Appointment Reminder

Name: _____

Appointment with: _____

Date: _____

Time: _____

Appointment with Patient Navigator _____ ☐ **N/A**

Date: _____

Time: _____

PLEASE BRING THE FOLLOWING WITH YOU

- **Proof Of Total Household Income: If you would like to be considered for our sliding scale rate.**

  Examples are: Recent paycheck stub, letter from employer, recent income tax return, government support, and if you are paying or receiving child support.

- **A Photo ID**

- **Insurance Card:**

  If you have insurance, please check to see if you need to pre-certify.
  If yes, you will need to call and pre-certify your appointment as failure to do so may result in non-payment of your insurance.

- **Court order (**if services are court ordered**)**

- **Anyone under 18 MUST be accompanied by a parent or legal guardian**
- **Call 24 hours before the scheduled appointment if you will not be able to keep this appointment. Charges may incur for any appointment not cancelled 24 hours in advance.**

QUESTIONS?

Please do not hesitate to contact your local SEKMHC office. www.sekmhc.org

Welcome

Southeast Kansas Mental Health Center

AshleyClinic

We are happy you are here and appreciate the opportunity to assist you!

What should I expect?

New SEKMHC clients will meet with an intake therapist to complete a comprehensive registration process, which includes a client interview, the completion of paperwork, and a psychological assessment. After your initial meeting, you and your therapist will review the information and determine if future sessions will be helpful.

If you have recently been a client, your information may be readily available and only need a simple update.

What's next?

If you and your therapist determine future sessions are necessary, you will be referred to a different therapist for treatment (who becomes your primary clinician), based on your preferences and schedule availability. He or she will help you establish your goals and develop strategies to attain your objectives through the creation of a treatment plan. You will be involved in planning your treatment at all points of your mental health journey.

We understand things come up.
Please keep in mind appointment
times are booked especially for you.
If you need to cancel your appointment,
please call your local office to cancel.

Will therapy be the only service provided by SEKMHC?

There are a variety of services that you and your therapist may choose that will support your efforts to reach your goals. These services will coordinate with your treatment plan. Some options may include:

- Case management
- Peer support
- Support group meetings
- Attendant care
- Medical Primary Care
- Medical Urgent Care
- Surgical/Specialty
- Assertive Community Treatment
- Individual Placements and Supports
- Laboratory
- Immunization
- Radiology

How do I know if I'm making progress?

Your primary clinician coordinates notes from all service providers you may see at SEKMHC and will review your goals and treatment plan with you each session. Through measuring and monitoring your progress, your therapist logs a progress note in your medical record after each meeting. As each goal in your treatment plan is achieved, focus is given to the next one on the list, until you and your therapist agree that it's time for discharge or changes should be made.

What do I do if I need special accommodations?

We want your visits to be as pleasant and productive as possible! If you need special accommodations, please let us know in advance. Our buildings and restrooms are wheelchair accessible. Please communicate your needs if you require any additional assistance.

Southeast Kansas Mental Health Center provides medically-necessary services equally to all regardless of race, color, religion, sex, national origin, age, disability, or the ability to pay.

Contact Us

We are here for you, whenever you need us.

(866) 973-2241 - 24/7 Crisis Services
Ashley Clinic - (620) 431-2500
@southeast kansas mental health center
@ashleyclinic
@sekmhc
@sekmhc
@sekmhc | @ashleyclinickansas
@sekmhc
@sekmhc
www.sekmhc.org | www.ashleyclinic.com

Payment Arrangements

Our Board of Directors has established financial policies for clients about payment for services. Fees are based on a sliding scale that takes into consideration household income and the number of household members.

Please provide proof of income to office staff to determine where you fit on the sliding scale for payment arrangements.
We will charge the full-service rate to your account if we have not received proper documentation to apply the sliding scale guidelines. However, we will adjust your account accordingly once you provide proof of income.

We NEVER deny services based on the inability to pay.

Proof of income may include:

- Pay stub
- Income tax forms
- Letter from employer
- Letter from probation officer
- Verification of cash assistance
- SSI or SSDI
- Child support order
- Any other government support for all individuals in the home

Payment Agreement

Once your fee is determined, we will ask you to sign a payment agreement. Once we receive a signed agreement, payment is expected at the time services are received. If this is impossible, our staff will provide monthly statements from which payment may be made. Staff will have access to your account information and can provide an outstanding balance amount upon request.

