Clifton-Fine Hospital
A SAMARITAN HEALTH PARTNER

Office Policies and Procedures for our Patients
Behavioral Health

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1014 Oswegatchie Trail Road
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P: (315) 848-5404 F: (315) 848-2835

# Welcome

At Clifton Fine Hospital we offer counseling and therapy services in-person and virtually. By receiving our services, we believe we can help you feel stronger in the face of challenges, change behaviors and thinking, help you heal from the past, assist you with building relationship skills, gain self-confidence, help you cope with symptoms, and support you by helping you handle strong emotions. Our therapists work hard to gain the necessary high-level training to help you achieve your mental health goals. We are committed to improving the lives of our patients here at Clifton Fine. We are glad you are here and look forward to helping you feel better.

## Office Hours

Patient Appointments vary by provider between the hours of 7:00AM to 5:00PM Monday-Friday. For the availability of your provider, please contact the office. Please note phone lines are open from 8:00AM to 4:00PM Monday-Friday.

## Telehealth Appointments

For your convenience, we offer telehealth appointments. Through this service, you are able to attend your visit from the comfort of your home.

## Crisis Management

Clifton Fine Behavioral Health does not provide crisis management or emergency services. If you are in crisis, are having suicidal or homicidal thoughts, or have an emergency please call 911 or go to your nearest emergency room. You may also call the following *hotlines*:

### Crisis Text Line:

New York State has partnered with Crisis Text Line, an anonymous texting service available 24/7. Starting a conversation is easy. **Text GOT5 to 741741.**

### OASAS HOPEline:

New York State's 24/7 problem gambling and chemical dependency hotline. For Help and Hope call **1-877-8-HOPENY** or **text HOPENY**

### 988 Suicide & Crisis Lifeline:

If your life or someone else's is in imminent danger, please call 911. If you are in crisis and need immediate help, please call or text: **988**

### Domestic Violence:

If you or someone else is in a relationship is being controlled by another individual through verbal, physical, or sexual abuse, or other tactics, please call: **1-800-942-6906**

## Patient Attendance

Clifton Fine's Outpatient Behavioral Health Services providers are dedicated to ensuring that your mental health care needs are met in a quality setting. We make every effort to schedule your visit at a time that is convenient to you.

1. Same Day Appointments
   If you are an active and established patient with our behavioral health program, same day appointments are available by calling 315-848-5404, option 5.
2. Arriving Late to a scheduled appointment
   We will do our best to accommodate your appointment, however it will be provider discretion to determine the need to keep the appointment or to reschedule.
3. Cancellation of an Appointment
   In order to be respectful of the medical needs of our patients please be courteous and call Clifton Fine Primary Care promptly if you are unable to attend an appointment. We ask that you try to call one (1) working day in advance. This time will be reallocated to someone who is in need of treatment. This is how we can best serve the needs of our patients. Appointments are in high demand, and your early cancellation will give another person the ability to have access to timely medical care.
4. No Show's
   A "No Show" is someone who misses an appointment without canceling with advance notice. No-shows inconvenience those individuals who needs access to medical care.
5. Follow up Appointments
   It is recommended that all patients have an upcoming appointment on the schedule.

**Your case with the behavioral health team may be close if you demonstrate a pattern of non-compliance with any of the following.**

- Missed Appointments

Missed appointments is defined as not keeping any previously scheduled appointment and failure to notify the office more than (1) working day in advance to the scheduled appointment:

- Missing two (2) consecutive appointments.
- Missing four (4) appointments within a 3 month period.
- Demonstration of a pattern of repeated cancellations and rescheduling of appointments (even with more than 1 working day in advance).

- Failure to schedule a counseling session after four consecutive weeks
  You may re-establish counseling by calling to schedule another appointment.
- Non-compliance with treatment recommendations

## Consent

I do hereby seek and consent to participate in counseling services provided by Clifton-Fine Hospital. If I am attending group counseling, I also understand and consent that confidentiality still applies, but that Clifton-Fine Hospital is not liable for group members breaking confidentiality. I understand that developing a treatment plan with this provider and regularly reviewing our work toward the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of participating in counseling with this mental health professional.

I consent for my mental health professional to consult with my Primary Care Provider with regards to my mental health treatment.

I understand that Clifton Fine Hospital Behavioral Health is treating me and we will do their best to accurately diagnose my condition and develop a plan of treatment that will help to foster my emotional health. This may include a recommendation for an evaluation to ascertain if medication therapy may be helpful for me.

