****

Thank you for your referral to Samaritan Behavioral Health, Inc.

CSD Referrals are to be made by completing the attached CSD Intake Packet and sending it to:

Samaritan Behavioral Health, Inc.

Access to Care

601 Edwin C. Moses Blvd

Dayton, OH 45417

Or Faxing to 937-734-8252

*A crisis or emergency referral should be made by calling CrisisCare directly at 224-4646.*

Referrals to Samaritan Behavioral Health outpatient services must contain the following information in order to meet regulatory requirements and initiate our diagnostic assessment.

After we have received the **completed** information, we will contact the foster parent to schedule an intake appointment.

Intake Packet Checklist - Please complete & send the following information to our Access to Care department:

❑ The CSD Intake Referral Information form, which includes reason for referral and relevant social/family history

❑ A Release of Information for the foster parent unless it is requested that they not be a part of the assessment or treatment process.

❑ Any additional releases for other persons, agencies, or schools should be included. A release of information is not necessary between Samaritan Behavioral Health and your organization since you have custody of the child. Release forms can be photocopied.

❑ A signed copy of the Consent for Treatment and Financial Authorization, giving permission to SBHI to treat.

❑ Health History Questionnaire

❑ HIPAA / Documentation & Client Services Review

We will also need a copy of the current Custody Order or a statement on agency letterhead stating that your agency currently has custody of the child. This item is MANDATORY. It must be received before an appointment will be scheduled.

If you have questions about the enclosed information, please call 937-734-8333. You may fax or mail the information to us. Thank you for your assistance and cooperation.

Sincerely,

Access to Care

Phone: (937) 734-4310

Fax: (937) 734-8252

Samaritan Behavioral Health, Inc. (SBHI)

**CSD INTAKE REFERRAL INFORMATION (please print)**

Referral Date: \_\_\_\_\_\_ Person Completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_

Caseworker Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Caseworker Phone: \_\_\_\_\_\_\_\_\_\_\_

Child’s Name: (Last, First, MI) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_ Ethnicity:  Hispanic or Latino  Not Hispanic or Latino

Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid #(12 digits): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caretaker Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caretaker Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Size: \_\_\_\_\_\_\_

Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lethality/Safety Issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School/Grade/Special Education Placement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Counseling History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relevant Social History Including Placement History, Number of Disruptions, and Family History:

Recommendations/Requests/Reason for referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SAMARITAN BEHAVIORAL HEALTH, INC.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| I hereby grant my permission for release, review and exchange of the following information relating to my care between the parties named here. This release is intended to cover all services provided by Samaritan Behavioral Health, Inc. which includes services provided by ⬩Samaritan CrisisCare; ⬩Community Care; ⬩SBHI-CAM; ⬩SBHI-Preble; ⬩School Services; ⬩Substance Abuse Services; ⬩Youth and Adult Services; and the ⬩Young Children's Assessment and Treatment Services (YCATS).  **Charges for records requests may apply.**  I am aware that once this information is released to another party, it may no longer be protected. I understand that I may further limit the type of exchange between the listed parties. List limitation, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Samaritan Behavioral Health, Inc. | | | | | | | | | | | | | | | | | | | | |  | | | AND |  | |  | | | | | | | | | |  | |
|  | | Admin Office: 601 Edwin C. Moses Blvd. | | | | | | | | | | | | | | | | | | | | |  | | |  |  | |  | | | | | | | | | |  | |
|  | | Dayton, OH 45417 | | | | | | | | | | | | | | | | | | | | |  | | |  |  | |  | | | | | | | | | |  | |
|  | | (937) 734-8333 FAX: (937) 567-3494 | | | | | | | | | | | | | | | | | | | | |  | | |  |  | | Phone: FAX: | | | | | | | | | |  | |
| Purpose of this request: (check all that may apply during the timeframe of this release) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | Continuity of Care / Treatment | | | | | | | | |  | | Legal | | | |  | | Insurance Claim | | | | | | | |  | | Patient Request | | | | |  | Other, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Ways information may be shared: (check all that may apply during the timeframe of this release) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | Mail | |  | | Fax | | |  | Phone | |  | | In Person | | | | | | |  | | | Picked Up | | | | |  | Shared via Community Patient Health Information Network or Approved Health Information Exchange Network | | | | | | | | | |
|  | |  | Sent to client via unencrypted e-mail (client request only) | | | | | | | | | | | | | | | | | |  | | | Provided to client via unencrypted CD, USB or flash drive (client request only & client pick-up only). Charges for device will apply. | | | | | | | | | | | | | | | | |
| Patient’s Name: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date of Birth: |  | |  |
| Name at time of treatment: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | Social Security #: |  | |  |
| Patient’s Address: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Phone #: |  | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ❒ Date Range of Released Information: from \_\_\_\_\_\_\_\_\_\_\_(SBHI admission date) to \_\_\_\_\_\_\_\_\_\_\_(180 days).  ❒ Other Date Range of Released Information: from \_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_.  This information MAY include treatment or rehabilitation for drug and/or alcohol abuse, psychiatric treatment, HIV Antibody Test (test for AIDS Virus) or AIDS and related conditions, IF they did occur. I specify that this release/exchange is to include: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | Mental Health (MH) Assessment | | | | | | | | | | | |  |  | | Psychiatric Evaluation | | | | | | | | | | | | |  |  | Drug/Alcohol Abuse Assessment &/or Treatment | | | | | |  |
|  | |  | MH Treatment Progress / Notes | | | | | | | | | | | |  |  | | Laboratory Report | | | | | | | | | | | | |  |  | Occupational Therapy Evaluation &/or Treatment | | | | | |  |
|  | |  | Treatment Plan - ISP | | | | | | | | | | | |  |  | | Pharmacological Treatment | | | | | | | | | | | | |  |  | School records / IEP/outcome measures/progress | | | | | |  |
|  | |  | Discharge Summary | | | | | | | | | | | |  |  | | Medications Prescribed | | | | | | | | | | | | |  |  | Court records | | | | | |  |
|  | |  | Consultation | | | | | | | | | | | |  |  | | Physician Orders | | | | | | | | | | | | |  |  | Pharmacy / Medication History | | | | | |  |
|  | |  | Primary medical information | | | | | | | | | | | |  |  | | Other Specified here: | | | | | | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Federal confidentially regulations prohibit the recipient of this released information from making any further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.  I understand that this authorization may be revoked at any time in writing, except to the extent that the program or person who is to make the disclosure has already acted in reliance on it. This authorization will remain in effect for 180 days after I sign and date the form below or until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. I understand that I may revoke my authorization at any time and for any reason. I understand that I can lengthen or shorten the authorization period by date, event, or condition.   |  |  | | --- | --- | | For Office Use Only: | | | Date Signed by Client/Guardian: |  | | Authorization Expiration Date (180 days): |  | | If REVOKED, Date of Revocation: |  |   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature/Client Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature Parent/Guardian Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Witness Date  Extended Date From to Signature Date | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If the signature is not that of the client/patient, explain, including authority to sign on behalf of the client and documentary evidence provided. \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ . SBHI-098 (10-22-15)  New Logo SBH_FinalLogotype_TwoColor.TIFSBHI CONSENT FOR TREATMENT AND FINANCIAL AUTHORIZATION FOR SERVICES   |  | | --- | | GENERAL CONSENT FOR TREATMENT  I, the undersigned, am the client/patient (or the client’s/patient’s duly authorized representative) and do hereby voluntarily consent to and AUTHORIZE  ❑ MENTAL HEALTH AND/OR ❑ DRUG AND/OR ALCOHOL ABUSE CARE AND TREATMENT FROM SAMARITAN BEHAVIORAL HEALTH, INC. which includes crisis intervention and /or assessment services performed by the Samaritan CrisisCare.  This agreement also will serve as the basis for determination of who is responsible for payment for services provided by Samaritan Behavioral Health, Inc. to the client/patient. I understand that all information will be kept confidential consistent with Federal and State laws.  Signature of client/patient or legal representative or agent Date | | RELEASE OF INFORMATION I understand my insurance company may need to know about me and the care I receive before it will pay my bill. I AUTHORIZE SAMARITAN BEHAVIORAL HEALTH, INC. TO GIVE ANY INFORMATION ABOUT MY TREATMENT FOR MENTAL HEALTH AND/OR DRUG AND/OR ALCOHOL ABUSE CONDITION, TO MY INSURANCE COMPANY OR OTHER PAYER FOR THIS VISIT TO DETERMINE WHETHER THEY ARE LIABLE TO PAY MY BILL.  I understand I may be eligible to receive services that are paid or partially paid by public funds. I AUTHORIZE SAMARITAN BEHAVIORAL HEALTH, INC. TO DISCLOSE THE ADAMHS BOARD FOR MONTGOMERY COUNTY (ALCOHOL, DRUG ADDICITION AND MENTAL HEALTH SERVICES BOARD) (ODADAS) AND OHIO DEPARTMENT OF MENTAL HEALTH (ODMH) AND THE AoD/MH/ADAMHS BOARD FOR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_COUNTY (fill in blank if applicable), INFORMATION REQUIRED BY U.S.C. 290AA-11 509 ODADAS, ODMH, and the ADAMHS Board for Montgomery County or the Preble County Mental Health and Recovery Board to enroll me in the County Behavioral Health Service Plan through the MACSIS CLAIMS SYSTEMS, TO DETERMINE MY ELIGIBILITY FOR PUBLIC FUNDS AND PAY SAMARITAN BEHAVIORAL HEALTH, INC. for service.  The purpose of the disclosure authorized herein is to enroll me in the Montgomery or Preble County Behavioral Health Services Plan through the MACSIS Claims system to determine my eligibility for public funds and pay SAMARITAN BEHAVIORAL HEALTH, INC. for services. I also understand that failure to sign the disclosure statement, the AoD/MH/ADAMHS Board may not be able to use public funds to pay for my services.  I understand that my records are protected under the federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 CFR Part 23, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.  I understand that I may revoke this consent at any time except to the extent that action has been taken and reliance on it, and that in any event, **this consent expires automatically after 365 days after my last treatment or discharge, completion of treatment, or last day of treatment.**  Signature of client/patient or legal representative or agent Date | | FINANCIAL AUTHORIZATION I authorize payment directly to Samaritan Behavioral Health, Inc. of the benefits herein specified and otherwise payable to me but not to exceed the regular changes. I understand that I am responsible for all charges until the bills are paid in full and for the balance of charges not covered by insurance.  If I should qualify for partial public funding, I understand I am responsible for the portion of the charge that the AoD/MH/ADAMHS Board does not cover.  MEDICARE PATIENTS ONLY – I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I authorize Samaritan Behavioral Health, Inc. to release to the Social Security Administration and/or Medicare program any information needed for this or a related Medicare. If for any reason Medicare (or my insurance company) denies payment, I authorize Samaritan Behavioral Health, Inc. to act on my behalf to appeal for payment. SUBSIDY FEE AGREEMENT If it is determined that I am financially eligible to receive a fee SUBSIDY for the service(s) I may receive, I agree to accept the following responsibilities in exchange for the fee subsidy.  **I WILL PAY THE REDUCED FEE AT THE TIME OF EACH VISIT.**  Samaritan Behavioral Health, Inc. will bill my insurance or the AoD/MH/ADMHS/PCMHR Board of my resident county as payer of services.  If my insurance fails to pay all or any part of my claim, I agree to furnish written proof of this reject to Samaritan Behavioral Health, Inc.  I AGREE TO, AND ACCEPT RESPONSIBILITY FOR THE SUBSIDY FEE DISCOUNT OF \_\_\_\_\_\_\_. (This may change, subject to the final approval of your County Behavioral Healthcare Board.)  My signature, or that of my authorized representative, indicates that I have read, understand and agree with the above conditions and have provided accurate information.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Client/Patient or Signature of Client’s/Patient’s Legal Representative or Agent / Date Witness (Signature of SBHI employee) / Date | | Client/Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID / File # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | SBHI-010 01/25/2013 |   **HEALTH HISTORY QUESTIONNAIRE**  This form should be completed as fully as possible by client and reviewed by medical staff.   