If the sliding scale fee seems to be unmanageable, you may submit a reduction request form for review by the Chief Executive Officer or Chief Financial Officer. They carefully consider each request before making a final determination.

After 120 days of nonpayment or no effort to reduce an outstanding balance, the Accounts Receivable Department staff will turn the account over to the Kansas set-off program for collection.

Our responsibility to you:

- Arrange accommodations to provide services to you in an alternate location if our facility is not accessible to you due to disability. Please let our staff know alternate accommodations are required.
- Provide treatment within the scope of services offered by the Center until the Treatment Plan is either ineffective, no longer necessary, or subject to noncompliance by the client.
- Refer the client to other resources if the Center is unable to provide the necessary care.
- Terminate treatment if the client does not participate in the service in good faith or does not appear to be benefiting from treatment.

We want to know what you think

https://forms.office.com/r/VABaJ07xCq

Your satisfaction is our measure of success. We welcome your opinions!

Please provide feedback with comments in our Suggestion Box, located in the lobby of each office. Your input helps us plan additional programs/services and provide better care.

Your responsibility to us:

- Actively participate in your treatment process
- Tell us if you or a family member are in crisis or if an emergency exists
- Keep scheduled appointments – or provide prior notice for cancellations
- Arrange for care of your children while you're receiving services
- Provide accurate financial and background information as requested and inform us of any changes
- Authorize communication with your primary care practitioners and other providers who are essential to a coordinated plan of care
- Pay for services according to our financial policies established by our Board of Directors
- Treat our agency staff with courtesy and respect
- Discuss termination of care with your therapist/counselor before leaving treatment
- Respect the confidentiality of other clients
- Assist SEKMHC in maintaining a safe environment
- Inform us of special accommodations needed due to disability or special condition
- Communicate with SEKMHC about any dissatisfaction you have about services you've received

Southeast Kansas Mental Health Center

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Case Number/Chart ID _____ Date _____

Last Name _____ First Name_____ Preferred Name _____

Maiden Name _____ Former Married Name(s) _____

Date of Birth _____ Age _____ Client Social Security Number _____

Physical Address _____ City/State/Zip _____

County _____ Home Phone _____ Cell Phone _____ Work Phone _____

Best way to contact _____ Best time to contact _____ Email _____

Primary Language _____ Other Language(s) Spoken _____

Client/Patient Information

Legal Sex at Birth: ☐Male ☐ Female

Race: ☐White ☐Black or African American ☐American Indian ☐Alaskan Native ☐Native Hawaiian

☐Pacific Islander ☐Asian ☐Other _____

Ethnicity: ☐Hispanic ☐Not Hispanic

Do you Have a Legal Guardian? ☐No ☐Yes If Yes, please provide the following:

Legal Guardian Name _____ Phone _____

Physical Address _____ City/State/Zip _____

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 hours) ☐ 3. Full-Time (more than 35 hours)

☐ 4. Retired ☐ 5. Unemployed ☐ 6. Active Military Duty ☐ 7.Not in Labor Force

Client Marital Status ☐1. Never Married ☐ 2. Married ☐ 4. Divorced ☐ 5. Separated ☐ 6. Widowed

☐ 7. Common-Law ☐ 00. Other _____

Client Student Status ☐1. Full-Time Student ☐2. Part-Time Student ☐3. Not a Student

Physical and Behavioral Health

Primary Care Provider _____ Primary Care Provider Telephone _____ Referred by_____

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

Name of Facility Address Inpatient/Outpatient Dates

_____

_____

_____

Has the patient received health services in the last 2 years? ☐ Yes ☐No If yes, please list:

Name of Facility Address Inpatient/Outpatient Dates

_____

_____

_____

Client Employment Information (If not employed, head of household employment information)

Employee Name _____ Employer_____ Occupation _____

Name (spouse) _____ Employer_____ Occupation _____

Address (City/State/Zip) _____ Phone _____

*List Sources of Household Income ***Proof of Income Must be Attached for Fee Adjustment**