## Confidentiality

You are our patient and are entitled to confidentiality rights under state and federal law. Confidentiality, however, does not apply under certain situations. We are obligated by law to notify appropriate agencies with regards to any report of abuse or neglect of a minor, elderly person or disabled person; or any suspicion thereof. This includes physical or sexual abuse. Also, we have a duty to protect if we suspect anyone is in danger of seriously harming/killing themselves or has made threats to hurt someone else. Except in these rare situations, your child may have the right to keep particular topics confidential from even his/her guardian. Please respect this confidentiality. If there is any concern of harm, suicide or other dangerous behavior, you will be informed.

## Minors

If a patient is a minor and parents are separated or divorced, the parent initiating treatment is responsible for notifying the other parent that counseling has been initiated and with providing counselor's contact information.

## Discontinuation of Services

I understand that I may stop treatment with this mental health professional at any time. I am aware that I may lose other services or may encounter negative consequences if I stop treatment.

*Please note that legitimate extenuating circumstances such as medical emergencies, inclement weather, etc will be taking into consideration.*

If you have any questions regarding this policy, please refer them to your provider or to the Office Manager.

## Receipt of Consent and Acknowledgement

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in the Office Policies and Procedures for our Behavioral Health Patients.

_____ _____

Printed Name Date of Birth

_____ _____

Signed Name Date

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# Patient Intake Questionnaire

*Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.*

## DEMOGRAPHICS

Date: ____ /____ / ____

Name:_____ Date of Birth:_____ /_____ /_____ Age: ____

| Sex Assigned at Birth | Gender Identity | Sexual Orientation |
|---|---|---|
| ☐Male | ☐Identifies as Male | ☐Straight/Heterosexual |
| ☐Female | ☐Identifies as Female | ☐Lesbian/Gay/Homosexual |
| ☐Intersex | ☐Transgender Male (Female to Male) | ☐Bisexual |
| | ☐Transgender Female (Male to Female) | ☐Unsure/Questioning |
| | ☐Non-Binary Person | ☐Other(specify): |
| | ☐Other (specify) | ☐Choose not to disclose |
| | ☐Choose not to disclose | |

## PRIMARY REASON(S) FOR SEEKING SERVICES

Please check any current behaviors and symptoms that occur more often than you would like them to:

| | | | |
|---|---|---|---|
| ☐ Aggression/Anger | ☐Depression | ☐Memory Impairment | ☐Irritability |
| ☐Anxiety | ☐Binging/Purging Food | ☐Sexual Concerns | ☐Cyber Addiction |
| ☐Panic Attacks<br>☐Distressing Thoughts | ☐Chest Pain/Heart Palpitations | ☐Sleeping Problems<br>☐ Avoiding People | ☐Substance Abuse/Addictive Behaviors |
| ☐Antisocial Behavior | ☐Fear/ Phobias | ☐Distractibility | ☐Elevated Mood |
| ☐Fatigue | ☐Gambling Problems | ☐Hallucinations | ☐Impulsivity |
| ☐Judgement Errors | ☐Loneliness | ☐Mood Shift | ☐ Alcohol Abuse |
| ☐Sick Often | ☐Suicidal Thoughts | ☐Trembling | ☐Worrying |

Other Mental Health Concerns (Specify):

_____

_____

_____

What are your goals for therapy?

_____

_____

_____

Do you feel suicidal at this time? ☐Yes ☐No

If Yes, Explain:

_____

_____

_____

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# MEDICAL HISTORY

Primary Care Physician: _____

Do you have an additional Therapist? ☐Yes ☐No Who: _____

Do you have a case manager? ☐Yes ☐No Who: _____

Current medical status

Diabetes ☐Yes ☐No

Elevated cholesterol ☐Yes ☐No

Coronary artery disease ☐Yes ☐No

Depression/Anxiety ☐Yes ☐No

Are you currently in treatment for any other medical condition? ☐Yes ☐No

If Yes, please explain: _____

_____

Please provide information about current medication(s), prescription or over-the-counter, which you take regularly:

| Medication | Dosage/Frequency |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

# COUNSELING/MENTAL HEALTH HISTORY

Counseling/Psychiatry ☐Yes ☐No Who: _____ When: _____

Your reaction to overall experience: _____

Suicidal Thoughts/Attempts ☐Yes ☐No Who: _____ When: _____

Your reaction to overall experience: _____

Drug/Alcohol Treatment ☐Yes ☐No Who: _____ When: _____

Your reaction to overall experience: _____

Hospitalizations ☐Yes ☐No Who: _____ When: _____

Your reaction to overall experience: _____

Involvement with Self-Help Groups (AA, AL-ANON, NA, OA)

☐Yes ☐No Who: _____ When: _____

Your reaction to overall experience: _____

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# FAMILY INFORMATION/PSYCHOSOCIAL HISTORY

Who Resides With You?

