FAMILY SERVICE OF THE CHAUTAUQUA REGION INC
332 East Fourth Street
Jamestown, NY 14701
Phone: (716) 488-1971
Fax: (716) 483-6878
familyservice@fscr.mygbiz.com

OBC FAMILY INFORMATION SHEET

Date: _____

Household Members: PLEASE INCLUDE YOURSELF (Client) ON LINE ONE

Name	DOB	Highest Level School Attended	Relationship	Race	Sex
1.			SELF(CLIENT)		
2.					
3.					
4.					
5.					
6.					

Public Assistance for your household? (Circle all that apply) SNAP Cash Assistance HEAP Section 8

Household Income: _____

Emergency Contact _____ **Phone #** _____

Relationship to client _____

Appointment Reminder Preference (Circle One) **Text** **Call Home** **Call Cell** **No Reminders**

(Check One) ☐ Detailed Messages Okay? *** ☐ Leave Callback Number Only

***With whom can we share detailed reminders? _____

Please notify office staff of any changes in your contact information so we can be sure to reach you.

Client's Primary Care Doctor/Office_____ **Phone:** _____

Client's Medications (Name, dose, prescribing doctor):

_____

_____

_____

_____

(Continue additional on back or name physician who has complete medication record)

Client's Allergies:

_____

Client's previous Mental Health/Substance Abuse Treatment (Hospital/Agency/Provider, Dates of service):

_____

_____

_____

Notice of Privacy Practices (NPP)

THIS NOTICE DECRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

GIVE. ADVOCATE. VOLUNTEER. LIVE UNITED

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect **09/01/2019**, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices. Before we make a significant change in our privacy practices, we will change the Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us at 332 E. 4th St. Jamestown, NY 14701.

Uses and Disclosures of Personally Identifiable Health Information

We will use the information about your health care which we have obtained from you or from others mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities which are called, in the law, health care **operations**. These uses and disclosures are necessary to make sure that all of our clients receive quality care and for our operation and management purposes. For example, the billing office will send invoice information to your insurance company if you wish them to pay their share of the costs. The entities and individual covered by this Notice may also share information with each other for purposes of our joint health care operations. This includes sharing of *aggregate*, *unidentifiable* client data to allow us to statistically evaluate and improve the quality of our services and secure grant funding. All data collected and used for these purposes are destroyed as soon as the evaluation of that data is complete.

Security

It is our responsibility to protect your information via both physical and electronic means. Our electronic health records are kept on our office server and encrypted. However, we do not have the technology to provide the same level of protection for email or texting. We recommend that you be careful not to send us sensitive PHI in these formats and use encryption if it is necessary to email PHI. Telehealth services (e.g. video conferencing) also may not have the same level of security and you should be cautious in deciding if you wish to use this modality and what you choose to share.

In order to disclose (release) your information outside our agency, we must have written permission. We will ask you to sign a Consent for Release of Information form.
There are very few situations where the laws allows/requires us to send information without your consent. These are:

1. When there is a serious threat to your health or safety or someone else's. In these situations, we will only share information with a person or organization who is able to help prevent or reduce the threat. For example, we are required to report child abuse or to call the police if someone threatens to harm another person. We would of course get help for you if you were suicidal or in a medical emergency.

2. When there is a court order that requires us to release information. This can happen, for example, in a child custody hearing. If we receive a subpoena, we will try to contact you or your attorney to find out how you want us to proceed. Our own attorney will advise us, the judge may have the final decision.

Your Rights Regarding Your Health Information

*You can customize how we communicate with you about your protected health information such as:

1. Where and how we communicate with you such as by phone, mail or neither, etc. We will try our best to do as you ask.
2. What specific information you want shared or not shared when you do sign a consent to release information.

*You have the right to look at the health information we have about you such as your medical and billing records. You can get a copy of your records, under some circumstances we may charge you or require identification. Contact our office to arrange to see your records.

*If you believe your record has incorrect or missing information, you can ask us to make changes to your health information. You have to make a request in writing and send it to our Privacy Officer. You must give us the reason for the change.

*We do not currently sell patient information. If we ever were to do so, you would be able to choose to also opt out of these practices.

*You have the right to a copy of this notice. If we change this NPP we will post the new version in our waiting area.

*If there is ever an accidental release of your personal health information (such as a hacker breaking into the system), we will notify you of this as soon as we can.

*You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in anyway.

*If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer, David Steward, who can be reached at (716)488-1971

After you have read this NPP we will ask you to sign the Acknowledgement Receipt on the service agreement form.