Amount Source Gross Monthly

Amount Source Gross Monthly

Amount Source Gross Monthly

List Those Dependent Upon Household Income

Name_____Age_____Relationship_____

Name_____Age_____Relationship_____

Name_____Age_____Relationship_____

Name_____Age_____Relationship_____

Name_____Age_____Relationship_____

Emergency Contact Information

Contact Name _____ Phone _____

Address (City/State/Zip) _____

Advanced Directives

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 ☐ No

Primary Insurance

Same as Patient ☐ Yes ☐ No

Primary Card Holder Name_____ Primary Card Holder's Date of Birth _____

Relationship to Patient _____

Insurance ID Number _____ Group Number _____

Physical Address (City/State/Zip) _____

Primary Cardholder Name _____ Company Name _____

Benefit Verification Date _____ Pre-certification Date & Information _____

Secondary Insurance

Same as Patient ☐ Yes ☐ No

Primary Card Holder Name_____ Primary Card Holder's Date of Birth _____

Relationship to Patient _____

Insurance ID Number _____ Group Number _____

Physical Address (City/State/Zip) _____

Primary Cardholder Name _____ Company Name _____

Benefit Verification Date _____ Pre-certification Date & Information _____

Person Responsible for Payment if Not Same as Patient

Last Name _____ First Name_____ Date of Birth _____

Relationship to Patient _____ Social Security Number _____ Phone _____

Physical Address (City/State/Zip) _____

Employer Name _____ Employer Phone_____

Veteran Status

If you are a veteran, did the VA refer you here for treatment? ☐ Yes ☐ No

Do you have a VA "fee basis ID card?" ☐ Yes ☐ No

Is your present medical condition due to an accident of any kind? ☐ Yes ☐ No

If yes, please explain

_____

_____

_____

Worker's Compensation Insurance Information

Date of Accident _____ Employer Name _____

Employer Address (City/State/Zip) _____

Employer Contact _____ Employer Phone_____

Employer's Work Comp Insurance Company Name _____

Insurance Policy Number _____ Work Comp Claim Number _____

Work Comp Address (City/State/Zip) _____

Work Comp Adjuster Contact _____ Adjuster Phone_____

Automobile, No-Fault or Liability Insurance

Date of Accident _____ Type of Insurance _____

If not an auto accident, please describe the accident _____

_____

Business/Property Owner Name _____ Address _____

Policyholder Name _____ Address _____

Insurance Company Name _____ Address _____

Legal Representative (if any) Name _____ Address _____

Southeast Kansas Mental Health Center

AshleyClinic

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 the use of this form for all my insurance submissions.
I authorize the Center to act as my agent to help me obtain payment from my insurance company.
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 Individual Rights, Welcome brochure, Notice of Privacy Practices, and Good Faith Estimate.
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

AshleyClinic

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.

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 _____

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

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 Practices* 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

AshleyClinic

*********MEDICARE ONLY**********

CLIENT'S NAME: _____ CASE #_____

MEDICARE ID#_____

ONE TIME AUTHORIZATION:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Southeast Kansas Mental Health Center for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

SIGNATURE DATE

WAIVER OF LIABILITY STATEMENT

Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a) (1) of the Medicare law. If Medicare determines that a particular services, although it would otherwise be covered, is not reasonable and necessary under Medicare programs standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for one of the following reason(s): a) Family Therapy, b) Individual therapy when provided on the same day as a Medication Review, or c) Individual Therapy provided by a therapist who is not a qualified Medicare provider. Qualified Medicare providers include M.D., Ph.D., and LSCSW's.

"I have been notified by my provider that he or she believes, that in my case, Medicare is likely to deny payment for the services identified above, for the reason(s) stated. If Medicare denies payment, I agree to be personally responsible for payment."

If you have Supplemental Insurance or Medicaid, the charge will be submitted to them. There is a possibility that they may allow the charge, even though Medicare has denied it. You will be responsible for payment on any unpaid charge.

_____ _____

SIGNATURE DATE

INDIVIDUAL RIGHTS

The following rights pertain to all individuals receiving services at the Southeast Kansas Mental Health Center and Ashley Clinic.

- Confidentiality: Your medical and psychological records will be held in confidence, subject to the following conditions:

- Information may be exchanged from time to time in professional consultation among members of the Southeast Kansas Mental Health Center and Ashley Clinic staff.

- Records may be disclosed to you or others upon your written consent, or by the written consent of your parent if you are under the age of 18. Once you authorize release of information, you can revoke the authorization. The consent and its revocation must be in writing.

- Southeast Kansas Mental Health Center and Ashley Clinic Executive Director may refuse to disclose portions of these records if it is felt that such disclosure would be injurious to your welfare. In this event, the Executive Director or designee would provide you with a written statement explaining why the disclosure would be injurious to your welfare. In the presence of a Court-Ordered request for information, individual consent is not required.

- No information will be disclosed to persons not otherwise authorized by Law to receive such information.

