Southeast Kansas Mental Health Center

304 N. Jefferson · PO Box 807 Iola, Kansas 66749 · Phone 620.365.5717 · Fax 620.365.8642 · www.sekhmhc.org ·

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 Government Issued Photo ID.** Examples are: US Passport or Passport Card, US Military ID Card, State Driver's License, State Non-Driver ID Card
- **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 at least 24 hours before the scheduled appointment if you will not be able to keep this appointment.
- **Inmates:** No charges will be assessed for services provided during incarceration. After release from jail, the patient assumes full financial responsibility for any services rendered.

QUESTIONS?

Please do not hesitate to contact your local SEKMHC office.

Welcome

Southeast Kansas Mental Health Center

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
@southeast kansas mental health center
@sekmhc
@sekmhc
@sekmhc
@sekmhc
www.sekmhc.org

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.

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

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.

Southeast Kansas Mental Health Center-Chemical Abuse
Income and Residency Verification

If you cannot afford to pay for Chemical Abuse Treatment, you may be eligible for assistance. One item from each of the lists below is required to determine if you are eligible for free services.

Client Name:_____**DOB:**_____**Date:**_____

Directions: Mark the box below of the item the client gives as Proof of Income and Residency. If one of the grey boxes is checked fill out the verification letter section below or if client has other signed verification attach that to this form.

INCOME (one item required) Check One		**RESIDENCY (one item required) Check One**	
☐	Pay stub	☐	Kansas Driver's License
☐	Income Tax return	☐	Kansas Native American Tribal Document
☐	Letter of unemployment benefits	☐	Kansas Medical Card
☐	Annual benefits letter	☐	Kansas ID Card
☐	Bank statements	☐	Apartment or house rent receipt or Utility Bill w/client's name and Kansas address
☐	Signed statement of family member or Friend (if this box is checked person verifying must fill out income section below or if they have signed another document attach it to this form.)	☐	Signed statement of family member or Friend (if this box is checked person verifying must fill out income section below or if they have signed another document attach it to this form.)
☐	Signed Statement from Criminal Justice Staff, PO, Social Services Staff or Similar Professional (If this box is checked person verifying must fill out income section below or if they have signed another document attach it to this form.)	☐	Signed Statement from Criminal Justice Staff, PO, Social Services Staff or Similar Professional (If this box is checked person verifying must fill out income section below or if they have signed another document attach it to this form.)

Verification Letter: Only needed if there are no other sources for verification

This letter serves as evidence of Proof of Residency and / or Proof of Income in the event there are no other sources for verification. Check box below of which section is being verified.

_____
Print Name of Family Member or Friend Verifying Income and / or Residency

_____
Relationship to Client

☐ Proof of income (fill in number of months)
To the best of my knowledge the above client has not been employed for the last_____months and has no income. (Number)

☐ Proof of Residency:
I certify that the above client is or has been residing at

_____
Address (client is or has been residing)

_____
Family Member or Friend Verifying's Signature

_____
Date

Southeast Kansas Mental Health Center

Face Sheet

ADAS ☐Yes ☐No _____%
DX _____
For CA Staff Use Only

Date _____ E-mail _____ Case No. _____

Name _____ Date of Birth _____ Age _____

Social Security # _____ Military/Veteran Status ☐Yes ☐No

Females Only: Maiden name _____ Former married names _____

Address _____ City/State/Zip _____

Phone # _____ Work Phone # _____

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

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

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

Legal Guardian _____ Phone # _____

Address _____

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

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

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

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

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

Ethnicity ☐Hispanic ☐NOT Hispanic

Primary Language _____ Other languages spoken _____

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

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

Responsible Party/Parties for Account (if responsibility is shared, please complete both sections):

Responsible Party Name _____ Relationship _____

Social Security # _____ DOB _____ Email _____

Responsible Party Name _____ Relationship _____

Social Security # _____ DOB _____ Email _____

Have you received previous mental health services? ☐ Yes or ☐ No If yes, please list:

Name of Facility	Address	Inpatient/Outpatient	Dates

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

Employee Name _____

Employer _____ Occupation _____

Name (spouse) _____

Employer _____ Occupation _____

Address/City/State/Zip_____ Phone _____

List sources of household income*	Source	Gross Monthly Amount

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

List those dependent upon household income

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Emergency Contact Name _____Telephone # _____ Address _____

