Southeast
Kansas
Mental Health
Center

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. 620-365-5717

Southeast Kansas Mental Health Center

AshleyClinic

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 _____

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 and Ashley Clinic

** Please sign and date each item below **

Acknowledgement and Authorization:

- I authorize SEKMHC and Ashley Clinic to release information required to process my claims:

Signed: _____ Date: _____

- I hereby assign my insurance benefits to be paid directly to the healthcare provider:

Signed: _____ Date: _____

- I have read and understand the Financial Policy for SEKMHC and Ashley Clinic:

Signed: _____ Date: _____

- I authorize SEKMHC and Ashley Clinic to obtain/have access to my medication history:

Signed: _____ Date: _____

- I have read and understand the Notice of Privacy Practices for SEKMHC and Ashley Clinic:

Signed: _____ Date: _____

Southeast Kansas Mental Health Center

AshleyClinic

BACKGROUND INFORMATION

Please take the time to complete this information form before your appointment. Bring the complete form with you to your appointment. If you need additional space to give more detail for a section, please write on the back. This information is protected under Federal Regulations governing Confidentiality of Substance Use Client Records and the Health Insurance Portability and Accountability Act (HIPPA).

Name: _____ **Date:** _____
First Middle Last

Prescription Medication:

Are you currently taking any medication? ___No ___Yes

Medication: _____ Dose: _____ Frequency: _____

Why Prescribed: _____ When Prescribed: _____ Doctor: _____

Medication: _____ Dose: _____ Frequency: _____

Why Prescribed: _____ When Prescribed: _____ Doctor: _____

Medication: _____ Dose: _____ Frequency: _____

Why Prescribed: _____ When Prescribed: _____ Doctor: _____

Medication: _____ Dose: _____ Frequency: _____

Why Prescribed: _____ When Prescribed: _____ Doctor: _____

Employment History (5 years required)**:**

Employer: _____ Type of Work: _____

City: _____ From-To: _____

Employer: _____ Type of Work: _____

City: _____ From-To: _____

Employer: _____ Type of Work: _____

City: _____ From-To: _____

Employer: _____ Type of Work: _____

City: _____ From-To: _____

Employer: _____ Type of Work: _____

City: _____ From-To: _____

Legal History: List your lifetime arrest record.

Date: ________________ Offense: ______________________ Substance Related: ___Yes ___No

Location (City or County, State): _________________________ Jail Time: __No ___Yes/How long: _____

Date: ________________ Offense: ______________________ Substance Related: ___Yes ___No

Location (City or County, State): _________________________ Jail Time: __No ___Yes/How long: _____

Date: ________________ Offense: ______________________ Substance Related: ___Yes ___No

Location (City or County, State): _________________________ Jail Time: __No ___Yes/How long: _____

Date: ________________ Offense: ______________________ Substance Related: ___Yes ___No

Location (City or County, State): _________________________ Jail Time: __No ___Yes/How long: _____

Date: ________________ Offense: ______________________ Substance Related: ___Yes ___No

Location (City or County, State): _________________________ Jail Time: __No ___Yes/How long: _____

Date: ________________ Offense: ______________________ Substance Related: ___Yes ___No

Location (City or County, State): _________________________ Jail Time: __No ___Yes/How long: _____

Alcohol Drug Treatment History:

Have you ever been in a treatment center for substance use problems? ___No ___Yes

Date: __________ Name of Treatment Center: ________________________ Number of Days: ____

City/State: _____________________ ____Inpatient or ____ Outpatient Completed: ___Yes ___No

Date: __________ Name of Treatment Center: ________________________ Number of Days: ____

City/State: _____________________ ____Inpatient or ____ Outpatient Completed: ___Yes ___No

Date: __________ Name of Treatment Center: ________________________ Number of Days: ____

City/State: _____________________ ____Inpatient or ____ Outpatient Completed: ___Yes ___No

Date: __________ Name of Treatment Center: ________________________ Number of Days: ____

City/State: _____________________ ____Inpatient or ____ Outpatient Completed: ___Yes ___No

Date: __________ Name of Treatment Center: ________________________ Number of Days: ____