- Kansas Statutes require that suspected cases of child or adult abuse be reported to the appropriate agency. You are also advised that threats of certain and immediate danger to yourself or others may be reported to appropriate authorities. When such a report is made, it may occur in conjunction with consultation with either the Executive Director, Medical Director, Director of Clinical Services, and/or Director of Community Support Services of the Southeast Kansas Mental Health Center and Ashley Clinic.

- You have the right to an explanation of the nature of all medications prescribed, the reasons for the prescription, and the most common side effects known to be associated with the medication.

- You have the right to an explanation of the nature, course of any treatment prescribed, approximate duration and any known risks associated with such

treatment. You have the right to request information on possible alternative treatment.

- If you are a voluntary individual, you have the right to refuse any and all treatment. All clients have the right to know the name and credentials of the person in charge of his/her treatment. You have the right to request a different treatment provider within the limits of the Center's ability to provide someone else. Let the provider or office staff know.

- If you are an involuntary or a Court-Ordered individual, you have the right to an explanation of the possible legal consequences, should you fail to comply with the prescribed evaluation and/or treatment program. (Note: the staff may or may not be aware of all possible legal consequences. The Center is responsible. for reporting your noncompliance to Court authorities.)

- You have the right to treatment in the least restrictive environment, dependent upon your treatment needs.

- You have the right to be treated with dignity, respect and professionalism and not be subjected to verbal or physical abuse or exploitation. You will receive services without discrimination.

- You have the right to receive services from a psychiatrist or physician not employed or contracted by the Southeast Kansas Mental Health Center and Ashley Clinic, provided that the necessary releases are signed to ensure coordination of care. The psychiatrist or physician providing such services will assume medical responsibility for all medications prescribed.

- You have the right to be accompanied or represented by a person of your own choosing during all contacts with the Southeast Kansas Mental Health Center and Ashley Clinic, providing that this does not compromise your right to confidentiality or prove detrimental to your treatment.

- You have the right to file, or have counsel or other representative file, a complaint concerning the violation of your rights or any other matter with the Executive Director. Forms for such complaints may be obtained from the receptionist at each Center location. Such complaints may be hand delivered to the Center office or sent by certified mail. You or your designee may be present when complaints are discussed, or the outcome determined.

These rights are in compliance with K.A.R. 30-60-50, Article 60-Licensing of Community Mental Health Center.

_____ _____

Signature Date

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

AshleyClinic

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

What is a Patient Navigator?

Welcome to Southeast Kansas Mental Health Center. One of the first steps in beginning services is to meet with a Patient Navigator. The Patient Navigator will conduct a 15-minute free, anonymous health study to provide better whole-person care.

Step One: Complete a Baseline Health Study

The health study consists of obtaining vitals and a short health questionnaire.

Step Two: Complete Reassessment Health Study and obtain vitals at six months

The client will continue to meet with the Patient Navigator every six months as long as the client receives services from Southeast Kansas Mental Health Center. When the Patient Navigator obtains vitals, they will collect the client's blood pressure, pulse, temperature, height, weight, and waist circumference. Fingerstick testing is also offered to check cholesterol, etc.

What does a Patient Navigator do?

- Help Clients Fill out Paperwork
- Resource Management for Clients
- Obtain Vitals
- Care coordination for other needed supports
- Follow-up from first appointment (our patient navigators will be following up with a phone call to check in on the client and remind them of their upcoming appointments. This will be done within 2 weeks of their initial appointment).

Southeast Kansas Mental Health Center

(866) 973-2241 | sekmhc.org

Serving Allen, Anderson, Bourbon, Linn, Neosho and Woodson Counties

We are here for you whenever you need us.

Consumer,

The Center is a Certified Community Behavioral Health Center (CCBHC). This supports the expansion of our services to provide the best care possible for each patient. To follow the regulations for the state, each patient will meet with a Patient Navigator to complete a health study. The first step is to complete a Baseline health study. The study consists of obtaining vitals and a short questionnaire. The second step is to complete a Reassessment health study and obtain vitals at 6 months. The patient would continue to meet with the Patient Navigator every 6 months forward as long as the patient is receiving services from Southeast Kansas Mental Health Center. When vitals are obtained by the Patient Navigator, he/she will collect the consumers blood pressure, pulse, temperature, height, weight, and waist circumference. The studies are anonymous. Each study completed is important to assist with the growth of the Center. Thank you for your participation. The Patient Navigators look forward to meeting with each patient.

This is a completely free service offered by the mental health center. Our Patient Navigators will conduct a 15-minute health study with you.

