$150.00 for 2 hours	XXXX
Alcohol/Drug Diagnostic Evaluation	90791	$150 per evaluation***	XXXX
Alcohol/Drug Information School (Adult)	61000	$100.00***	XXXX
Alcohol/Drug Information School (Adolescent)	61000	$50.00***	XXXX
Tobacco Cessation	90829	$60.00	XXXX
Tobacco Cessation Class	25200	$40.00	XXXX

PLEASE READ THIS CONTRACT BEFORE SIGNING

I authorize use of this form for all my insurance submissions.
I authorize the Center to act as my agent in helping me obtain payment from my insurance.
I authorize payment directly to the Center for services rendered. I understand that a claim will be filed at the unadjusted cost per hour. If my insurance does not reimburse the Center in the amount of my fee, I understand that I am responsible for my bill.
I authorize the Center to disclose information needed for billing purposes to all my insurance companies. I acknowledge receipt and I have reviewed and understand the Financial Policies. I agree to comply with these policies.
I understand that 24 hours notice is required when canceling or rescheduling my appointment.
I certify that I have received the Welcome brochure, Notice of Privacy Practices, Good Faith Estimate, and Clients Rights.
I certify that I understand my rights and responsibilities.
I certify that I have provided accurate information.
I certify that I have read and agree to this contract.
I certify that the fee was discussed with me.

_____
Provider Name

_____ _____ _____
Client/Parent or Legal Representative Date Witness

PLEASE MAKE COPY FOR CLIENT - ORIGINAL IS FILED IN CASE RECORD

Southeast Kansas Mental Health Center

Informed Consent For Voluntary Initial Assessment and Treatment

Client Name: _____

I understand that by signing this consent for initial assessment and treatment that I am agreeing to participate in an evaluation at Southeast Kansas Mental Health Center. The purpose of this evaluation is to assess my current mental health or substance abuse needs and to develop specific treatment recommendations related to my concerns that have brought me to the Center.

I understand that the initial evaluation will be conducted by a licensed professional at Southeast Kansas Mental Health Center.

The evaluation will consist of interviews, but I may also be asked to participate in psychological testing to assess my needs more thoroughly.

I understand that my therapist may need to discuss my case in a confidential manner with a professional associate and/or supervisor for the purpose of providing higher quality service to me. I am aware that I may be asked to see additional professional staff who may participate in my evaluation and treatment. I understand that these discussions will be kept confidential unless I authorize that information be released or unless allowed or required by law. These exceptions to confidentiality are specified in the *Privacy Policy* of which I have been given a copy.

I understand that some treatment recommendations may be addressed during the initial interview(s). Once the evaluation is complete and an initial treatment plan has been formulated, I will be given the opportunity to review and discuss with my therapist my diagnosis and treatment, including alternatives to these recommendations.

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

I understand that some services may be made available through telemedicine and not in person with a provider. I have the right to not have services provided by telemedicine.

I hereby consent to participate in the process of assessment and treatment at Southeast Kansas Mental Health Center.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

Southeast Kansas Mental Health Center

CHILD & ADOLESCENT INTAKE ASSESSMENT[1]

This information is part of your confidential medical record. Your answers are important to providing the best possible treatment. Please answer as many questions as possible. Mark any questions you prefer to answer in person.

Clinician Use Only: *ID:* _____ _____ *Date:* _____
Time In/Out: _____ *Units:* ____ ____
Intake Assessment, Code ☐ *ADMN (New) or* ☐ *ADMR (Reopen)*

IDENTIFYING INFORMATION

Client Name: _____ DOB:_____ Age:_____

☐ Male ☐ Female Height:_____ Weight:_____ lbs.

Distinguishing physical characteristics (i.e., hair color, disabling condition, etc.): _____

_____

Physical Aids Present (i.e., glasses, cane, walker, hearing aid, etc.): _____

_____

School Status: _____ Cultural Identity: _____

Living with Whom?_____ How long in area? _____

Type of Residence:_____ Who referred you?

☐ self ☐ friend
☐ family member ☐ law enforcement
☐ mental health professional ☐ physician/nurse
☐ ad in phone book ☐ minister
☐ agency ☐ co-worker
☐ Other_____

PARENT INFORMATION

Your Name: _____ Age:_____

Other parent in residence Name: _____ Age:_____

How long have you been the primary caretaker? _____

Do you share joint custody? ☐ yes ☐ no If yes, how long? _____
If divorced, does the other custodial parent agree services should be sought? ☐ yes ☐ no ☐ don't know
Will both parents in residence be involved in treatment? ☐ yes ☐ no ☐ don't know
Will both biological parents be involved in treatment? ☐ yes ☐ no ☐ don't know

[1]Adapted from instrument of Western Arkansas Counseling and Guidance Center, Ft. Smith, Arkansas (2005), used with permission.