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Client Name (Last, First, MI):** | | | | **Age:** | **ID#:** | **Today’s Date** | | | | **Has the client had any of the following Medical Conditions?** | | | | | | | | | | **Medical Condition** | **No** | **Yes** | **Medical Condition** | | | | **No** | **Yes** | | Asthma |  |  | Oral Health/Dental | | | |  |  | | Arthritis &/or Bone/Joint Problems |  |  | Stomach/Bowel Problems | | | |  |  | | Bleeding Disorder |  |  | Stroke | | | |  |  | | Blood Pressure (high or low) |  |  | Thyroid | | | |  |  | | Cancer |  |  | Tuberculosis | | | |  |  | | Cirrhosis/Liver Disease / Hepatitis/ Jaundice |  |  | AIDS/HIV | | | |  |  | | Diabetes |  |  | Hepatitis C | | | |  |  | | Epilepsy/Seizures |  |  | Sexual Transmitted Disease | | | |  |  | | Eye Disease/Blindness/Vision Changes/ Glaucoma |  |  | Learning Problems | | | |  |  | | Fibromyalgia/Muscle Pain |  |  | Speech Problems | | | |  |  | | Headaches |  |  | Eating Problems | | | |  |  | | Head Injury/Brain Tumor |  |  | Sexual Problems | | | |  |  | | Hearing Problems/Deafness |  |  | Sleep Problems | | | |  |  | | Heart Disease |  |  | Appetite / Nutritional Problems | | | |  |  | | Kidney Disease |  |  | Confusion / Memory Problems | | | |  |  | | Lung Disease |  |  | Other: | | | |  |  | | **Please give details of any of the above checked conditions.** | | | | | | | | | | **Please note family history of any of the above conditions and client’s relationship to that family member.** | | | | | | | | |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Pain Screening:** Pain Issues?  No  Yes Does pain currently interfere with your activities?  No  Yes | | | | | | | If yes, how much does it interfere with these activities (please check)  Not at All  Mild  Moderate  Severe  Extremely | | | | | | | Please indicate the source of the pain. | | | | | | | **Health Care Utilization** | | | | | | | Name of Primary Care Physician:        None | | | | | Date of Last Physical Exam:        Unknown | | Number of visits for outpatient healthcare in past 6 months: | | | Number of visits to the Dentist in past 6 months: | | | | Number of visits to the Emergency Room in past 6 months: | | | | | | | Number of Admissions to the Hospital in past 6 months:       in past 3 years:       (Please provide detail below) | | | | | | | Hospital | City | Date | | Reason | | |  |  |  | |  | | |  |  |  | |  | | |  |  |  | |  | | |  |  |  | |  | | | **Allergies/Drug Sensitivities**  No Known Allergies  No Known Medication/Drug Allergies | | | | | | | Medications/Drugs  Food  Insects  Animals  Materials  Other: | | | | | | | Specify Allergen and Reaction: | | | | | | | **(Continued on Reverse Side)** | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Pregnancy History:** Currently Pregnant? No  Yes If yes, list expected due date:  If currently pregnant, stage of pregnancy:  Unsure  1st Trimester  2nd Trimester  3rd Trimester  Receiving pre-natal healthcare?  No  Yes If yes, provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Week Prenatal care began:  Child birth within last 5 years?  No  Yes Are you currently breastfeeding?  No  Yes  Total number of births:       Any significant pregnancy history?  No  Yes If yes, explain: | | | | | | | | | | | | | | | | | | | | | | **Immunizations** (required for child or MR/DD only) Not Applicable | | | | | | | | | | | | | | | RN Review: None Reported | | | | | | | Immunizations - Has client had or been immunized for the following diseases? Please check. | | | | | | | | | | | | | | | | | | | | | |  | | Chicken Pox | |  | Diphtheria | | |  | German Measles | | | |  | Hepatitis B | | |  | | Measles | | |  | | Mumps | |  | Polio | | |  | Small Pox | | | |  | Tetanus | | |  | | Other: | | | Immunizations Within the Past Year | | | | | | | | | | | | | | | | | | | | | | **Height/Weight** | | | | | | | | | | | | | | | | | | | | | | Height: | | | If reporting for a child, has height changed in the past year?  No  Yes. If yes, by how much (+ or -)? | | | | | | | | | | | | | | | | | | | Weight: | | | Has client’s weight changed in the past year?  No  Yes. If yes, by how much (+ or -)? | | | | | | | | | | | | | | | | | | | **Advance Directive / Living Will:** Do you have an Advance Directive/Living Will for medical care or psychiatric care? (If you were unable to make decisions for yourself)  No  Yes If yes, provide details:  Do you have a guardian or payee (adults)?  No  Yes If yes, details: : | | | | | | | | | | | | | | | | | | | | | | **Prescription and Over-the-Counter Medications**  No Medications | | | | | | | | | | | | | | | | RN Review: None Reported | | | | | | Name of Prescription, over-the-counter medication or herbal therapy | | | | | | Taken for what condition | Dose/  Route/ Frequency | | | Side Effects? | | Medication Adherence  Check one box for each medication | | | | | | Prescriber | | | |  | | | | | |  |  | | |  | | Taken fully as prescribed  Taken partially as prescribed  Taken with assistance | | | | | |  | | | |  | | | | | |  |  | | |  | | Taken fully as prescribed  Taken partially as prescribed  Taken with assistance | | | | | |  | | | |  | | | | | |  |  | | |  | | Taken fully as prescribed  Taken partially as prescribed  Taken with assistance | | | | | |  | | | |  | | | | | |  |  | | |  | | Taken fully as prescribed  Taken partially as prescribed  Taken with assistance | | | | | |  | | | |  | | | | | |  |  | | |  | | Taken fully as prescribed  Taken partially as prescribed  Taken with assistance | | | | | |  | | | |  | | | | | |  |  | | |  | | Taken fully as prescribed  Taken partially as prescribed  Taken with assistance | | | | | |  | | | | **Print Name of Person Completing this Questionnaire** | | | | | | | | | | **Signature of Person Completing this Questionnaire** | | | | | | | | | **Date** | |  | | | | | | | | | |  | | | | | | | | |  | | **Comments by clinician (non-medical), if any:**        No Comments | | | | | | | | | | | | | | | | | | | | | **Signature of Non-Medical Clinician Reviewer, if applicable: Date:** | | | | | | | | | | | | | | | | | | | | | **Recommendations, or Referrals by Medical Reviewer**        No Recommendations/ Referrals Needed | | | | | | | | | | | | | | | | | | | | | **Check Referral(s) Needed and Specify Action(s):**  Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Healthcare Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Specialty Care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | **Recommendations shared with client?**  No  Yes If yes, client’s response? | | | | | | | | | | | | | | | | | | | | | **If No, how will recommendations be shared with client?** | | | | | | | | | | | | | | | | | | | | | **Medical Reviewer Signature/Credentials** (Nurse, PA, NP, MD, DO) **Date:** | | | | | | | | | | | | | | | | | | | |   Revised 10-16-15  **Samaritan Behavioral Health, Inc. (SBHI)**  **HIPAA / Documentation & Client Services Review**  SBHI Programs include: ⬩CrisisCare ⬩Community Care ⬩SBHI-CAM ⬩SBHI-Preble ⬩School Services  ⬩Substance Abuse Services ⬩Youth and Adult Outpatient  **Form Completed On:**  **Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_**  **Client Preferences for Methods of Contact (HIPAA):**   1. New/changed phone numbers? (update new info in CL Contact screen)   ❒ Cell/Mobile #: (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ Primary phone? ❒Yes (*update new info in Contact module)*  ❒ Home Phone #: (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ Primary phone? ❒Yes (*update new info in Contact module)*  ❒ Other Phone #: (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ Primary phone? ❒Yes (*update new info in Contact module)*   1. May we call you at your current contact phone numbers? ❒ Yes ❒ No ❒ N/A ❒ No Response 2. May we leave a message, voice mail or with anyone who answers? ❒ Yes ❒ No ❒ N/A ❒ No Response 3. May we call your pharmacy? ❒ Yes ❒ No ❒ N/A ❒ No Response   Pharmacy Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Phone ( ) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_   1. May we send letters and other notices to your home address? ❒ Yes ❒ No ❒ N/A ❒ No Response 2. SBHI-CAM only: May we send text appointment reminders? ❒ Yes ❒ No ❒ N/A ❒ No Response   **Documents Reviewed/Completed with Client/Guardian:** (review & check at Intake/Registration & Annually)  ❒ Review and Update Client/Guardian Address, Phone(s), Insurance Information/ Scan Documents *(Intake & Annually)*  ❒ Consent to Treat (explanation of any and all financial obligations, fees and financial arrangements) – (Intake only)  ❒ HIPAA – Client Preferences for Methods of Contact *(Intake & Annually)*  ❒ HIPAA Notice of Privacy Practices *(Intake & Annually)*  ❒ Circumstances in which Information May Be Disclosed *(Intake & Annually)*  ❒ Client/Patient Rights and Responsibilities pamphlet, which includes the Grievance procedure *(Intake & Annually)*  ❒ Notice of Enrollment in MACSIS and GOSH system - *(Intake)* – Montgomery & Preble Board funded *only*  ❒ MACSIS/BH Enrollment E-1 *(Intake)*  ❒ MACSIS Residency Verification & Determination *(Intake & Annually)* – Montgomery & Preble Board funded *only*  ❒ ADAMHS Subsidy Application and Client “No Income Statement” *(Intake & Annually)* – Montgomery Board funded *only*  ❒ Income Declaration *(Intake & Annually)* – Preble Board funded *only*  ❒ Health History Questionnaire *(Intake & Annually);* ❒ MH Outcomes (age 5+) - *(Intake & Annually)*  ❒ Release of Information *(Intake & Annually);* ❒ Client Satisfaction Survey - *(Intake & Annually)*  From Client Services Guide: *(Intake only)*  ❒ Assessment of Needs ❒ Attendance Guidelines ❒ Code of Ethics ❒ Therapy and Treatment Planning Process  ❒ Program Rules, including Involuntary Termination ❒ Informed Consent - Risks, Benefits & Alternatives to Treatment  ❒ Restraint, smoking/tobacco use, illicit/licit drugs, weapons  From Client Fire & Safety Guide: *(Intake only)* ❒ Fire detection, suppression, warning of fire hazards; tornado procedures  **Acknowledgement of Receipt and Review of Documents**  With my signature below, I acknowledge that I have given SBHI my preferences for method of contact (HIPAA). I have also received a  copy of the HIPAA Notice of Privacy, a copy of the Circumstances under Which Information May Be Disclosed, and a copy of the Client  Rights and Responsibilities pamphlet that includes the Client Grievance Procedure. The items checked above were reviewed with me.  I was given the opportunity to ask questions and have these materials read to me.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Client/Patient Signature Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent/Guardian Printed Name and Signature Date  ❑ Unable to Obtain Client/Guardian Signature Reason & Plan to Obtain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Staff Printed Name and Signature Date Form update: 10/22/15 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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**NOTICE OF PRIVACY PRACTICES**