_____ _____

Signature Date

If you have any further questions, please contact the office you are being seen in.

Southeast Kansas Mental Health Center

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

402 S. Kansas
Chanute, KS 66720

1322 S. Grant
Chanute, KS 66720

505 S. Plummer Ave
Chanute, KS 66720

401 Woodland Hills BLV Box #6
Fort Scott, KS 66701

212 State Street
Fort Scott, KS 667010

519 S. Elam
Garnett, KS 66032

1106 S. 9th
Humboldt, KS 66748

111 S. 9th
Humboldt, KS 66748

304 N. Jefferson
PO Box 807
Iola, KS 66749

826 E. Madison
Iola, KS 66749

401 S. Washington
Iola, KS 66749

223 E. Main Street
Mound City, KS 66056

505 W. Fifteenth
Pleasanton, KS 66075

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
- ☐ Legal/Court ordered
- ☐ School
- ☐ Other: _____
- ☐ 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)
- ☐ Hospitalization Screening
- ☐ MHC Treatment Report Form
- ☐ Progress Notes: FROM _____TO _____
- ☐ Medical Report
- ☐ Legal Reports
- ☐ Education Reports
- ☐ Medications
- ☐ Labs
- ☐ Appointments
- ☐ Billing
- ☐ 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	

Informed Consent

Client's Name: _____

Social Security Number: _____ **Date of Birth:** _____

Southeast Kansas Mental Health Center, Ashley Clinic, and Yates Center Dental have merged as one company to strive towards whole person care for all individuals served.

Your treatment team now includes your provider with Southeast Kansas Mental Health Center, Ashley Clinic, and Yates Center Dental therefore, information can be shared with provider on your treatment team.

_____ _____

Signature of the Patient: **Date of Signature:**

_____ _____ _____

Signature of personal representative: **Relationship:** **Date of Signature:**

_____ _____

Witness Signature: **Date of signature:**

Southeast Kansas Mental Health Center

AshleyClinic

ADULT 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.

IDENTIFYING INFORMATION

Client Name: _____ DOB:_____ Age:_____

☐ Male ☐ Female ☐ Other_____

Who referred you?

☐ self
☐ family member
☐ mental health professional
☐ minister
☐ co-worker
☐ friend
☐ law enforcement
☐ physician/nurse
☐ agency
☐ other_____

PRESENTING CHALLENGE

What is the MOST SIGNIFICANT CHALLENGE or reason you are seeking help today? _____

_____

How would you rate the severity of this challenge? ☐ mild ☐ moderate ☐ significant ☐ extreme

How long have you had this challenge? _____

How often does the challenge 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 ☐ _____

What is on goal you have for yourself by seeking treatment?

_____

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

_____

What **would you like** regarding your services at Southeast Kansas Mental Health Center? For example, is there a service or medical treatment that you do not want?

_____

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

STRENGTHS, ABILITIES, NEEDS & PREFERENCES

What are **three (3)** resources **(strengths)** that will help in your treatment?

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

You possess many different **abilities** that can be utilized to help overcome your problems. What are **six (6)** of your abilities that may be most useful in your treatment? I . . .

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

Who would you want to make care decisions for you if you could not?

How do you want people to treat you?

What do you want your loved ones to know if something happens to you?

For additional information on Advanced Directives: Kansas Advance Directives (wichitamedicalresearch.org)

FAMILY OF ORIGIN

You were raised by? ☐ parents ☐ parent/step-parent ☐ single parent ☐ Other _____

List any developmental problems you recall experiencing such as premature birth, bedwetting, slow physical development, speech problems, delayed sexual development.

_____

What do you think about how you were raised? _____

_____

What kind of relationship do you have today with those who raised you? _____

What kind of relationship did do you have with your brothers and sisters? _____

_____

Did those who raised you, or your brothers/sisters have mental health or drug/alcohol challenges? What about extended family?

_____

What challenges did you have as a child or adolescent? (mental health, drug/alcohol, neglect, abuse, etc.)

_____

What significant issues of details about your childhood would you add to this information?

_____

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

Have you been impacted by a traumatic event or experience? ☐ yes ☐ no When? _____
Have you ever been forced to have sexual contact? ☐ yes ☐ no When? _____
Have you participated in High-Risk behavior for HIV? ☐ yes ☐ no
(multiple sexual partners, or a partner with multiple sexual partners, shared needles)
Would you like to share more about your trauma history that you may wish to discuss?