City/State: _____________________ ____Inpatient or ____ Outpatient Completed: ___Yes ___No

Southeast Kansas Mental Health Center

AshleyClinic

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

Patient,

The Center has become a Certified Community Behavioral Health Clinic (CCBHC). This certification 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 patient's 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

304 N. Jefferson
PO Box 807
Iola, KS 66749

402 S. Kansas
Chanute, KS
66720

1322 S. Grant
Chanute, KS
66720

519 S. Elm
Garnett, KS 66032

401 Woodland Hills
Blvd. Box #6
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
- ☒ 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	

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

Southeast Kansas Mental Health Center | AshleyClinic

Consent to Treat
For Voluntary Assessment and Treatment

Individual Served Name: _____

I understand that by signing this consent for initial assessment and treatment that I am agreeing to participate in an evaluation at this clinic. The purpose of this evaluation is to assess my current physical and behavioral health needs and to develop specific treatment recommendations related to my concerns that have brought me to the Clinic.

I understand that the initial evaluation will be conducted by a licensed professional. The evaluation will consist of a thorough evaluation, but I may be asked to do additional testing to assess my needs more thoroughly.

I understand that my provider may need to discuss my case in a confidential manner with a professional associate and/or supervisor for the purpose of providing higher quality care to me. I am aware that I may be asked to see additional professionals 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 *Notice of Privacy Practices* of which I have been given a copy.

I understand that some treatment recommendations may be addressed during the initial evaluation. Once the initial evaluation and treatment plan has been created, I will be given the opportunity to review and discuss with my professional; 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 by notifying the clinic in writing.

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

I hereby consent to participate in the process of evaluation and treatment at Southeast Kansas Mental Health/Ashley Clinic.

_____ _____
Individual Served Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

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 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 and that missed appointments will be charged at the sliding scale rate.
I certify that I have received the Guide to Services, Welcome brochure, and 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

Expiration Date 12/31/2024

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.

AshleyClinic

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 <u>all possible</u> 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

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.

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:**

- ✓ 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 ADD REVISED DATE

SUPPORTIVE COMMUNITY RESOURCE NEEDS ASSESSMENT

Complete this **Needs Assessment Tool** and bring it with you to your Alcohol Drug Evaluation. Focus on making healthy changes in your life. Use this opportunity to focus on your self and **become aware of life issues or concerns you would like assistance resolving**. During the Alcohol Drug Evaluation, your Counselor may also identify some issues that you may wish to address. **Mark each item below that applies to you. Your Counselor may be able to provide contact information for a Supportive Community Resource for each specific need.**

Basic Needs

- ☐ food assistance
- ☐ cash assistance
- ☐ help to find housing for: ___ low income; ___ abused women; ___ homeless
- ☐ help weatherizing / repairing my home
- ☐ help with my utility bills
- ☐ employment
- ☐ child care
- ☐ education
- ☐ church
- ☐ disaster assistance
- ☐ Kansas Identification Card
- ☐ other _____

Physical Health

- ☐ Kansas Medical Card
- ☐ low income ☐ medical clinic ☐ dental clinic
- ☐ testing | ☐ treatment for ☐ sexually transmitted infections ☐ Hepatitis C ☐ HIV / AIDS
- ☐ test for TB
- ☐ help to stop smoking
- ☐ help to lose weight
- ☐ prescription payment
- ☐ hearing test ☐ hearing aid
- ☐ disability application
- ☐ support group for _____
- ☐ other _____

Mental Health

- ☐ Mental Health Therapy for ☐ my self ☐ family member_____
- ☐ parenting skills
- ☐ current abuse or ☐ history of abuse | ☐ emotional ☐ physical ☐ sexual
- ☐ I have been accused of abusing | ☐ spouse ☐ child ☐ other | kind of abuse_____
- ☐ referral for psychiatric medication
- ☐ referral for Case Manager
- ☐ disability application
- ☐ support group for _____
- ☐ other _____

Legal

- ☐ attorney for | ☐ divorce ☐ disability ☐ protection from abuse order ☐ other_____
- ☐ drivers license ☐ ignition interlock device
- ☐ urinalysis