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

The terms of this Notice of Privacy Practices apply to Samaritan Behavioral Health, Inc. (SBHI) operating as a clinically integrated health care arrangement composed of SBHI and all of its locations, physicians, and other licensed professionals seeing and treating clients at these sites. A complete listing of our service locations is available upon request. The members of this clinically integrated health care arrangement will share protected health information of our clients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our clients’ protected health information and to provide clients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all protected health information maintained by us. You may receive a copy of any revised notices from the location in which you have received services or a copy may be obtained by mailing a request to the Director of Quality and Compliance, Elizabeth Place, 4th Floor, 601 Edwin C. Moses Blvd., Dayton, OH 45417.

**Uses and Disclosures of Your Protected Health Information**

**Your Authorization:** Except as outlined below, we will not use or disclose your protected health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization. There are certain uses and disclosures of your protected health information for which we will always obtain a prior authorization, and these include:

* **Marketing communications**, ***unless*** the communication is made directly to you in person, is simply a promotional gift of nominal value, is a prescription refill reminder, general health or wellness information, or a communication about health related products or services that we offer or that are directly related to your treatment;
* **Most sales** of your protected health information unless for treatment or payment purposes or as required by law; and
* **Psychotherapy notes** unless otherwise permitted or required by law.

**Uses and Disclosures for Treatment:** We will use and disclose your protected health information as necessary to provide, coordinate, or manage your treatment. For instance, therapists, doctors, nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, test, etc. We may also release your protected health information to another health care facility or professional who is not affiliated with our organization but who is or will be providing health or mental health treatment to you.

**Uses and Disclosures for Payment:** We will use and disclose your protected health information as necessary for the payment of those health professionals and facilities that have treated you or provided services to you. For instance, we may forward information regarding your diagnosis and treatment to your insurance company to arrange a payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for payment of your bill.

**Uses and Disclosures for Health Care Operations:** We will use and disclose your protected health information as necessary, and as permitted by law, for our healthcare operations which include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving the clinical treatment and care of our clients. We may also disclose your protected health information to another health care facility, health care professional, or health plan for such things as quality assurance and case management but only if that facility, professional, or plan also has or had a client relationship with you.

**Health Information Exchange:** We may participate in health information exchanges (HIEs) to facilitate the secure exchange of your electronic health information between and among other health care providers, health plans, and health care clearinghouses that participate in the HIE. In order to provide better treatment and coordination of your health care, we may share and receive your health information for treatment, payment, or other health care operations. Your participation in the HIE is voluntary, and your ability to obtain treatment will not be affected if you choose not to participate. You may opt-out at any time by notifying the SBHI Medical Records Department. However, your choice to opt-out does not affect health information that was disclosed through an HIE prior to the time that you opted out.