_____

EDUCATIONAL HISTORY

What is the last grade you completed? ☐ 6th or less ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED

College: ☐ freshman ☐ sophomore ☐ junior ☐ senior ☐ masters ☐ doctorate

Any specialized or technical training (i.e., cosmetology, welding, etc.)? _____

Are you currently pursuing your education? ☐ yes ☐ no What field of study? _____

Did you have any testing or supports for your schooling?
☐ Individual Education Plan ☐ 504 Plan ☐ ADHD testing ☐ Special Education ☐ Learning Disability

How well did you get along with teachers? _____

MILITARY SERVICE

☐ Check here if never in the military.

Which branch and job did you serve in? _____ For ____ Years

Why did you leave? _____

What challenges did you experience in the military?_____

What type of discharge did you receive? _____
What significant military related information do you want to add?

_____

EMPLOYMENT, FINANCES AND LEISURE

Are you currently: ☐ employed ☐ unemployed ☐ laid off ☐ on disability How long?_____

Where did you last work (or currently work)? _____

What was/is your position there? _____

Where did you work the longest? _____ How long? _____

How many jobs have you had in the last 5 years? _____

What problems have you had on the job? _____

What problems related to finances do you have? _____

What interests, activities, or hobbies do you pursue in your free time? _____

_____

What significant employment or financial related information do you want to add?

_____

FAMILY AND SIGNIFICANT RELATIONSHIPS

Marital Status? ☐never married ☐married ☐divorced ☐separated ☐widow(er) ☐living as married

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

Partner/Spouse Name:_____DOB:_____Age:_____

Is partner/spouse employed? ☐ yes ☐ no Employer: _____ Position:_____

Total number of children: ___his ___hers ___ours

With whom do you live? _____

What problems exist in your current intimate relationship? _____

_____

What problems do you have with your children?_____

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

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

SPIRITUAL BACKGROUND

With what religion do you identify?
☐ None ☐ Christianity ☐ Judaism ☐ Islam ☐ Buddhism ☐ Taoism ☐ Native American
☐ Other: _____

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

What problems have you had regarding spiritual issues? _____

How might your faith/spirituality help you overcome your problems? _____

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

Have you ever been arrested or taken to court? ☐ yes ☐ no
Have you ever been placed in a correctional institution? ☐ yes ☐ no When? _____ How Long? _____

Juvenile arrests? _____

Adult arrests? _____

What are your current legal issues or problems? _____

_____

MEDICAL HISTORY

Have you had any of the following symptoms in the past 60 days (please check)?

☐ Ankle swelling	☐ Pulse Irregularity	☐ Lightheadedness	☐ Sleep Problems
☐ Breathing Difficulty	☐ Nervousness	☐ Memory Problems	☐ Cramps
☐ Vomiting	☐ Vision Changes	☐ Seizures	☐ Gait Unsteadiness
☐ Muscle Weakness	☐ Shakiness	☐ Dizziness	☐ Numbness
☐ Coughing	☐ Tremor	☐ Falling	☐ Bedwetting
☐ Hair Change	☐ Nosebleeds	☐ Confusion	☐ Diarrhea
☐ Hearing Loss	☐ Chest Pain	☐ Panic Attacks	☐ Constipation
☐ Headaches	☐ Tingling in limbs	☐ Loss of Consciousness	☐ Other_____

Pregnant? ☐ yes ☐ no If yes, expected delivery date _____
Hospitalized in last three (3) years? ☐ yes ☐ no If yes, where and why _____
_____
Allergies/Drug Sensitivity: ☐ None ☐ Food _____
☐ Medication _____ ☐ Other _____

Weight Change in last year by more than five (5) pounds? ☐ yes ☐ no If yes, how much (+/-) _____

Check any of the medical conditions that apply:

☐ Anemia	☐ Arthritis	☐ Asthma	☐ Blood Pressure	☐ Bone/Joint Pain
☐ Cancer current	☐ Cancer past	☐ Cirrhosis/Liver Disease	☐ Diabetes	☐ Epilepsy/Seizures
☐ Eye Disease/Blindness	☐ Fibromyalgia	☐ Glaucoma	☐ Head Injury/Brain Tumor	☐ Heart Disease
☐ Hepatitis/Jaundice	☐ Kidney Disease	☐ Lung Disease	☐ Oral Health/Dental	☐ Stroke
☐ Thyroid	☐ Tuberculosis	☐ Anxiety	☐ Depression	☐ Other_____

ALCOHOL & DRUG USE AND TREATMENT (You may choose not to answer any of the following questions.)