If divorced, other Biological Parent's Name: _____ Age:_____

Address: _____ City/State/Zip:_____

Home Phone: _____ Work Phone: _____ Message Phone: _____

If there is joint custody, list any recent problems _____

PRESENTING PROBLEMS

What is the MOST SIGNIFICANT problem or reason for seeking help today? _____

_____

How would you rate the severity of this problem? ☐ moderate ☐ significant ☐ extrene

How long this been a problem? _____

How often does the problem occur? ☐ constantly ☐ daily ☐ weekly ☐ monthly ☐ less often

Has there been:
Suicide thinking or attempts ☐ In the last month? ☐ Today ☐ _____

Thoughts of harming others or attempts ☐ In the last month? ☐ Today ☐ _____

How difficult was it to get your child or adolescent to come for help? _____

In what ways have the problems troubled you? _____

_____

Is there a court order to receive treatment? ☐ yes ☐ no

On the next page are some common problem areas for children/adolescents. To help focus on the most important issues, please complete the following checklist.

1) ☑ Check only **Problem Areas** with moderate or greater distress.
2) For each checked, also check the level of **Distress**, how long this has been a problem (**Duration**) and how often problem **Occurs**.

	PROBLEM AREAS	DISTRESS			DURATION					OCCURS				
		Moderate	Significant	Extreme	Less than 6 months	6	12	24	over 24	Constantly	Daily	Weekly	Monthly	Less often
☐	Academic Underachievement	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Adoption/Foster Care Issues	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Anger Management / Temper	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Antisocial Behavior / Legal System	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Anxiety or Panic	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Attachment Issues	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Attention/Concentration Problems	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Bedwetting/Soiling/Toileting	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Blended Family Problems	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Bullying or Intimidating Others	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Childhood Trauma	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Chronic Pain/Physical Problems	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Conduct Disorder/Delinquency	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Dependency/Separation Anxiety	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Depression	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Disruptive/Attention Seeking	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Divorce Adjustment	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Eating Disorder	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Family Conflict	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Fire Setting	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Impulse Control	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Losing Touch With Reality	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Low Self-Esteem	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Lying or Manipulative	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Obsessive and/or Compulsive	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Oppositional/Defiant/"doesn't mind"	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Paranoid/Suspicious	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Peer/Sibling Conflict	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Phobias/Fears	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Physical Abuse	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Relationship Conflicts	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	School Related Problems	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Sexual Abuse	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Sexual Confusion or Behavior	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Sleep Disturbance	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Social Discomfort	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Social Skills Deficits	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Speech/Language Difficulties	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Spiritual Confusion	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Substance Abuse/Dependence	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Suicidal Thoughts/Attempts	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Unresolved Grief/Loss	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
☐	Other:	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐

What do you hope to get from treatment?_____

_____

What do you expect from your treatment team? _____

_____

What do you think your role in treatment will be? _____

Who else, such as family members or friends, will be involved in treatment? _____

_____

What **problems** or **needs** do you have that might hinder treatment or ability to reach your desired goals?

_____

What **preferences** do you have regarding your treatment program at Southeast Kansas Mental Health Center? For example, is there a service that you do not want?

_____

_____

_____

_____

_____

_____

CHILD/ADOLESCENT STRENGTHS, ABILITIES, NEEDS & PREFERENCES

What are **two (2)** resources **(strengths)** of your child or adolescent that will help in treatment?

- ☐ Family Support
- ☐ School
- ☐ Intelligence
- ☐ Network of Friends
- ☐ Stable Finances
- ☐ Good Health
- ☐ Spiritual
- ☐ Available Transportation
- ☐ Other: _____

Your child or adolescent possesses many different **abilities** that can be utilized to help overcome problems. What are **four (4)** of abilities that may be most useful in treatment? He or she can . . .

- ☐ take medication
- ☐ work cooperatively with others
- ☐ request help from others
- ☐ use self-help materials
- ☐ follow directions
- ☐ maintain consistent behavior
- ☐ be assertive
- ☐ provide leadership
- ☐ resolve conflicts
- ☐ keep appointments
- ☐ complete tasks assigned
- ☐ other: _____
- ☐ express thoughts and feelings
- ☐ abstain from alcohol/drugs
- ☐ analyze problems
- ☐ develop solutions to problems
- ☐ manage time effectively
- ☐ other: _____

FAMILY AND SIGNIFICANT RELATIONSHIPS

Child / Adolescent raised by? ☐ parents ☐ grandparent(s) ☐ single parent ☐ Other _____

What do you think about how your child was raised?_____

_____

What kind of relationship do you have today with your child? _____

How many brothers or sisters does you child have? _____

What kind of relationship does your child have with his or her brothers and sisters?_____

_____

Parent Marital Status?