**Family and Friends Involved in Your Care:** With your approval, from time to time we may disclose your protected health information to designated family, friends, and others who are involved in your care, or are involved in payment for your care, in order to facilitate that person’s involvement in caring for you or in paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

**Business Associates:** Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, legal services, etc. At times, it may be necessary for us to provide certain protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

**Fundraising:** We may contact you to donate to a fundraising effort on our behalf.  You have the right to “opt-out” of receiving fundraising materials/communications and may do so by calling the Director of Quality and Compliance at (937) 734-8333, identifying yourself and stating that you do not wish to receive future fundraising requests.  You may also write to us at Samaritan Behavioral Health, Director of Quality and Compliance, Elizabeth Place, 4th Floor, 601 Edwin C. Moses Blvd., Dayton, OH 45417, together with a statement that you do not wish to receive fundraising materials or marketing communications from us.   We will honor your request after the date we receive your direction.

**Appointments and Services:** We may contact you to provide appointment reminders or test results. You have the right to request, and we will accommodate reasonable requests, to receive communications regarding your protected health information from us by alternative means or at alternative locations. For instance, if you would prefer that appointment reminders not be left on voice mail or sent to a particular address, we will accommodate all reasonable requests. You may request such confidential communication in writing by sending your request to the Director of Quality and Compliance, Elizabeth Place, 4th Floor, 601 Edwin C. Moses Blvd., Dayton, OH 45417.

**Health Products and Services:** We may use your protected health information from time to time to communicate with you about health products and services necessary for your treatment, to advise you of new products and services we offer, and to provide general health and wellness information.

**Research:** In limited circumstances, we may use and disclose your protected health information for research purposes. For example, a research organization may wish to compare outcomes of all clients that received a particular drug and will need to review a series of medical records. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board which oversees the research or by representations of the researchers that limit their use and disclosure of client information.

**Confidentiality of Alcohol and Drug Abuse Client Records:** The confidentiality of alcohol and drug abuse client records maintained by this facility is protected by federal law and regulations. Generally, the facility may not say to a person outside the program that you attend a drug or alcohol program or disclose any information identifying you as an alcohol or drug abuser unless: (1) you consent in writing; (2) the disclosure is allowed by a court order; or (3) the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. Federal law and regulations do not protect information about a crime committed by you either at our facility or against any person who works for the facility or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

**Other Uses and Disclosures:** We are permitted or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization. We may release your protected health information:

* For any purposes required by law;
* As required by law if we suspect child abuse or neglect; we may also release your protected health information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence. The duty to report abuse, including abuse of children, elderly persons and adults with developmental disabilities, supersedes (by law) any requirements of confidentiality. In general, professionals and persons involved in the human services system are required to report abuse if they have reason to believe there is a wound, injury, disability, neglect or emotional condition which reasonably indicates that abuse has occurred.
* When an individual’s condition represents an immediate threat to the physical safety of self or others, information may be disclosed for the purpose of preventing danger/harm.
* When an individual represents a substantial and immediate risk of serious physical impairment or injury to himself as manifested by evidence that he is unable to provide for and is not providing for his basic physical needs because of mental illness, information may be disclosed for the purpose of preventing danger/harm.
* An attorney representing the Alcohol, Drug Addiction and Mental Health Services Board (ADAMHS) for Montgomery County (if appropriate) or Preble County (if appropriate) has authority to obtain records of individual clients/patients for whom involuntary commitment (hospitalized against your will) proceedings have been initiated. The ADAMHS Boards are a state-funding source and by law must track such information. Information that may be disclosed under this provision is limited to your treatment, treatment needs, and outcomes for success.
* Information in your treatment file may be subject to an order by the court. At that time, Samaritan Behavioral Health Inc. would obey an order from a court to provide your record.
* The Ohio Legal Rights Service has authorization to secure a record of a client/patient when their representation of a client/patient warrants such action.
* Representatives of the ADAMHS Board and the Ohio Department of Mental Health (ODMH) and Ohio Department of Alcohol and Drug Addiction Services (ODADAS) may gain access to client/patient records for the purpose of evaluating the quality of services. They provide funds for services and by law are permitted to audit information.
* Additional exceptions may occur for the purpose of continuity of care/treatment where information may be shared without your prior permission to other healthcare providers who are, or will be, providing you with care. Other exceptions are related to fiscal billing and auditing, program analysis and authorized research. In each instance, only minimal information will be released to qualified personnel with a legitimate need to know.
* A parent, including a non-custodial parent or legal guardian, has the right to review information in the file pertaining to the child, the child’s treatment and disclosures made by the child, unless specified otherwise in a court order.
* A legal guardian of an adult has the right to review information in a file pertaining to that adult.
* For public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
* Immunizations records released to a student’s school, but only if parents or guardians (or the student if not a minor) agree either orally or in writing;
* To the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;
* To your employer when we have provided health care to you at the request of your employer to determine workplace-related illness or injury; in most cases you will receive notice that information is disclosed to your employer;
* If required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
* If required to do so by subpoena or discovery request; in most cases you will have notice of such release;
* To law enforcement officials as required by law to report wounds, injuries, and crimes;
* To coroners and/or funeral directors consistent with law;
* If necessary to arrange for an organ or tissue donation from you or a transplant for you;
* If, in limited instances, we suspect a serious threat to health and safety;
* As required by armed forces services if you are a member of the military; we may also release your protected health information if necessary for national security or intelligence activities; and
* To workers’ compensation agencies if necessary for your workers’ compensation benefit determination.