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

Reimbursement Information

PRIMARY INSURANCE _____

ID # _____ Group # _____

Cardholder Address _____ City _____ State/ZIP _____

Cardholder's Name _____Cardholder DOB _____

Client's relationship to cardholder _____

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

SECONDARY INSURANCE (attach copy) _____

ID # _____ Group # _____

Address _____ City _____ State/ZIP _____

Insured's Name _____ DOB _____

Client's relationship to insured _____

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

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

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

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

WORKER'S COMPENSATION INSURANCE INFORMATION

Date of accident _____ Employer Name and Address _____

Names of Workers Compensation Insurance_____

Name of Person or company Insured_____

Insurance company Claim or Policy #_____

Worker's compensation Claim #_____

Name of Worker's Compensation Agency where claim was filed_____

Address_____

Has the case been settled ☐Yes Date_____ ☐No

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

Phone number of Legal Representative_____

AUTOMOBILE, NO-FAULT OR LIABILITY INSURANCE INFORMATION:

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

Business /Property Owner_____Address:_____Telephone#:_____

Type of insurance: Premises Medical _____ Liability_____

Name of Policy holder_____ Address of Policyholder_____

Policy Number or Claim ID Number_____ Insurance Company_____

Address of Insurance company_____

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

Southeast Kansas Mental Health Center

Agreement for Financial Responsibility

Client _____ Case # _____

2019		***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 Evaluation	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

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

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

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

*********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**

Southeast Kansas Mental Health Center

304 N. Jefferson
PO Box 807
Iola, KS 66749
620-365-5717
fax: 620-365-8255

1322 S. Grant
Chanute, KS 66720
620-431-7890
fax: 620-431-7927

519 South Elm
Garnett, KS 66032
785-448-6806
fax: 785-448-6960

401 Woodland Hills
Blvd. Box #6
Fort Scott, KS 66701
620-223-5030
fax: 620-223-1650

505 W. 15th
Pleasanton, KS 66075
913-352-8214
fax: 913-352-8236

1106 S. Ninth
PO Box 39
Humboldt, KS 66748
620-473-2241
fax: 620-473-3334

CAS - Consent for Release of Confidential Information

Client/Patient Name		Case Number	
Date of Birth		Social Security Number	

I hereby authorize Southeast Kansas Mental Health Center to__ ☐ **Release**__ ☐ **Obtain**

Name of Individual Agency			
Address, City, State, Zip			
Telephone Number		Fax Number	

the following information ☐**Release** ☐ **Obtain**

☐ Diagnostic Evaluation	☐ Relapse Prevention Plan	☐Referral for TB Screening/Evaluation
☐ Verification of Compliance	☐ Verification of Completion	☐ TB Risk Assessment
☐ Status Report	☐ Service Requested	☐ Results of TB Screening/Evaluation
☐ Discharge Plan	☐ Court Order	☐ Client Compliance Documentation
☐ Discharge Summary	☐	☐ Emergency Medical Information
☐	☐	☐ Provide Insurance/Third Party Claim

The purpose or need is to

☐	Assist in the provision of services	☐	Advise compliance with recommendations
☐	Communicate Medical Emergency	☐	

This consent to disclose may be revoked by me at any time upon my written request except to the extent action has been taken in reliance thereon. This consent will not exceed more than one year. This consent expires on _____.

I understand that my records are protected under the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. pts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Client Signature _____ Date _____

Parent/Guardian/
Legal Representative _____ Date _____

Relationship _____

Witness Signature _____ Date _____

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information, if held by another party is NOT sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be subject to penalties. Drug Abuse Office and Treatment Act of 1971 (21 USC 1175) Comprehensive Alcohol Abuse, Federal Register, V Col. 40 No 127-Tuesday, July 1, 1975.

Southeast Kansas Mental Health Center

Applicant Name: _____

Address: _____

Social Security #:_____ **Home Phone:**_____ **Cell Phone:** _____

PLEASE LIST ALL MEMBERS IN YOUR HOUSEHOLD INCLUDING YOURSELF

NAME	APPLICANT RELATIONSHIP	DATE OF BIRTH	DOES THIS PERSON HAVE HEALTH INSURANCE?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

TOTAL NUMBER OF FAMILY MEMBERS: _____

INCOME SOURCE – All members of household must provide all sources of income.

Recent Tax Return	Pension/Retirement	Alimony	Support Letter	Employment Letter
Paycheck Stubs	Military/Veteran	Child Support	Public Assistance	In Kind Living Support
Self-Employment	Social Security	Worker's Compensation	Unemployment/ Disability	Other

NAME	SOURCE OF INCOME	FREQUENCY OF INCOME	AMOUNT	TOTAL ANNUAL INCOME
			$	$
			$	$
			$	$

TOTAL HOUSEHOLD ANNUAL INCOME: $ _____

I certify that the above information is complete and correct. If any of the above information is false, untrue, misleading or incomplete, I understand that I may be required to pay full price for the services received according to the established fee schedule. By signing below, I give my consent to release any and all information from all sources needed to substantiate the above information.