☐never married ☐married ☐divorced ☐separated ☐widow(er) ☐living as married

How many times have you been married?_____ How long each time?_____

_____

Total number of children: ___his ___hers ___ours. If children live with you, please give:

Name: _____ Age___ Sex___ ☐ his ☐ hers ☐ ours

Name: _____ Age___ Sex___ ☐ his ☐ hers ☐ ours

Name: _____ Age___ Sex___ ☐ his ☐ hers ☐ ours

Name: _____ Age___ Sex___ ☐ his ☐ hers ☐ ours

What problems exist in your current intimate relationship? _____

_____

How much stress do you feel from parenting? ☐ None ☐ Some ☐ A lot ☐ Overwhelmed

How many close friends do you have? _____ How well do you get along with others? _____

To what organizations, clubs or teams do you belong? _____

_____

What problem(s) have you, your spouse and other children had? What about extended family?

Problems with	Father	Father's Mother	Father's Father	Father's Brother(s)	Father's Sister(s)	Father's Uncle(s)	Father's Aunt(s)
Aggressiveness, defiance as a child							
Attention, overly active, impulse control as a child							
Learning disabilities							
Dropped out of school							
Mental Retardation							
Psychosis or schizophrenia							
Depression for more than two (2) weeks							
Anxiety disorder that impaired work							
Tics or Tourette's Disorders							
Alcohol and/or Drug Abuse							
Law Enforcement							
Physical Abuse							
Sexual Abuse							

Problems with	Mother	Mother's Mother	Mother's Father	Mother's Brother(s)	Mother's Sister(s)	Mother's Uncle(s)	Mother's Aunt(s)
Aggressiveness, defiance as a child							
Attention, overly active, impulse control as a child							
Learning disabilities							
Dropped out of school							
Mental Retardation							
Psychosis or schizophrenia							
Depression for more than two (2) weeks							
Anxiety disorder that impaired work							
Tics or Tourette's Disorders							
Alcohol and/or Drug Abuse							
Law Enforcement							
Physical Abuse							
Sexual Abuse							

Child's or Adolescent's Brothers and Sisters -- WRITE IN *FIRST NAME(s)* IF A PROBLEM

Problems with	**Brother(s) First Name(s)**	**Sister(s) First Name(s)**
Aggressiveness, defiance behavior as a child		
Attention, overly active, and/or poor impulse control as a child		
Learning disability		
Dropped out of school		
Mental Retardation		
Psychosis or schizophrenia		
Depression lasting more than two (2) weeks		
Anxiety disorder than impaired school work		
Tics or Trourette's Disorders		
Alcohol and/or Drug Abuse		
Law Enforcement		
Physical Abuse		
Sexual Abuse		

DAILY ACTIVITY STRENGHTS AND LIMITATIONS

CHILD / ADOLESCENT DAILY ACTIVITIES[1]		**Mark the following (S) if STRENGTH Or (L) if LIMITATION If neither, leave blank**
1. Personal Care	Helps or manages general cleanliness: daily bath, shower, brush teeth	
2. Grooming	Assists or manages general appearance: hair, shave, comply with school rule	
3. Dress	Assists or responsibly cares for clean clothes, comply with school dress code	
4. Household Stability	Contributes to stability in the home (age-wise): respects others & property, shares in chores, involves caretakers in school-related projects, grades	
5. Physical & Mental Health	Assists or manages adequate weight, moods, outdoor exercise, aches; takes medications or over-the-counter drugs only with adult supervision.	
6.Communicate	Greets adults; listens, expresses feelings, anger, opinions effectively.	
7. Safety within environment	Plays it safe? Avoids guns, knives, matches, dangerous people or places where there likely is trouble or abuse; if driving, has safe record.	
8. Managing Time	Assists or manages time for promptly, regularly attending school & work (age-appropriate); completes tasks, sleeps, wakes up, eats on regular basis?	
9. Managing Money	Reliably handles or manages monetary allowance: abstains from overspending personal limits, betting, stealing, and borrowing?	
10. Nutrition	Eats at least 2 basically nutritious meals with caretakers; eats healthy snacks.	
11. Problem Solving	Understands presenting problems, reasons for seeking services; focuses on possible solutions for age-appropriate time periods; assists or manages difficult situations	
12. Family Relationships	Feels close to at least one other person at home; gets along with family or caretakers, feels loved?	
13. Alcohol, Drug Use	Abstains from smoking cigarettes, drinking alcohol, doing drugs or inhalants of any kind; avoids high risk drinking situations & people who use drugs	
14. Leisure Entertainment	Enjoys 2 or more fun & relaxing activities: music, watching or playing sports, reading, computer-board games, cards, artistic hobbies, movies, TV?	
15. Community Resources	Uses community activities, resources: after-school sponsored tutoring, clubs, sports, Scouts, YM/YWCA, library, church, dance.	
16. Peers/Social	Makes, keeps same-age friends; avoids bullying, gangs, cults, antisocial groups	
17. Sexual Behavior	Behavior is sexually responsible with girls, boys (and age-appropriate)? Avoids sexual activities, infections, pregnancy?	
18. Work & Productivity	Feels good about performance at school, considers grades to be good, completes school projects without undue difficulty. Has vocational goals.	
19. Coping Skills	Accepts adult correction without undue arguing, temper outburst; tolerate frustration, copes with disappointments, retains self-worth.	
20. Behavior Norms	Controls threatening or physical expression of anger, violent behaviors--either to self or others or to property. Law-abiding and responsible with rules, car, etc.	