Ohio law requires that we obtain a consent from you in many instances before disclosing the performance or results of an HIV test or diagnoses of AIDS or an AIDS-related condition, before disclosing information about drug or alcohol treatment you have received in a drug or alcohol treatment program, and before disclosing information about mental health services you may have received. For full information on when such consents may be necessary, you can contact the Director of Quality and Compliance, Elizabeth Place, 4th Floor, 601 Edwin C. Moses Blvd., Dayton, OH 45417.

**Rights That You Have**

**Access to Your Protected Health Information:** You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. We will charge you per page if you request a copy of the information. We will also charge for the postage if you request a mailed copy and will charge for preparing a summary of the requested information if you request such summary. You can obtain a request form from the program where you received services.

You have the right to obtain an electronic copy of your health information that exists in an electronic format, and you may direct that the copy be transmitted directly to an entity or person designated by you, provided that any such designation is clear, conspicuous, and specific with complete name and mailing address or other identifying information. We will charge you a fee for our labor and supplies in preparing your copy of the electronic health information.

**Amendments to Your Protected Health Information:** You have the right to request in writing that protected health information we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. In order to be considered by us, all amendment requests must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If any amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an amendment request form from the program where you have received services.

**Accounting of Disclosures of Your Protected Health Information:** You have the right to receive an accounting of certain disclosures by us of your protected health information for six years prior to the date of your request. Requests must be made in writing and signed by you or your representative. Accounting request forms are available from the program where you have received services. The first accounting in any 12-month period is free. You will be charged a fee for each subsequent accounting you request within the same 12-month period.

**Restrictions on Use and Disclosure of Your Protected Health Information:** You have the right to request, in writing, restrictions on certain of our uses and disclosures of your protected health information for treatment, payment, or health care operations. A restriction request form can be obtained from the program where you have received services. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing, any agreed-to restriction by sending such notice to the Director of Quality and Compliance, Elizabeth Place, 4th Floor, 601 Edwin C. Moses Blvd., Dayton, OH 45417. We will honor any request to restrict disclosures to your health plan if the information to be disclosed pertains solely to a health care item or service for which SBHI has been paid in full.

**Breach Notification:** In the unlikely event that there is a breach or unauthorized release of your protected health information, you will receive notice and information on steps you may take to protect yourself from harm.

**Complaints:** If you believe your privacy rights have been violated, you can file a complaint, in writing, with the SBHI Privacy Rights Officer, Elizabeth Place, 4th Floor, 601 Edwin C. Moses Blvd., Dayton, OH 45417. You may also file a complaint, in writing, within 180 days of a violation of your rights with the Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601. There will be no retaliation for filing a complaint.

**Acknowledgment of Receipt of Notice:** You will be asked to sign an acknowledgment form that you received the Notice of Privacy Practices.

**For Further Information:** If you have questions or need further assistance regarding this Notice, you may contact the Director of Quality and Compliance, Elizabeth Place, 4th Floor, 601 Edwin C. Moses Blvd., Dayton, OH 45417. As a client, you have the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means.

**Effective Date:** This Notice of Privacy Practices is effective 9/1/2013.