The effective date of this notice is June 8, 2020

Family Service of the Chautauqua Region, Inc
332 East Fourth Street
Jamestown, NY 14701
Phone: 716-488-1971
Fax: 483-6878
www.fscrmentalhealth.com

SERVICE AGREEMENT – Counselor

I agree to the following: (check off to acknowledge understanding and sign below to indicate agreement.)

____ I will attend scheduled appointments regularly and on time and call in advance if unable to honor my appointment time. (Call 488-1971, messages can be left after business hours.) Frequent missed appointments may result in cancellation of service.

____ Family Service has my consent to release the minimal required information to my insurance company for billing purposes. My Signature below can be used as "Signature on File" for insurance claim forms. Insurance payments can be made directly to Family Service.

____ I understand that I will be responsible for the service fee if I choose not to use my eligible insurance to pay for services.

____ I will be responsible to pay a $25 fee for any returned checks.

____ My standard co-pay, if applicable, is due at the time of each session.

____ I understand that services not covered by my insurance are my responsibility to pay. (This includes: co-pay, deductibles not yet met, or any service that my insurance plan does not cover.)

____ I understand that failure to pay for services after making agency staff aware of difficulties and obtaining accommodations may result in the need for cancellation of services here and transfer to another agency.

COUNSELOR FEE SCHEDULE (LCSW / LMSW)

Initial Assessment..... $140
30 minute session $50
45 minute session $100
60 minute session $120

We accept Cash, Personal Checks, and Credit Cards

Family with patient $95
Family without patient.. $103
Group session..... $80

There are additional fees for crisis sessions

If you have concerns about ability to pay, please discuss with us at any time during the course of your treatment.

_____ _____
Signature of client or person responsible for payment — Date

_____ _____
Signature of client receiving services (if different) — Date

_____ _____
Parent/legal guardian (if applicable) — Date

I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

☐ NPP was obtained/read on FSCR website ☐ NPP document was received/reviewed ☐ NPP was read/explained to me

_____ _____
Client/parent Initials — Date

☐ Verbal consent obtained for all above client signatures in lieu of written signiature due to COVID19 physical distancing/client safety.

_____ _____
FSCR Staff completing registration — Date

Revision 6/2020

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FSCR
Building Healthy Families Since 1903

Consent For Release Of Protected Health Information – Primary Care Provider (PCP)

Client Name (Print) _____ Date of Birth _____

To allow us to coordinate care with your primary care doctor, we request that you sign this consent to share information. You can decide how much information we share and if there is any information that you do not want to be shared. At your request, your therapist will review information with you before it is released. You do not have to agree to release information in order to receive treatment from Family Service.

If you do not agree to have any information shared with your primary care doctor, please initial next line below and continue to the boxes at the bottom of the page.

_____I decline to allow coordination of care or sharing of my protected health information with my PCP.

If you agree, please complete (1-5) checking off the authorization options you will allow and complete the bottom of the page.

1. Authorization for Release of Information: Family Service of the Chautauqua Region, Inc may share information from my clinical records with the following physician/ medical office:

_____
(Please Print Name of Physician or Medical Practice, address and phone number)

2. The purpose of the sharing of information is to coordinate care and/or make referrals/recommendations.

3. I authorize the following information to be obtained from my physician:
___medication list ___history and physical exam notes ___Diagnoses
___verbal exchange of information ___HIV-related information
___ALL OF THE ABOVE This includes all dates of service unless specified here:_____

4. I authorize the following information to be released to my primary care physician:
___medication concerns/updates ___assessment reports ___Diagnoses
___progress notes ___treatment summary/updates ___Discharge Report
___Presence in Treatment ___Drug & Alcohol Information
___ALL OF THE ABOVE This includes all dates of service unless specified here:_____

5. This authorization expires when I am discharged from this treatment episode unless otherwise specified here:

_____
(After that date, no more information can be released unless a new Authorization is signed.)

I can cancel this authorization at any time in writing. No information will be shared from that date forward.

I would like a copy of this form. □ Yes	
I acknowledge that: I have read this form and understand its contents. I am the patient, or person duly authorized either by the patient or otherwise, to sign this consent and accept its terms.	
Signature of Client	Date
Signature of Parent/Legal Guardian if under the age of 18y/o	Date
Witness (Staff Signature)	Date

September 2018

Over 100 Years of Service

Mission: To strengthen the mental health and well being of individuals, families, and our community.