[2]Adapted from Daily Living Activities Scale, Willa Pressmanes, used with permission.

DISCIPLINE

What methods have been used to discipline the child or adolescent?	Successful	Unsuccessful
Verbal reprimands		
Time out (isolation)		
Removal of privileges		
Removal of toys or activities		
Rewards		
Physical punishment		
Spend time with		
Let them have their way		
Avoid conflict		

How often does your child or adolescent comply with your first command? ☐ Always ☐ Never
☐ More than half the time ☐ Less than half the time

How often does your child or adolescent eventually comply with your commands? ☐ Always ☐ Never
☐ More than half the time ☐ Less than half the time

How much agreement and consistency do you and your spouse show in discipline? ☐ Always ☐ Never
☐ More than half the time ☐ Less than half the time

SPIRITUAL BACKGROUND

Are you a member of a local religious group? ☐ yes ☐ no Which one? _____
How active are you? ☐ extremely ☐ very ☐ somewhat ☐ not at all
How important is your faith? ☐ extremely ☐ very ☐ somewhat ☐ not at all

How might your faith/spirituality help? _____
Is there any spiritually related information you would like to add?

DEVELOPMENTAL FACTORS

Mother's health during pregnancy? ☐ Good ☐ Fair ☐ Poor ☐ Don't know

Alcohol consumed during pregnancy? ☐ yes ☐ no If yes, how much? _____

Street Drugs consumed? ☐ yes ☐ no If yes, used _____

During pregnancy used Tranquillizers (Valium, Librium, Xanax)? ☐ Cigarettes? ☐ Diabetes medication?
☐ Coffee or caffeine drinks? ☐ Seizure Medication? ☐ Antibiotics? ☐ Sleeping Medication?
☐ Psychiatric Medication _____

Number of previous pregnancies? _____ This delivery was ☐Normal? ☐Early? ☐ Long Labor?
☐Eclampsia? ☐Problem of Toxemia? ☐Rh Incompatibility? ☐Unusual Stress? ☐Breech delivery?
☐Water broke more than 24 hours early? ☐Induced delivery? ☐Forceps? ☐Cesarean?
☐Birth Defects? _____

As an infant, child was ☐Normal? ☐Slow? ☐Advanced? ☐Other_____

_____

As a toddler, child was ☐Normal? ☐Slow? ☐Advanced? ☐Other_____

_____

☐Bladder training problems? If so, started at age _____ He or she _____

☐Bowel training problems? If so, started at age _____ He or she _____

☐Ear problems? If so, started at age _____ He or she _____

☐Sleep problems? If so, started at age _____ He or she _____

☐Eating problems? If so, started at age _____ He or she _____

☐Other pre-school problems?_____

MEDICAL HISTORY

How is your child's or adolescent's health? ☐Very Good ☐Good ☐Fair ☐Poor ☐Very Poor

He or she has been treated for ☐Hearing ☐Vision ☐Coordination ☐Speech ☐Breathing

☐ Chronic health problem(s): _____

Has your child or adolescent had any of the following illnesses?

Mumps	☐	Chicken Pox	☐
Measles	☐	Whooping Cough	☐
Scarlet Fever	☐	Pneumonia	☐
Encephalitis	☐	Ear Infections	☐
Seizures	☐	Lead Poisoning	☐
Allergies	☐	Frequent runny nose	☐
Frequent Colds	☐	Frequent sinus infection	☐

Other: _____

Has your child or adolescent had any of the following accidents?

Broken bones	☐	Severe lacerations	☐
Head injury	☐	Severe bruises	☐
Stomach pumped	☐	Eye injury	☐
Lost teeth	☐	Sutures	☐

Other: _____

Has your child or adolescent had any of the following?

Tonsillitis	☐	Adenoids	☐
Hernia	☐	Appendicitis	☐
Eye, ear, nose, & throat	☐	Digestive Disorder	☐
Urinary tract	☐	Foot, Leg or Arm Disorder	☐
Burns	☐	Diabetes	☐

Other: _____

Has your child or adolescent had any of the following symptoms in the past 60 days?

