Clinical Consent for Treatment

What you can expect from New Day Counseling and Psychiatric Services, Inc.:

- **Informed Consent**: You have the right to make informed decisions about your care and will be provided information about the services that you receive, as well as, those services that may be recommended. You have the right to refuse any recommended service and to discontinue a service at any time. You have the right to ask for a different service provider if you are not comfortable with the assigned provider.

- **Confidentiality**: Your personal information will be protected by New Day according to Federal and State Law. No information will be released without your written consent, except in the following situations:
  - A danger of harm to yourself and /or others is present; including possible child/elder abuse/neglect
  - The client is a minor –A non-residential parent of a child is entitled to access, under the same terms and conditions as the residential parent, to any record that is related to the child and to which the residential parent of the child legally is provided access, unless the court determines that it would not be in the best interest of the child for the non-residential parent to have this access. **If such a court order exists, <u>it is the</u> <u>responsibility of the residential parent to provide a copy of the order to the</u> <u>agency</u>. If a court order is not provided, the non-residential parent will <u>not</u> be denied access.**
  - Audits and Compliance Reasons - Your record may be accessible to any of the following: mental health and recovery services board auditors, funding source auditors, and authorized agency personnel, for the purpose of ensuring that quality care is provided to you and that the services provided are in compliance with accrediting entities, funding sources (including insurance companies) and professional standards.
  - Confidentiality of substance abuse information in client records is maintained in accordance with 42 CFR Part 2. A written copy of the statute is available upon request.

What New Day Counseling and Psychiatric Services, Inc. expects from you:

- Regular attendance at scheduled appointments
- Cancellation of appointments 24 hours in advance
  - A $25.00 fee will be charged for appointments that are cancelled less than 24 hours in advance.
- Payment at the time of service, unless other payment arrangements are made
- Participation of your parents/guardians/family when determined necessary by you and your treatment provider
- Reports of increase in symptoms and thoughts of harm to self and/or others
- Notification of changes in your income, insurance, living situations, etc.

Clinical Consent for Treatment

Benefits and Risks of Treatment:
The recovery process has many benefits, which may include an improved quality of life, improved decision-making skills, enhanced ability to function on a daily basis, and an increased sense of wellbeing. However, you may also experience a temporary increase in uncomfortable feelings, and in some cases, changes in your personal relationships can occur.

Discontinuation of Services:
The agency reserves the right to discontinue services for reasons such as:

- Treatment goals have been met to your satisfaction
- Not making an attempt to pay the agreed on fee
- Canceling or failing to show for two appointments without a valid reason
- Physical aggression or verbal threat to other clients/persons on the premises of New Day or to New Day staff members
- Refusing to be an active participant in the treatment process

By signing below, I verify that I have read the above Consent for Treatment guidelines and agree to them as stated, and that I have been given copies of the *Clinical Services Consent for Treatment* and the *Client Rights and Grievance Procedures booklet.* These documents contain the *Notice of Privacy Practices for Healthcare Providers*, a summary of *42 CFR part 2*, and program rules and expectations. I am also authorizing New Day Counseling and Psychiatric Services of Stark County, Inc. to evaluate and treat myself and/or ______________________, for whom I claim legal responsibility as parent/guardian, for both mental health services and alcohol or other drug related services.

____ ____________________
Client Signature Date

____ ____________________
Parent/Guardian Signature Date

____ ____________________
Staff Signature Date

Refusal to Consent:
I refuse to consent to treatment. I understand that my refusal to consent means that treatment, including the diagnostic assessment, will not be provided to me.

____ ____________________
Client Signature Date

____ ____________________
Parent/Guardian Signature Date

____ ____________________
Staff Signature Date

Client/Guardian Financial Responsibility

All appointments must be kept (on time) or canceled at least 24 hours in advance. Failure to do so will result in a $25 cancellation fee. Clients should arrive at least 5 to 10 minutes prior to scheduled appointment. Insurance information must be provided at the initial visit. As each individual insurance plan may vary in coverage, we strongly suggest you consult your specific plan to determine your coverage. Please update the office with any insurance changes as soon as possible, to avoid processing delays, errors, and issues.

FEES

The Initial Diagnostic Assessment is $150. Our counseling basis fee thereafter is $110 per counseling session. Should your session exceed the established time frame per session you will be billed accordingly.

FEE PAYMENT

Payment of determined fee (deductibles, copays, and/or coinsurance) is to be made at each visit. We are aware that circumstances exist that may prohibit a full payment and we will be glad to work with you if you bring this to our attention. Failure to pay agreed upon fees will result in suspension or termination of services, and the possible referral to a collections agency.