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Relationship Status:

☐ Single Length of Time _____
☐ Separated Length of Time _____
☐ Divorced Length of Time _____
☐ Widowed Length of Time _____
☐ Legally Married Length of Time _____
☐ Unmarried, Living Together Length of Time _____

Assessment of Current Relationship (if applicable): ☐Good ☐Fair ☐Poor

Additional Information (e.g., raised by a person other than parents, information about spouse/children not living with you, etc.)

_____

_____

_____

## DEVELOPMENT

Are there special, unusual or traumatic circumstances that affected your development? ☐Yes ☐No
If yes, please describe:

_____

_____

History of Abuse? ☐Yes ☐No
If yes, which type(s)? ☐ Sexual ☐ Physical ☐ Verbal ☐ Emotional

Childhood Issues? ☐ Neglect ☐ Inadequate Nutrition ☐ Other (specify):_____

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that in the past month you:

1. Had nightmares about it or thought about it when you did not want to? ☐Yes ☐No

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2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? ☐Yes ☐No
3. Were constantly on guard, watchful, or easily startled? ☐Yes ☐No
4. Felt numb or detached from others, activities or your surroundings? ☐Yes ☐No

## EDUCATION

Years of Education: _____Currently enrolled in school? ☐Yes ☐NO ☐ High school graduate/G.E.D.

☐ Vocational No. of years: _____ Graduated: ☐Yes ☐No Major_____
☐ College No. of years: _____ Graduated: ☐Yes ☐No Major _____
☐ Graduate No. of years: _____ Graduated: ☐Yes ☐No Major _____

Other Training: _____

Special Circumstances (e.g., learning disabilities, gifted):

_____

## SOCIAL RELATIONSHIPS

Check how you generally get along with other people: (Please check all that apply)

☐ Affectionate ☐ Aggressive ☐ Avoidant ☐ Leader
☐ Follower ☐ Friendly ☐ Fight/Argue Often ☐ Outgoing
☐ Shy/ Withdrawn ☐ Submissive ☐Other (specify):
_____

## SUBSTANCE USE HISTORY

Do you have any current/historical substance or alcohol abuse? ☐Yes ☐No

If yes:

Have you ever felt you ought to cut down on your alcohol or substance use? ☐Yes ☐No
Have people criticized your alcohol or substance use? ☐Yes ☐No
Have you ever felt bad or guilty about your alcohol or substance use? ☐Yes ☐No
Have you ever used alcohol or substances first thing in the morning to steady your nerves or to get rid of a hangover? ☐Yes ☐No
Do you smoke, vape, or chew? ☐Yes ☐No
Do you use prescription medications recreationally? ☐Yes ☐No
Do you believe that your alcohol or substance use has created problems in your life, job, and/or relationships? ☐Yes ☐No

If yes, describe:

_____

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## SPIRITUAL/RELIGIOUS

How important are spiritual matters to you? ☐Not ☐Little ☐Somewhat ☐Very
Are you affiliated with a spiritual/religious group? ☐Yes ☐No

If yes, Describe: _____

Were you raised within a spiritual/religious group? ☐Yes ☐No
If yes, Describe: _____
Would you like your spiritual/religious beliefs incorporated into the counseling? ☐Yes ☐No

## LEGAL

Are you involved in any active legal cases/disputes (traffic, civil, criminal?) ☐Yes ☐No
If yes, please describe and indicate the court and nature of dispute/charges:

_____

_____

Are you currently on probation or parole? ☐Yes ☐No

Past History:
DWI, DUI, etc: ☐Yes ☐No
Criminal Involvement: ☐Yes ☐No
Civil Involvement: ☐Yes ☐No
Filed a Restraining order or subjected to one currently: ☐Yes ☐No

## EMPLOYMENT

Currently Employment Status: ☐Fulltime ☐Part-Time ☐Unemployed ☐Laid-Off ☐Disabled ☐Retired

## LEISURE/RECREATIONAL/STRENGTHS

Describe areas of interest or hobbies (e.g., art, reading, crafts, sports, outdoor activities, church activities, exercising, travel, etc.)

_____

_____

_____

Please identify your personal strengths:

_____

_____

_____

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Telehealth Consent

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I, _____(patient) ___/___/___ (Date of Birth) hereby consent to engaging in telehealth at Clifton Fine Behavioral Health as part of my treatment. I understand that telehealth include of the practice of health care delivery, assessment, diagnosis, consultation, and therapy using interactive audio/video through secure webcam and/or phone communications.