☐ Ankle Swelling	☐ Coughing	☐ Lightheadedness	☐ Penile Discharge	☐ Urination Difficulty
☐ Breathing Difficulty	☐ Pulse Irregularity	☐ Memory Problems	☐ Cramps	☐ Bedwetting
☐ Vomiting	☐ Vision Changes	☐ Seizures	☐ Vaginal Discharge	☐ Blood in Stool
☐ Muscle Weakness	☐ Shakiness	☐ Dizziness	☐ Nervousness	☐ Diarrhea
☐ Mole/Wart Changes	☐ Tremor	☐ Falling	☐ Sleep Problems	☐ Constipation
☐ Hair Change	☐ Nosebleeds	☐ Confusion	☐ Gait Unsteadiness	☐ Sweats (Night)
☐ Hearing Loss	☐ Chest Pain	☐ Panic Attacks	☐ Numbness	☐ Sweats (Other)
☐ Headaches	☐ Tingling in Arms & Legs	☐ Loss of Consciousness	☐ Rash	☐ Bleeding gums

SEXUAL HISTORY (Reminder: You may choose not to answer any of the following questions)

Did your family or school provide sex education? ☐ yes ☐ no
Is there a problem with sexual behavior? ☐ yes ☐ no
Was child ever forced to have sexual contact? ☐ yes ☐ no When? _____
Has he or she contracted a sexually transmitted disease? ☐ yes ☐ no
Sexually active in any way? ☐ yes ☐ no
What other significant sexually oriented problems do you wish to discuss?

LEGAL HISTORY (Reminder: You may choose not to answer any of the following questions)

Has your child or adolescent had contact with law enforcement? ☐ yes ☐ no
Has you child or adolescent ever been arrested or taken to court? ☐ yes ☐ no
Has your child or adolescent ever been placed in a correctional institution? ☐ yes ☐ no
If yes, when? _____ How Long? _____ Where? _____

Current legal issues or problems? _____

MENTAL HEALTH HISTORY & TREATMENT

☐ Check here if child or adolescent has never been in mental health treatment

OUTPATIENT TREATMENT HISTORY

Treated By:	From: Date to Date		For What Problems?	Results of Treatment

PSYCHIATRIC HOSPITALIZATIONS

Hospital:	From: Date to Date		For What Problems?	Results of Treatment

PSYCHIATRIC MEDICATIONS

Medication	Amount	Prescribed By:	Taken From Date to Date		Results of Treatment

What mental health related information would you like to add?

After completing treatment, how do you plan to maintain progress? _____

<u>Thank you</u> for taking the time to complete this background information.
Please place this in the envelope provided, put your name on the outside and seal to insure privacy.
<u>Bring to your appointment.</u>

Southeast Kansas Mental Health Center

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

304 N. Jefferson
PO Box 807
Iola, KS 66749

402 S. Kansas
Chanute, KS 66720

519 S. Elm
Garnett, KS 66032

212 State St.
Fort Scott, KS 66701

505 W. 15th
Pleasanton, KS 66075

1106 S. 9th
Humboldt, KS 66748

204 S. Main
Yates Center, KS
66783

Client Name	Client Case #
Client Address	
Date of Birth	Phone #

I hereby authorize the Southeast Kansas Mental Health Center to
☐ release to ☐ obtain from

Organization/Individual Name/Relationship

Address

Telephone/Fax

The purpose or need is to:

- ☐ Assist in the provision of services
- ☐ Personal use
- ☐ Criminal Justice
- ☐ Coordination of Treatment
- ☐ Other: _____
- ☐ Legal/Court ordered
- ☐ School
- ☐ Other: _____

the following information:
From:_____To _____

- ☐ Admission Evaluation Report
- ☐ Diagnosis Only
- ☐ Treatment Plan(s)
- ☐ Psychiatric Consultation Report
- ☐ Psychological Evaluation Report
- ☐ Discharge Summary
- ☐ Progress Review(s)
- ☐ Alcohol and Drug Treatment information
- ☐ Hospitalization Screening
- ☐ Progress Notes: FROM_____TO _____
- ☐ MHC Treatment Report Form
- ☐ Medical Report
- ☐ Legal Reports
- ☐ Education Reports
- ☐ Medications
- ☐ Labs
- ☐ Appointments
- ☐ Other _____
- ☐ Other:

Expiration

This authorization shall remain in effect until_____ at which time this authorization expires, but no later than one year
(month/day/year)
from the date listed below. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by providing verbal or written notice of revocation to Southeast Kansas Mental Health Center. I understand that fees may be charged for preparing and sending copies of records.

I acknowledge that I am aware that certain information that I am consenting to release is confidential and protected by Federal and State Law. I acknowledge upon signing this consent that I am waiving my rights under these laws and I am aware of the specific protections afforded or am waiving my rights to being informed of the specific provisions of these laws, Statute 42 CFR – Part 2. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the privacy regulations.