Southeast Kansas Mental Health Center

APPLICANT SIGNATURE:_____ **DATE:** _____

FOR OFFICE USE ONLY

DOCUMENTS PROVIDED IN THE APPLICATION:

PROOF OF INCOME	☐ Profit & Loss (3 mo)	☐ Alimony
☐ Tax Return	☐ Public Assistance	☐ Child Support
☐ Form W-2	☐ Social Security	☐ Military Family Allotments
☐ 1099 MISC	☐ Unemployment	☐ Annuity Payments
☐ 1099 INT	☐ Workers Compensation	☐ Sale of Property
☐ Paycheck Stubs	☐ State Disability	☐ Gifts
☐ Employment Letter	☐ Pension/Retirement	☐ Inheritance
☐ Self Declaration of Income	☐ Income from rents	☐ Savings

Calculation and Notes:

Family Size:	**Total Gross Annual Household Income:**

Sliding Fee Level:		

Southeast Kansas Mental Health Center

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.

Southeast Kansas Mental Health Center

INDIVIDUAL RIGHTS

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

- Confidentiality: Your medical and psychological records will be held in confidence, subject to the following conditions:
- 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's Chief Executive Officer 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 Chief Executive Officer 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 Chief Executive Officer, Medical Director, Director of Clinical Services, and/or Director of Community Support Services of the Southeast Kansas Mental Health Center.
- 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 not employed or contracted by the Southeast Kansas Mental Health Center, provided that the necessary releases are signed to ensure coordination of care. The psychiatrist 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, 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 Chief Executive Officer. Forms for such complaints may be obtained from the office assistants 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.

Southeast Kansas Mental Health Center

Electronic Communication Consent

Client Name: _____
DOB: _____
SSN: _____

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

Cell Phone/Text Number: _____ Email address: _____

Cell Phone/Text Number: _____ Email address: _____

E-Mail and Text Messaging Risk Factors and Responsibilities

Risks:

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

Conditions for use:

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

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

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

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

_____ _____

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

_____ _____

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

_____ _____ _____

Signature of Witness (Print Name) Date

Southeast Kansas Mental Health Center

Tele-video 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 tele-video 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 tele-video 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 tele-video mental health/chemical abuse service session.

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

I consent to Southeast Kansas Mental Health Center tele-video 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

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.

Southeast Kansas Mental Health Center

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 consumer. To follow the regulations for the state, each consumer 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 consumer would continue to meet with the Patient Navigator every 6 months forward as long as the consumer 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 consumer.

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

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

QUESTIONNAIRE ABOUT DRINKING ALCOHOL

Name:_____ Date:_____

The following questions concern information about your involvement with alcohol during the past 12 months. Carefully read each statement and decide if your answer is "YES" or "NO". Then, check the appropriate box beside the question. Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months

YES	NO	
☐	☐	1. Do you feel you are a normal drinker? (By normal we mean you drink less than, or as much as most people.)
☐	☐	2. Does your spouse, a parent, or other close relative ever worry or complain about your drinking?
☐	☐	3. Do you ever feel guilty about your drinking?
☐	☐	4. Do friends or relatives think you are a normal drinker?
☐	☐	5. Are you able to stop drinking when you want to?
☐	☐	6. Have you ever attended a meeting of Alcoholics Anonymous?
☐	☐	7. Has drinking ever created problems between you and your spouse, a parent, or other close relative?
☐	☐	8. Have you ever gotten into trouble at work or school because of drinking?
☐	☐	9. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?
☐	☐	10. Have you ever gone to anyone for help about your drinking?
☐	☐	11. Have you ever been in a hospital because of drinking? If YES: Was this for (a) detox; (b) alcohol treatment; (c) alcohol-related injuries or medical problems, such as cirrhosis or physical injury incurred while under the influence of alcohol?
☐	☐	12. Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages (DUI)?
☐	☐	13. Have you ever been arrested, even for a few hours, because of other drunken behavior?

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

Authorization for Carelon Behavioral Health to Release Confidential Information

Important: By completing all sections of this form you allow Carelon Behavioral Health to disclose health care information to the individuals you identify for up to one year. You may allow Carelon to share health care information with your family, providers, legal representative, or **anyone** you wish to have access. Please fill in all sections as incomplete forms may be returned.

Please note: It is also important for your doctor to have access to your medical information to ensure you receive the best care possible, including any follow-up care that may be needed. To allow Carelon the ability to send your health care information to your doctor, complete and sign this form. We will only send information that pertains to your care.

If your request involves alcohol or substance use information, please pay attention to the special instructions in the applicable sections.

SECTION 1: WHOSE HEALTH CARE INFORMATION IS TO BE RELEASED?

I, _____ **(Member Name)** authorize Carelon (or any Carelon Behavioral Health subsidiary holding my information) to disclose my health care information as described below.