What treatment have you had for Alcohol/Drug related challenges? ☐ none ☐ AA/NA
☐ outpatient treatment ☐ residential treatment ☐ detoxification ☐ hospitalization

When and where? _____

SUBSTANCE USE	AGE STARTED	AGE STOPPED OR CURRENT	AVERAGE FREQUENCY IN PAST YEAR	AVERAGE AMOUNT USED EACH TIME	COMMENTS
ALCOHOL (beer, wine, liquor)					
CAFFEINE (coffee, tea, soda, energy drink,"No-Doze," etc.)					
NICOTINE (cigarettes, vaping, chew, snuff, cigars, pipe)					
CANNABIS (marijuana, hash, edibles, hash oil)					
OTHER (methamphetamine, cocaine, prescription drugs, etc) _____					
OTHER_____					

MENTAL HEALTH HISTORY & TREATMENT

☐ Check here if you have never been in mental health treatment.

MENTAL HEALTH TREATMENT (Outpatient and/or inpatient) HISTORY

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

MEDICATIONS (Current and past)

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

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

Southeast Kansas Mental Health Center

AshleyClinic

NOTICE OF PRIVACY PRACTICES

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

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

WHY WE ARE PROVIDING THIS NOTICE:

Southeast Kansas Mental Health Center and Ashley Clinic compile health 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 appointment reminders. We may use your protected health information to remind you of appointments, including leaving a voicemail message, text, and or email.
For payment. We may use and disclose health information about you to obtain payment for healthcare services that you received. We may use health information about you to arrange for payment (such as preparing bills and managing accounts). We also may disclose health information about you to others (such as insurers, collection agencies, and consumer reporting agencies). In some instances, we may disclose health information about you to an insurance plan before you receive certain healthcare services because, for example, we may need to know whether the insurance plan will pay for a particular service. 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.
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.

1. For our healthcare operations. We may use and disclose health information about you in performing a variety of business activities that we call "healthcare operations." These "healthcare operations" activities allow us to, for example, improve the quality of care we provide and reduce healthcare costs. **Examples** include:
    A. Reviewing and evaluating the skills, qualifications, and performance of healthcare providers taking care of you.
    B. Providing training programs for students, trainees, healthcare providers or non-healthcare professionals to help them practice or improve their skills.
    C. Cooperating with outside organizations that evaluate, certify or license healthcare providers, staff or facilities in a particular field or specialty.
    D. Working with others (such as lawyers, accountants, and other providers) who assist us to comply with this Notice and other applicable laws.
2. For Business Associate Agreements. Southeast Kansas Mental Health Center and Ashley Clinic provide services through business associate contracts, for which we may disclose protected health information about you so that they may perform the job that we have asked them to do, and bill you or your third-party payer for the services rendered. We require the business associate to appropriately safeguard your protected health information through a **Business Associate Agreement** with Southeast Kanas Mental Health Center and Ashley Clinic. **Examples** include clearinghouses for billing, software vendors, some insurers, and drug wholesalers.
3. As Required by Law. We will use and disclose health information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose health information. For example, state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.
4. When permitted by law, we may use or disclose health information about you without your permission for various activities that are recognized as "national priorities." We will only disclose health information about you in the following circumstances when we are permitted to do so by law. Below are brief descriptions of the "national priority" activities recognized by law.
    A. **Threat to health or safety:** We may use or disclose health information about you if we believe it is necessary to prevent or lessen a serious threat to health or safety.
    B. **Public health activities:** We may use or disclose health information about you for public health activities. Public health activities require the use of health information for various activities, including, but not limited to, activities related to investigating diseases, reporting child abuse and neglect, monitoring drugs or devices regulated by the Food and Drug Administration, and monitoring work-related illnesses or injuries. For example, if you have been exposed to a communicable disease (such as a sexually transmitted disease), we may report it to the State and take other actions to prevent the spread of the disease.
    C. **Abuse, neglect, or domestic violence:** We may disclose health information about you to a government authority (such as the Department of Social Services) if you are an adult and we reasonably believe that you may be a victim of abuse, neglect, or domestic violence.
    D. **Health oversight activities:** We may disclose health information about you to a health oversight agency – which is basically an agency responsible for overseeing the healthcare system or certain government programs. For example, a government agency may request information from us while they are investigating possible insurance fraud.
    E. **Court proceedings:** We may disclose health information about you to a court or an officer of the court (such as an attorney). For example, we will disclose health information about you to a court if a judge orders us to do so.
    F. **Law enforcement:** We may disclose health information about you to a law enforcement official for specific law enforcement purposes. For example, we may disclose limited health information about you to a police officer if the officer needs the information to help find or identify a missing person.
    G. **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.
    H. **Coroners and others:** We may disclose health information about you to a coroner, medical examiner, or funeral director or to organizations

that help with organ, eye and tissue transplants.