I understand that enrollment, eligibility, payment, or treatment is not conditioned upon the execution of this authorization.

Client/Patient Signature		Date	
Parent/Guardian/Legal Representative		Date	
Relationship to Client			
Witness Signature		Date	

Southeast Kansas Mental Health Center

Televideo Mental Health/Chemical Abuse Consent Form

I understand that:

1. I have the option to withhold consent at this time or to withdraw this consent at any time, including any time during a session, without affecting the right to future care, treatment, or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

2. The potential benefit of Southeast Kansas Mental Health Center televideo mental health/chemical abuse services is that I will be able to talk with mental health/chemical abuse staff or providers from this local setting for an evaluation of my needs.

3. The potential risk of Southeast Kansas Mental Health Center televideo mental health/chemical abuse services is that there could be a partial or complete failure of the equipment being used which could result in the inability of the mental health/chemical abuse staff or provider to complete the evaluation, mental health /chemical abuse services, and/or prescription process.

4. No video or voice recording is made or preserved of any Southeast Kansas Mental Health Center televideo mental health/chemical abuse service session.

5. All existing or applicable protections for confidentiality apply to any Southeast Kansas Mental Health Center televideo mental health/chemical abuse service session.

6. All existing laws regarding client access to mental health/chemical abuse information and copies of mental health/chemical abuse records apply to any Southeast Kansas Mental Health Center televideo mental health/chemical abuse service session.

I consent to Southeast Kansas Mental Health Center televideo mental health/chemical abuse services in circumstances in which mental health/chemical abuse staff or providers appropriate to my needs are not immediately available at my site. My mental health/chemical abuse care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information, and all of my questions have been answered. I understand the written information provided above.

_____ _____

Signature of Client Date

_____ _____ _____

Signature of Responsible Adult Relationship to Client Date

_____ _____

Signature of Witness/Interpreter Date

Southeast
Kansas
Mental Health
Center

Electronic Communication Consent

Client Name: _____
DOB:_____
SSN: _____

Purpose: Consent to allow SEKMHC staff to correspond by e-mail/text message to myself. These can be used for scheduling, appointment reminders, billing, and other forms of client communication/information. I am responsible for providing SEKMHC with current email address and cell phone number.

Cell Phone/Text Number:_____ Email address: _____

Cell Phone/Text Number:_____ Email address: _____

E-Mail and Text Messaging Risk Factors and Responsibilities

Risks:

- Emails can be circulated, forwarded, and stored in numerous paper and electronic files.
- Email or text messages can be sent out and received by many recipients, some or all of whom may be sent the message accidently.
- Emails/text messages are not always encrypted and could be read by someone with the skills to do so.
- Email or text messages senders could misaddress a message.
- Emails or text messages are easier to falsify than handwritten or signed documents.
- Even if someone deleted an email or text message, there may still be a backup copy.
- Employers and on-line services may have a right to archive or inspect emails/text messages transmitted.
- Email/text messages can be intercepted, altered, forwarded or used without authorization or detection.
- Emails or text messages are a part of the client's file and therefore can be used as evidence in court.
- Emails or text messages can be used to introduce viruses into computer systems.

Conditions for use:

- We can't guarantee that email or texts will be read, received or responded to within a particular time frame.
- No one should use text or email for emergencies or any matter that is time sensitive in nature. Please call 911, the crisis line or go to the nearest ER for care.
- Texting and emails are to be used during business hours and not to be used after hours or during weekends and holidays and we can't guarantee a response during these times.
- All emails or text messages received or sent may be made part of the client record.

- Messages may be forwarded internally via email to staff.
- Messages may be forwarded to independent third parties with signed release on file.
- The center uses Facebook, has a website, and third-party applications that we use to connect with the community and to provide tools to assist with problem solving/learning skills. If you use these sites to connect with us, we can't guarantee confidentially on these sites.

By signing below, I agree to Electronic Consent Form and request that my provider communicate with me electronically. I can revoke in writing at any time. I understand risks involved and agree to the conditions above. The center may use third party applications, and these will be explained to me at the time. I hereby release, discharge and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information authorized below.

Messages may be communicated to me via email, cell phone and by texting/SMS on my cell phone.

_____ _____

*Client or Client's Parent/Legal Guardian Signature Date

_____ _____

Printed Name Print Relationship to client (if other than self)

_____ _____ _____

Signature of Witness (Print Name) Date

Southeast Kansas Mental Health Center

Expiration Date 12/31/2023

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 620 343-2211.