INSURANCE

All insurance is processed through our office. The initial counseling appointment is a Diagnostic Assessment, charged at $150 per hour for up to two hours. A fee of $110 per counseling session is charged thereafter. Depending on the insurance provider involved, payment may be none, partial or 100%. The client is responsible for any amount not covered by their insurance provider. Clients will be reimbursed for any overpayment.

If the client has insurance coverage and neglects to submit proper documentation to the office, then the client becomes responsible for the full amount due.

Should you have questions regarding any of the above, please feel free to talk with our Office Manager. All information remains confidential. We are glad to be of service to you and look forward to your visits.

By signing below I indicate that I agree to the terms listed above, and understand my financial responsibility regarding services provide by New Day Counseling and Psychiatric Services, Inc.

____ ____________________

Client/Legal Guardian Signature Date

Client/Guardian Release of Information

I, ___________________________ (Client Name, please print), ____________________ (Date of birth)

OR

I, _________________________ (Legal guardian, please print), legal guardian for ________________________ (Client name)

hereby give New Day Counseling and Psychiatric Services, Inc. permission to discuss personal medical information for the above named client with the following individual(s):

Name	Date of Birth	Relationship to Client
____	____________________	____________________
____	____________________	____________________
____	____________________	____________________
____	____________________	____________________

I understand that the information that may be discussed includes, but is not limited to: My health history, diagnostic results, plan of care, and medical financial information unless otherwise restricted here:

____

____

____

I understand that this authorization will remain in effect until terminated by myself in writing.

____ ____________________

Client/Legal Guardian Signature Date

I. Client Rights and Grievance Procedure

As a client, you are entitled to know and understand your legal rights in accordance with the rules and regulations of the Ohio Department of Mental Health (ODMH) (Ref: OAC 5122-26-18) and/or the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) (OAC 3793:2-1-07) and/or the Ohio Department of Job and Family Services (ODJFS).

The following information is for your reference. Any staff person, the Client Rights Officer (CRO) or Client Rights Alternate will be glad to answer your questions or concerns or assist you in filing a grievance. In a crisis or emergency situation, you will be verbally advised of your immediate pertinent rights, such as the right to consent or refuse treatment and the consequences of that agreement or refusal.

Please contact:

Greg Emanuelson
130 1st St NW, Massillon, Ohio 44647
(330) 833-0234 x5501 / Fax (330) 837-7705

ALTERNATE: Richard Stein
1207 West State Street, Suite M, Alliance, Ohio 44601
330-821-8407 x 5557 / Fax (330) 821-8506

II. Definitions

A. The "Client Rights Officer" (CRO) is an individual designated by New Day Counseling and Psychiatric Services., to protect the human and civil rights of persons served by accepting and overseeing the complaint and grievance process on behalf of a client or their designated representative.
B. The "Client Rights Officer **Alternate**" will assume duties of the CRO if he/she is unavailable or the subject of a grievance.
C. The "client" is any individual applying for or receiving services at this agency.
D. A "complaint" means any concern communicated by a client or their designated representative questioning the personal care or treatment received. A complaint is less formal than a grievance.
E. "Grievance" means a written complaint initiated either verbally or in writing by a client or by any other person or agency on behalf of a client regarding denial or abuse of any client rights.

III. Client Rights: New Day Counseling and Psychiatric Services, Inc. will protect and enhance the rights of all persons applying for or receiving mental health services and will establish procedures for the resolution of client grievances.

Client Rights:

1) The right to be treated with consideration and respect for the personal dignity, autonomy and privacy;
2) The right to service in a humane setting which is the least restrictive as defined in the treatment plan;
3) The right to be informed of one's own condition; of proposed or current services, treatment or therapies; and, of the alternatives;
4) The right to consent to or refuse any services, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment or therapy on behalf of a minor client;
5) The right to a current, written, individualized service plan that addresses one's own mental health, physical health, social, cultural and economic needs, and that specifies the provision of appropriate and adequate services as available either directly or by referral;
6) The right to active and informed participation in the establishment, periodic review, and reassessment of the individualized service plan;
7) The right to freedom from unnecessary or excessive medication;
8) The right to freedom from unnecessary physical restraint or seclusion;
9) **The right to be informed of and refuse any unusual or hazardous treatment procedures;**
10) The right to be advised of and refuse to be observed by techniques such as one-way vision mirrors, tape/video recorders, televisions, movies, photographs, or any other observation or recording device not used for building security purposes;
11) The right to consult with independent treatment specialists or legal counsel, at one's own expense;
12) The right to confidentiality of communications and of all personally identifying information within the limitations and requirements for disclosure of various funding and/or certifying sources, state or federal law, unless release of information is specifically authorized by the client or parent or legal guardian of a minor client or court-appointed guardian of the person of an adult client;
13) The right to have access to one's own psychiatric, medical or other treatment records, unless access to particular identified items of information is specifically restricted for that individual client for clear treatment reasons in the client's Service Plan. "Clear treatment reasons" shall be understood to mean only severe emotional damage to the client such that dangerous or self-injurious behavior is an eminent risk. The person restricting the information shall explain to the client and other person's authorized by the client the factual information about the individual client that necessitates the restriction. The restriction must be renewed at least annually to retain validity. Any person authorized by the client has unrestricted access to all information. Client shall be informed in writing of agency policies and procedures for viewing or obtaining copies of personal records;
14) The right to be informed in advance of the reason(s) for transfer, termination or discontinuance of service provision or provider, and to be involved in planning the consequences of that event;
15) The right to receive an explanation of the reasons for denial of service;
16) The right to be informed of available prevention services;
17) The right not to be discriminated against in the provision of services on the basis of religion, race, color, creed, sex, sexual orientation, national origin, age, lifestyle, physical or mental handicap, developmental disability, HIV infection, AIDS, or inability to pay;
18) The right to be fully informed of the cost of services;
19) The right to be informed of all consumer rights;
20) The right to exercise any and all rights without reprisal in any form including continued and uncompromised access to service;
21) The right to file a grievance in accordance with agency procedures;
22) The right to have oral and written instructions concerning the procedure for filing a grievance.

IV. Client Service Policy

In addition to the Client Rights, New Day Counseling and Psychiatric Services, Inc. shall observe the following policies:

1. Eligibility for services will not be denied regardless of age, sex, sexual orientation, race, creed, national origin or inability to pay.
2. No verbal or written information about clients will be communicated outside of the agency without the client's written authorization unless there is clear or imminent danger to others or themselves. Court ordered information would be released.
3. Access to client's records shall be limited to the client's service provider and supervisor and other staff members directly involved in the case.
4. All statistical and general information submitted by the agency to any local, state or federal funding source would be done so anonymously. No client data will be submitted to any funding source with identifying information.
5. Grievances may be voiced to the service provider or Client Rights Officer. If the client remains dissatisfied with services, redress may be sought by contacting the Board of Directors Grievance Committee. A copy of the grievance procedure is posted and available upon request.
6. If a worker determines that he/she is unable to provide professional services, he/she will suggest an appropriate referral in a timely manner.

V. Client Grievance Procedure

Applicants or clients of New Day Counseling and Psychiatric Services, Inc., who believe they have been maltreated or treated unfairly by the agency or any staff member have the right to file a grievance at any time. All grievances shall be processed promptly according to the following procedures:
Note: The grievance procedure allows for the skipping of steps in the process. The grievant may, at any time, contact the CRO, the Counselor, Social Worker, Marriage and Family Therapist Board, the Ohio Department of Mental Health, the Ohio Department of Alcohol and Drug Addiction Services, the Ohio Department of Job and Family Services, the Ohio Legal Rights Service or any other appropriate professional licensing or regulatory entity to address any concern regarding the care they have received at New Day Counseling and Psychiatric Services, Inc.

1. Upon request, any employee of New Day Counseling and Psychiatric Services, Inc. will explain any and all aspects of client rights and the grievance procedure to you. The procedures are also posted in a highly visible location at each agency site.
2. Any complaint by you or your designated representative should first be addressed with the involved staff person. If you are not able to reach a satisfactory conclusion with them, please bring the matter to the attention of that person's supervisor. Please allow the supervisor up to 3 working days to address the matter.
3. If you are not able to come to a satisfactory resolution with the staff member's supervisor, you may appeal to the Client Rights Officer (CRO) who will investigate the complaint, gather facts, and try to resolve the issue. Depending on the nature and severity of the concern, this process may take several days. The CRO will advise you or your representative of the progress of the investigation as it unfolds. If resolved, a written statement of the results will be given to you or your designated representative.
4. If you or your designated representative do not feel the complaint has been resolved satisfactorily, you may file a written grievance stating exactly what happened, when it happened, the name of the staff member(s) involved, and what you would like to see done. The CRO shall forward the grievance to the President of the Board of Trustees who shall appoint a committee of at least three (3) board members to hear the grievance.
5. The Grievance Committee shall conduct a hearing and render a decision in writing within 20 working days from the date of filing the grievance. All parties to the grievance shall be notified of the scheduled time and place of the grievance hearing. Each party has the right to appear in person at the grievance hearing. A written statement of the results will be given to you or your designated representative.
6. If, at any time, you are dissatisfied with the grievance procedure, you may contact the Counselor, Social Worker, Marriage and Family Therapist Board, the Ohio Department of Mental Health, the Ohio Department of Alcohol/Drug Addiction Services, or the Ohio Legal Rights Service. These agencies can be contacted at:

CSWMFT Board
50 West Broad Street, Suite
Columbus, Ohio 43215-5919
614-466-0912

Ohio Department of Mental Health
1075 E. Broad Street – 8th Floor
Columbus, OH 43215-3430
614-466-7264

Ohio Department of Alcohol/Drug Addiction Services
Two Nationwide Plaza
280 North High Street, 12th Floor
Columbus, OH 43215-6108
614-466-3445

Ohio Legal Rights Services
50 West Broad Street, Suite 1400
Columbus, OH 43215-5923
614-466-7264 or 800-282-9181

NOTICE OF PRIVACY PRACTICES: New Day Counseling and Psychiatric Services

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY HAVE ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY. This notice applies to all of the records of your case generated by New Day Counseling and Psychiatric Services (The Agency), whether made by the agency or a business associate.** This notice is inclusive of a summary of the confidentiality of substance abuse records as required by 42 CFR Part 2.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. **Please note you may have other rights under state law and professional code of ethics that are not required to be listed here. These other rights reinforce the issue of confidentiality and privacy expected of clients receiving services at our Agency, and HIPAA requirements do not in any way change or weaken those rights. We will continue to operate in a manner that will ensure your confidentiality with your service provider or the Agency Privacy Officer.** You many request a copy of any revised Notice of Privacy Practices by calling the office and asking that a revised copy be sent to you in the mail, or you may ask for a copy at the time of your next appointment.

1. **How We May Use and Disclose Medical Information About You:** Your protected health information (hereinafter referred to as PHI) may be used and disclosed by your service provider, our office staff, and others in or outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to collect payment for your health care bills and to support the operation of the agency. Following are examples of the types of uses and disclosures of your protected health care information that are permitted:

- **TREATMENT:** We will use and disclose such portions of your PHI to provide, coordinate, or manage your health care and any related services. This may include the coordination or management of your health care with a third party, including assessment group.
- PAYMENT: **Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you and may include, but are not limited to, the following: making a determination of eligibility, or coverage for insurance benefits, reviewing services provided to you for medical necessity, undertaking utilization review activities, reports to credit bureaus or collection agencies, and to our attorneys for collection, if necessary.**
- **AGENCY OPERATIONS:** We may use or disclose, as needed, your PHI in order to support the business activities of the Agency. These activities include, but are not limited to the following: quality assessment, employee reviews, health care or financial audits, training, licensing and conducting or arranging for other business activities.

2. **Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization:** Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time, in writing (or orally for substance use information), except to the extent that your service provider or the Agency has taken action in reliance upon your written authorization. You understand that once your diagnosis or treatment is provide to you, our actions seeking payment in connection with the diagnosis or treatment provided to you are in reliance upon your written authorization.
3. **Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization:** We may use and disclose your PHI in the following instances and you have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use of disclosure of the PHI then your service provider may, using their professional judgment, determine whether the disclosure is **in your best interest.** In this case, only the PHI that is relevant to your health care will be discussed**.**
   - **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any person you identify, PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based upon our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is required for your care of your location, general condition, or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.
   - **Emergencies:** We may disclose your PHI in an emergency treatment situation. If this happens, your service provider shall try to obtain your acknowledgement of receipt of the Agency's Notice of Privacy Practices as soon as reasonably practicable after the delivery of treatment.
4. **Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object:** We may use or disclose your PHI in the following situations without your consent or authorization. These situations include the following:
   - **Required By Law:** We may use or disclose your PHI to the extent that law requires the use or disclosure.
   - **Public Health:** We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.
   - Communicable Diseases: **We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.**
   - **Health Oversight:** We may disclose your PHI to a health oversight agency for activities authorized by law such as audits, investigation, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights agencies and/or programs.
   - **Abuse or Neglect:** We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
   - **Food and Drug Administration:** We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biological product deviations, track products to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance as required.
   - **Legal Proceedings:** We may disclose your PHI in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal, or in response to a subpoena, discovery request or other lawful process.
   - **Law Enforcement:** Under certain circumstances, we may disclose PHI for law enforcement purposes. These circumstances include (1) the purpose of identifying or locating a suspect, fugitive, material witness or missing person; (2) the purposes of providing assistance to a victim of a crime; (3) suspicion that a death has occurred as a result of criminal conduct; (4) in the event that a crime occurs on the premises of the Agency; and, (5) in the case of medical emergencies (not on the Agency's premises) where it is likely that a crime has occurred.
   - **Coroners, Funeral Directors and Organ Donation:** We may disclose your PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or other tissue donation purposes.
   - **Criminal Activities:** Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.
   - **Military Activity and National Security:** When the appropriate conditions apply we may use or disclose PHI of individuals who are Armed Forces personnel (1) for the activities deemed necessary for appropriate military command authorities, (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, (3) to foreign military authorities if a member of that foreign military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities including for the provision of protective services to the President or others legally authorized.
   - Workers' Compensation: **Your PHI may be used as authorized to comply with Workers' Compensation laws.**
   - **Inmates:** We may use your PHI if you are an inmate of a correctional facility and your service provider created or received your protected health information in the course of providing care for you.
   - **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 CFR Section 164.500 et seq.
5.