I understand that I need to have broadband internet connection or a smart phone device with good cellular connection at home or at a location deemed appropriate for services. I also understand that in the case of technology failure, I may contact Clifton Fine Behavioral Health Services via phone to coordinate alternative methods of treatment.

I understand that I will be responsible for any copayments or coinsurances that apply to my telehealth visit.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to telehealth. Telehealth platform is HIPAA compliant to protect my privacy and confidentiality.

I understand that I have the right to withdraw my consent at any time. As long as this consent is in force (has not been revoked) Clifton Fine Behavioral Health may provide health care services to me via telehealth without the need for me to sign another consent form.

_____ _____
Patient Signature Date

_____ _____
Patient/Guardian Signature Date

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# CONSENT TO USE OF ELECTRONIC COMMUNICATIONS

Patients of Clifton Fine Hospital may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. I consent to communicate with Clifton Fine Hospital using the following means of electronic communication.

☐Text Message | Cell Phone Number (____)-_____-_____

☐Email | Email Address _____

**Patient Acknowledgement and Agreement**

| |
|---|
| I understand that this request to receive electronic communications will apply to all future appointment reminders/feedback/health information unless I request a change in writing. |
| I understand I have the right to withdraw my consent to receive/obtain electronic communications from Clifton Fine Hospital at any time. |
| I agree to notify Clifton Fine Hospital if my cell phone number or email changes. |
| I understand that I assume any costs incurred related to receipt/sending of text messages. |
| I understand that electronic media and delivery methods such as e-mail and text messaging pose certain risks to the privacy and security of my protected health information. I agree to assume such risks personally and to hold Clifton Fine Hospital and agents harmless in the event that my protected health information is breached or compromised because of my directing and authorizing Clifton Fine Hospital and agents to transmit or deliver such information electronically. |

**Patient (Please Print)**: _____

**Signature:** _____**Date**: ___/___/____

DATE _____

# PATIENT REGISTRATION

## PATIENT INFORMATION

SOCIAL SECURITY # _____

FIRST NAME _____ MIDDLE INITIAL _____

LAST NAME _____ MAIDEN NAME _____

SEX _____ DATE OF BIRTH _____/_____/_____

MARITAL STATUS _____ ETHNICITY _____

BILLING ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____)_____ ❒ *Please check*

CELL PHONE (_____)_____ ❒ *preferred method*

WORK PHONE (_____)_____ ❒ of *contact.*

E-Mail _____ ❒

CHECK ONE ❒ Unemployed ❒ Retired ❒ Student ❒ Employed

**EMPLOYER & ADDRESS** _____

## INSURANCE INFORMATION – Please present card(s)

**PRIMARY INS.** ❒ Commercial ❒ Medicare ❒ Medicaid ❒ Comp

INSURANCE COMPANY _____

POLICY # _____

CARDHOLDER'S NAME _____ DOB _____

RELATIONSHIP TO PATIENT _____

**CARDHOLDER'S EMPLOYER & ADDRESS** _____

_____

**SECONDARY INS.** ❒ Commercial ❒ Medicare ❒ Medicaid ❒ Comp

INSURANCE COMPANY _____

POLICY # _____

CARDHOLDER'S NAME _____ DOB _____

RELATIONSHIP TO PATIENT _____

**CARDHOLDER'S EMPLOYER & ADDRESS** _____

**Primary Pharmacy:**_____ **Secondary Pharmacy:** _____

***FOR PEDIATRIC PATIENTS ONLY:*** ***Please check each name that has custody/permission to contact. Legal docs may be requested.***

❒ Mother _____ Phone _____ Maiden Name _____

❒ Father _____ Phone _____

## GUARANTOR / RESPONSIBLE PARTY (If not SELF, then the Insurance Subscriber or Parent/Guardian if minor)

SOCIAL SECURITY # _____ SEX _____ RELATIONSHIP TO PATIENT _____

FIRST NAME _____ MIDDLE _____ LAST NAME _____ DOB _____

HOME ADDRESS _____ HOME PHONE (_____) _____

_____ WORK PHONE (_____) _____

CITY _____ STATE _____ ZIP _____ CELL PHONE (_____) _____

## EMERGENCY CONTACT (Parent/Guardian if Minor, in addition to Guarantor)

FIRST NAME _____ MIDDLE _____ LAST NAME _____DOB_____

SEX _____ RELATIONSHIP TO PATIENT _____

HOME PHONE (___) _____ WORK PHONE (___) _____ CELL PHONE (___) _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

***Please check one and initial:*** ❒ I authorize _____ ❒ I do not authorize _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize the release of any information to my current insurance company or third party contractor upon their request.