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

If you have questions about any part of this notice or if you want more information about our privacy practices, please contact:
Nathan Fawson, Executive Director, 304 N. Jefferson, PO Box 807, Iola, KS 66749, Phone 620/365-8641

WHY WE ARE PROVIDING THIS NOTICE:

Southeast Kansas Mental Health Center compiles information relating to you and the treatment and services you receive. This information is called protected health information (PHI) and is maintained in a designated record set. We may use and disclose this information in various ways. Sometimes your agreement or authorization is necessary for us to use or disclose your information and sometimes it is not. This Notice describes how we use and disclose your protected health information and your rights. We are required by law to give you this Notice, and we are required to follow it. We may change this Notice at any time if the law changes or when our policies change. If we change the Notice you will be given a revised Notice.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION THAT MAY BE MADE *WITHOUT YOUR AUTHORIZATION*:

For your treatment. We may share your protected health information with other treatment providers. For example, if you have a heart condition we may use your information to contact a specialist and may send your information to that specialist. We may send your information to other treatment providers, as necessary.

For payment. We may share your protected health information with anyone who may pay for your treatment. For example, we may need to obtain a pre-authorization for treatment or send your health information to an insurance company so it may pay for treatment. However, if you pay full fee out of pocket for your treatment and make a specific request that we not send information to your insurance company for that treatment, we will not send that information to your insurer except under certain circumstances.

1. For our healthcare operations. We may use and disclose your protected health information when it is necessary for us to function as a business. For example, when we contract with other businesses to do specific tasks for us, we may share your protected health information related to those tasks. When we do this, the business agrees in the contract to protect your health information and use and disclose such health information only to the extent Southeast Kansas Mental Health Center would be able to do so. These businesses are called Business Associates. Another example is if we want to see how well our staff is doing, we may use your protected health information to review their performance.
2. For appointment reminders. We may use your protected health information to remind you of appointments, including leaving a voicemail message.
3. For Surveys. We may use and disclose your protected health information to contact you to assess your satisfaction with our services.
4. For providing your information on treatment alternatives or other services. We may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you. We may also use and disclose protected health information to tell you about health-related benefits or services that may be of interest to you. In some cases the facility may receive payment for these activities. We will give you the opportunity to let us know if you no longer wish to receive this type of information.
5. To discuss your treatment with other people who are involved with your care. We may disclose your health information to a friend or family member who is involved in your care. We may also disclose your health information to an organization assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. Unless you inform us that you do not want any information released, we may tell individuals who ask, your location in the hospital and provide a general statement of your condition.
8. As Required By Law. We will disclose your protected health information when the law requires us to do so.
9. To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of another person.
10. Military and Veterans. The protected health information of members of the United States Armed Forces members of a foreign military authority may be disclosed as required by military command authorities.
11. Employers. We may disclose your protected health information to your employer if we provide you with health care services at your employer's request and the services are related to an evaluation for medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. We will tell you when we make this type of disclosure.
12. Workers' Compensation. We may release your protected health information for workers' compensation or similar programs providing you benefits for work-related injuries or illness.
13. Public Health Risks. We may disclose your protected health information for public health activities which include the prevention or control of disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of devices or products; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or to notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence.
14. Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These activities are necessary for the government to monitor the health care system, government programs, and civil rights laws.
15. Legal Proceedings. We may disclose your protected health information when we receive a court or administrative order. We may also disclose your protected health information if we get a subpoena, or another type of discovery request. If there is no court order or judicial subpoena, the attorneys must make an effort to tell you about the request for your protected health information.
16. Law Enforcement. When a law enforcement official requests your protected health information, it may be disclosed in response to a court order, subpoena, warrant, summons, or similar process. It may also be disclosed to help law enforcement identify or locate a suspect, fugitive, material witness, or missing person. We may also disclose protected health information about the victim of a crime; about a death we believe may be the result of criminal conduct; about criminal conduct at Southeast Kansas Mental Health Center; or in an emergency to report a crime, the location of the crime, victims of the crime, or to identify the person who committed the crime.
17. Coroners, Medical Examiners, and Funeral Directors. We may disclose your protected health information to a coroner, medical examiner, or a funeral director.
18. National Security and Intelligence Activities. When authorized by law, we may disclose your protected health information to federal officials for intelligence, counterintelligence, and other national security activities.
19. Protective Services for the President and Others. We may disclose your protected health information to certain federal officials so they may provide protection to the President, other persons, or foreign heads of state, or to conduct special investigations.
20. Inmates or Persons in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your protected health information to the correctional institution or a law enforcement official when it is necessary for the institution to provide you with health care; when it is necessary to protect your health and safety or the health and safety of others; or when it is necessary for the safety and security of the correctional institution.
21. Fundraising. We may send you information as part of our fundraising activities. You have the right to opt out of receiving this type of communication.