I. **Workers' compensation:** We may disclose health information about you in order to comply with workers' compensation laws.

J. **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.

K. **Treatment alternatives:** 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.

L. **Research organizations:** We may use or disclose health information about you to research organizations if the organization has satisfied certain conditions about protecting the privacyof health information.

M. **Certain government functions:** We may use or disclose health information about you for certain government functions, including but not limited to military and veterans' activities and national security and intelligence activities. We may also use or disclose health information about you to a correctional institution in some circumstances where that information may be needed for health care purposes.

5. Fundraising. If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us. Please contact our Privacy Officers to opt-out of fundraising communications if you chose to do so.

AUTHORIZATIONS:

Other than the uses and disclosures described above (#1-5), we will not use or disclose health information about you without the "authorization" – or signed permission – of you or your personal representative. In some instances, we may wish to use or disclose health information about you, andwe may contact you to ask you to sign an authorization form. In other instances, you may contact us to ask us to disclose health information and we will ask you to sign an authorization form.

If you sign a written authorization allowing us to disclose health information about you, you may later revoke (or cancel) your authorization in writing (except in very limited circumstances related to obtaining insurance coverage). If you would like to revoke your authorization, you may write us a letter revoking your authorization. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization and taken some action.

The following uses and disclosures of health information about you will only be made with your authorization (signed permission):

- ✓ Uses and disclosures for marketing purposes.
- ✓ Uses and disclosures that constitute the sales of health information about you.
- ✓ Most uses and disclosures of psychotherapy notes if we maintain psychotherapy notes.
- ✓ Any other uses and disclosures not described in this Notice.

YOUR HEALTH INFORMATION RIGHTS:

1. Right to Copy of This Notice. You have a right to have a paper copy of our Notice of Privacy Practices at any time. If you would like to have a copy of our Notice,ask the receptionist for a copy, or contact our Privacy Officers.
2. 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.
3. 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.
4. Right to Accounting. You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting, fill out a **specific form,** or contact our Privacy Officer. Accounting Request Forms are available from our Privacy Officer.
   The accounting will not include several types of disclosures, including disclosures for treatment, payment or healthcare operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request that include disclosures for treatment, payment, or healthcare operations. The accounting will also not include disclosures made prior to April 14, 2003.
   You have the right to one accounting per year at no cost.
5. Right to Request Restrictions. 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.
6. 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.
7. Breach Notification. You also have the right to be notified in the event of a breach of health information about you. If a breach of your health information occurs, and if that information is unsecured (not encrypted), we will notify you promptly with the following information:
   - ✓ A brief description of what happened.

- ✓ A description of the health information that was involved.
- ✓ Recommended steps you can take to protect yourself from harm.
- ✓ What steps we are taking in response to the breach.
- ✓ Contact procedures so you can obtain further information.

8. Right to File a Complaint. If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a written complaint either with us or with the federal government.

We will not take any action against you or change our treatment of you in anyway if you file a complaint. To file a written complaint with us, you may bring your complaint directly to our Privacy Officer, or you may mail it to the following address:

ATTN: Privacy Officer
SEKMHC / Ashley Clinic
P.O. Box 807
Iola, KS 66749

To file a written complaint with the federal government, please use the following contact information:
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
Toll-Free Phone: 1-(877) 696-6775 Website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html Email: OCRComplaint@hhs.gov

YOUR RIGHTS REGARDING ELECTRONIC HEALTH INFORMATION TECHNOLOGY:

Southeast Kansas Mental Health Center and Ashley Clinic 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.

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.

ACKNOWLEGEMENT OF RECEIPT:

You will be asked to sign an acknowledgement of receipt of this Notice of Privacy Practices. If you have any questions regarding this Notice of Privacy Practices, please contact our Privacy Officers.

CHANGES TO THIS NOTICE:

If we change the Notice, you will be given a revised 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 waiting area and on our website.

Effective Date: 03/23/2013, Revised 03/13/13, Revised 05/29/15 , Revised 01/10/24.