***Please check one and initial:*** ❒ I authorize _____ ❒ I do not authorize _____

## Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, acknowledge that I have received a copy of Clifton Fine Hospital's notice of Privacy Practices. This Notice describes how Clifton Fine HOspital may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

***Please check one and initial:*** ❒ I received _____ ❒ I do not receive _____

**If this patient is a minor, the following individuals may accompany my child to appointments in my absence.**

| | Name of Individuals | Relationship | Phone |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |

Or, check here if applicable: ❒ I do not authorize any individuals _____

_____ _____ _____ _____

**SIGNATURE** (Patient or Parent/Guardian if Minor) Initials RELATIONSHIP TO PATIENT (if Minor) DATE

Clifton-Fine Hospital
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*Trusted Care. Close to Home.*

For more information or explanation you may contact our *Privacy Officer: 315-848-3351*

*This notice is also available on our website: cliftonfinehospital.org*

# Your Information. Your Rights. Our Responsibilities.

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

## Your Rights

**You have the right to:**

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

## Your Choices

**You have some choices in the way that we use and share information as we:**

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

## Our Uses and Disclosures

**We may use and share your information as we:**

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

## Your Rights

**When it comes to your health information, you have certain rights.**
This section explains your rights and some of our responsibilities to help you.

| | |
|---|---|
| **Get an electronic or paper copy of your medical record** | · You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.<br>· We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. |
| **Ask us to correct your medical record** | · You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.<br>· We may say "no" to your request, but we'll tell you why in writing within 60 days. |
| **Request confidential communications** | · You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.<br>· We will say "yes" to all reasonable requests. |
| **Ask us to limit what we use or share** | · You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.<br>· If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. |
| **Get a list of those with whom we've shared information** | · You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.<br>· We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. |
| **Get a copy of this privacy notice** | · You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. |
| **Choose someone to act for you** | · If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.<br>· We will make sure the person has this authority and can act for you before we take any action. |
| **File a complaint if you feel your rights are violated** | · You can complain if you feel we have violated your rights by contacting us using the information on page 1.<br>· You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**<br>· We will not retaliate against you for filing a complaint. |

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

| | |
|---|---|
| **In these cases, you have both the right and choice to tell us to:** | · Share information with your family, close friends, or others involved in your care<br>· Share information in a disaster relief situation<br>· Include your information in a hospital directory<br>*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.* |
| **In these cases we *never* share your information unless you give us written permission:** | · Marketing purposes<br>· Sale of your information<br>· Most sharing of psychotherapy notes |
| **In the case of fundraising:** | · We may contact you for fundraising efforts, but you can tell us not to contact you again. |

## Our Uses and Disclosures

### How do we typically use or share your health information?

We typically use or share your health information in the following ways.

| | | |
|---|---|---|
| **Treat you** | · We can use your health information and share it with other professionals who are treating you. | ***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.* |
| **Run our organization** | · We can use and share your health information to run our practice, improve your care, and contact you when necessary. | ***Example:*** *We use health information about you to manage your treatment and services.* |
| **Bill for your services** | · We can use and share your health information to bill and get payment from health plans or other entities. | ***Example:*** *We give information about you to your health insurance plan so it will pay for your services.* |

*continued on next page*

**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

| | |
|---|---|
| **Help with public health and safety issues** | · We can share health information about you for certain situations such as:<br>· Preventing disease<br>· Helping with product recalls<br>· Reporting adverse reactions to medications<br>· Reporting suspected abuse, neglect, or domestic violence<br>· Preventing or reducing a serious threat to anyone's health or safety |
| **Do research** | · We can use or share your information for health research. |
| **Comply with the law** | · We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. |
| **Respond to organ and tissue donation requests** | · We can share health information about you with organ procurement organizations. |
| **Work with a medical examiner or funeral director** | · We can share health information with a coroner, medical examiner, or funeral director when an individual dies. |
| **Address workers' compensation, law enforcement, and other government requests** | · We can use or share health information about you:<br>· For workers' compensation claims<br>· For law enforcement purposes or with a law enforcement official<br>· With health oversight agencies for activities authorized by law<br>· For special government functions such as military, national security, and presidential protective services |
| **Respond to lawsuits and legal actions** | · We can share health information about you in response to a court or administrative order, or in response to a subpoena. |

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- We do not create or manage a hospital directory

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

## Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

*Effective: 4/4/2003, 10/1/2017, 1/28/2021, 1/4/2023*