OTHER USES AND DISCLOSURES:

1. Most uses and disclosures of psychotherapy notes, uses and disclosures for marketing purposes, and uses and disclosures that constitute a sale of protected health information require your authorization. Psychotherapy notes are a particular type of protected health information. Mental health records generally are not considered psychotherapy notes. Your authorization is necessary for us to disclose psychotherapy notes.
2. There are some circumstances when we directly or indirectly receive a financial (e.g., monetary payment) or non-financial (e.g., in-kind item or service) benefit from a use or disclosure of your protected health information. Your authorization is necessary for us to sell your protected health information. Your authorization is also necessary for some marketing uses of your protected health information.
3. Other uses and disclosures of your protected health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. You may revoke your authorization in writing at any time, provided you notify us. If you revoke your authorization, it will not take back any disclosures we have already made.

YOUR HEALTH INFORMATION RIGHTS:

1. Right to Access. You have the right to access, or to inspect and obtain a copy of your protected health information. To exercise this right, you should contact the Privacy Officer because you must complete a specific form so we have the information we need to process your request. You may request that your records be provided in an electronic format and we can work together to agree on an appropriate electronic format. Or you can receive your records in a paper copy. You may also direct that your protected health information be sent in electronic format to another individual. You may be charged a reasonable fee for access. We can refuse access under certain circumstances. If we refuse access, we will tell you in writing and in some circumstances you may ask that a neutral person review the refusal.
2. Right to Amend Your Records. If you feel that your protected health information is incorrect or incomplete, you may ask that we amend your health records. To exercise this right, you must contact the Privacy Officer to complete a specific form stating your reason for the request and other information that we need to process your request. We can refuse your request if we did not create the information, if the information is not part of the information we maintain, if the information is part of information that you were denied access to, or if the information is accurate and complete as written. You will be notified in writing if your request is refused and you will be provided an opportunity to have your request included in your protected health information.
3. Right to an Accounting. You have a right to an accounting of disclosures of your protected health information that is maintained in a designated record set. This is a list of persons, government agencies, or businesses who have obtained your health information. To exercise this right, you should contact the Privacy Officer because you must complete a specific form to provide us with the information that we need to process your request. There are specific time limits on such requests. You have the right to one accounting per year at no cost.
4. Right to a Restriction. You have the right to ask us to restrict disclosures of your protected health information. To exercise this right, you should contact the Privacy Officer because you must complete a specific form to provide us with the information that we need to process your request. If you self-pay for a service and do not want your health information to go to a third party payer, we will not send the information, unless it has already been sent, you do not complete payment, or there is another specific reason we cannot accept your request. For example, if your treatment is a bundled service and cannot be unbundled and you do not wish to pay for the entire bundle, or the law requires us to bill the third party payer (e.g., a governmental payer), we cannot accept your request. We do not have to agree to any other restriction. If we have previously agreed to another type of restriction, we may end that restriction. If we end a restriction, we will inform you in writing.
5. Right to Communication Accommodation. You have the right to request that we communicate with you in a certain way or at a specific location. To exercise this right, you should contact the Privacy Officer because you must complete a specific form to provide us the information that we need to process your request.
6. Breach Notification. You have the right to be notified if we determine that there has been a breach of your protected health information.
7. Right to Obtain the Notice of Privacy Practices. You have the right to have a paper copy of this Notice. You may request a copy from the Privacy Officer.
8. Right to File a Complaint. If you believe your privacy rights as described in this Notice have been violated, you may file a written complaint with our Privacy Officer or with the U.S. Department of Health and Human Services – Office for Civil Rights (Regional Office at Kansas City), 601 East 12th Street Room 248, Kansas City MO 64106, 816.426.7277, or through www.hhs.gov/ocr/privacy/hipaa/complaints/index.html. You will not be penalized for filing a complaint.

YOUR RIGHTS REGARDING ELECTRONIC HEALTH INFORMATION TECHNOLOGY

Southeast Kansas Mental Health Center participates in electronic health information technology or HIT. This technology allows a provider or a health plan to make a single request through a health information organization or HIO to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or health care operations. HIOs are required to use appropriate safeguards to prevent unauthorized uses and disclosures.

You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO.

If you choose this option, you do not have to do anything.

Second, you may restrict access to all of your information through an HIO (except as required by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.org or by completing and mailing a form. This form is available at http://www.KanHIT.org. You cannot restrict access to certain information only; your choice is to permit or restrict access to all of your information.

If you have questions regarding HIT or HIOs, please visit http://www.KanHIT.org for additional information.

If you receive health care services in a state other than Kansas, different rules may apply regarding restrictions on access to your electronic health information. Please communicate directly with your out-of-state health care provider regarding those rules.

CHANGES TO THIS NOTICE:

We reserve the right to change this Notice at any time. We reserve the right to make the revised Notice effective for protected health information that we currently maintain in our possession, as well as for any protected health information we receive, use, or disclose in the future. A current copy of the Notice will be posted in our facility. Effective Date: 03/23/2010, Revised 03/13/13, Revised 05/29/15