Additional Member Identifying Information Member ID#: _____ DOB: _____

Phone Number: _____ Name of Health Plan: AAPS

SECTION 2: WHO IS TO RECEIVE THIS HEALTH CARE INFORMATION?

Print the Name(s) of person, provider or entity who will be receiving your information and contact information (if known):

Southeast Kansas Mental Health Center

1322 S Grant

Chanute, KS 66720

Phone number of who will be receiving your information: 620-431-7890

Is it ok to include information from past, present, and/or future treating provider(s)?: ☑Yes ☐No

SECTION 3: WHY SHOULD THIS HEALTH CARE INFORMATION BE RELEASED?

Reason ("At my request" is an acceptable response): facilitate state funding

Specify, if possible: ☑Care Coordination/Management ☑Claim Assistance ☑Quality of Care Review

☐Other (Please explain reason): _____

SECTION 4: WHAT HEALTH CARE INFORMATION MAY BE RELEASED?

BY INITIALING the items on the following page, you authorize Carelon to release specific types of information to the party identified in Section 2 above:

Authorization for Carelon Behavioral Health to Release Confidential Information

____ Mental health information and/or records **(INITIALS REQUIRED)**

X____ Alcohol or substance use information and/or records **(INITIALS REQUIRED)**

Optional: ☐ Claims info ☐ Authorizations ☐ Explanation of benefit letters ☐ Denials/Appeals info ☐ Clinical notes

____ HIV/AIDS related information and/or records **(INITIALS REQUIRED)**

____ Other health information, please specify **(INITIALS REQUIRED)**: _____

Special instructions, if any (you may specify provider, date span, service type, etc.): none

_____

SECTION 5: HOW LONG SHOULD THIS AUTHORIZATION LAST?

This authorization shall be in force and effect **for one year** or until I revoke it, in the manner described below or until **(insert expiration date or event**) _____ *(whichever is shorter)*.

SECTION 6: WHAT ARE MY RIGHTS?

- You have a right to request a copy of this form and to request a copy of the information that is being disclosed.
- You do not have to sign this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits.
- The information disclosed by this authorization may be at risk for re-disclosure by the recipient and if that happens, it might no longer be protected by federal privacy laws.
- You have a right to revoke this authorization at any time. ***But if you revoke this authorization, the revocation will not affect the disclosure of any information that Carelon has already sent to the recipient***.
- If you authorized release of alcohol or substance use information to a healthcare organization that is not your treating provider, for the next two years, you have the right to find out who within that organization actually saw your information. You should contact the organization directly for that information.

Please note that if you have authorized the release of ONLY alcohol or substance use treatment records, you may revoke this authorization verbally. Revocation involving all other types of health care records must be in writing.

_____ _____

Signature of the Member or the Member's Legally Authorized Representative* Date

_____

Print Name

**** NOTE: If you are signing as the individual's Legally Authorized Representative, attach a copy of the appropriate legal document(s) granting you the authority to do so. Examples would be a health care power of attorney, a court order, guardianship papers, etc.*** **A financial or business power of attorney is NOT sufficient.**

Southeast Kansas Mental Health Center

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

J. **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.

K. **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.

L. **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
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 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 03/02/26

Southeast Kansas Mental Health Center

Informed Consent for Participation in Data Collection

Project Title: Expanding Continuity of Care Capacity for Substance Use Disorder for Southeast Kansas
Grant: TI-25-002

Client's Name: _____

Client Case Number: _____ **Date of Birth:** _____

Purpose of the Data Collection
You are being invited to participate in data collection activities for a SAMHSA-funded program aimed at improving services for individuals experiencing substance use and behavioral health challenges. The purpose of this data collection is to evaluate program effectiveness and meet federal grant reporting requirements. Information may be entered into SAMHSA's performance reporting system (SPARS) in a de-identified manner.

Types of Data Collected
If you agree to participate, the following de-identified client-level data maybe be used in our reporting:

- *Demographics: Age, gender, race/ethnicity, education, employment status*
- *Substance Use: Past 30-day use, primary/secondary substances*
- *Mental Health Status: Psychological distress, functioning, diagnoses*
- *Housing Status*
- *Criminal Justice Involvement*
- *Physical Health Status: General health, chronic conditions*
- *Social Connectedness*
- *Service Utilization: Type and frequency of services received*
- *Outcome Measures: Improvements in functioning, reduced substance use, improved housing/employment status*

Voluntary Participation
Your participation is voluntary. Your decision to participate or not will not affect the care or services you receive.

If you have any questions about this project, contact Krissi Tummons, MSW, LAC, via email at ktummons@sekmhc.org

By signing below, you acknowledge that you have read and understood this form and consent to participate in the data collection activities described.

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

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

_____ _____
Witness Signature: **Date of Signature:**