6. **Your Rights:** The following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights:
   - **You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the information. A "designated record set" contains medical and billing records and any other records that your service provider and the Agency uses for making decisions about you. You will be charged a reasonable fee if you are requesting copies. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of or use in a civil or administrative action or proceeding, and protected health information that is subject to law that prohibits access to such information. Depending on the circumstances, a decision to deny access may be appealed. Please contact our Privacy Officer if you have any questions about access to your medical records.
   - **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may **not be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.** The agency is not required to agree to a restriction that you may request. If the Agency believes it is in your best interest to permit use and disclosure of your PHI, your information will not be restricted. If the Agency does agree to the requested restriction, we may not use or disclose your information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your service provider.
   - **You have the right to request to receive confidential communications from us by alternated means or at an alternate location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other contained in a designated record set for as long as we maintain the information. A "designated record set" contains medical and billing records and any other records that your service provider and the Agency uses for making decisions about you. You will be charged a reasonable fee if you are requesting copies. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of or use in a civil or administrative action or proceeding, and protected health information that is subject to law that prohibits access to such information. Depending on the circumstances, a decision to deny access may be appealed. Please contact our Privacy Officer if you have any questions about access to your medical records.
   - **You have the right to request to receive confidential communications from us by alternated means or at an alternate location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. Please make this request in writing to our Privacy Officer.
   - **You may have the right to have the Agency amend your protected health information.** This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have any questions about amending your medical record.
   - **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you for a facility directory, to a family member or friend involved in your care, or for notification purposes.

     You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.
   - **You have the right to obtain a paper copy of this notice from us.**

6. **Complaints:** You may file a complaint with us or with the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer, Karen Anderson, for further information about the complaint process.

I acknowledge that I have received the New Day Counseling & Psychiatric Services, Inc. Client Rights, the Grievance Procedure, and a Notice of Privacy Practices.

______________________________________ ____________________

Client/Legal Guardian Signature Date

Client Questionnaire

Client Name: ____ Date: ________________

Please help New Day get to know you (or your child) by completing this questionnaire.

Provide a brief description of why you (or your child) are seeking services (symptoms and problems, when they started, who referred you, etc.)

____

____

____

Describe what goals and expectations you (or your child) have for treatment (what you want to gain from services, how long you expect it to take, etc.)

____

____

____

Psychosocial Checklist ***(****Check all the problem areas that apply)*

- ☐ nutritional/eating pattern changes/disorders
- ☐ impulsivity
- ☐ relationship/family difficulties
- ☐ inattention
- ☐ depressed mood/sad
- ☐ substance use/addictions
- ☐ bereavement/grief issues
- ☐ other addictive behavior
- ☐ anxiety
- ☐ sleep problems
- ☐ traumatic stress
- ☐ legal problems
- ☐ anger/aggression
- ☐ employment problems
- ☐ oppositional behavior
- ☐ school problems
- ☐ mood swings/hyperactivity
- ☐ housing problems

Explain problems checked above and provide any information that may assist us in helping you (or your child).

____

____

____

____

____

____

HEALTH HISTORY QUESTIONNAIRE

This form should be completed as fully as possible by client but reviewed by medical or clinical staff

Client Name (First, MI, Last)	**Client No.**	**Age**

	Now	Past	Never	What Treatment Received and Date(s)
Anemia	☐	☐	☐	
Arthritis	☐	☐	☐	
Asthma	☐	☐	☐	
Bleeding Disorder	☐	☐	☐	
Blood Pressure (high or	☐	☐	☐	
Bone/Joint Problems	☐	☐	☐	
Cancer	☐	☐	☐	
Cirrhosis/Liver Disease	☐	☐	☐	
Diabetes	☐	☐	☐	
Epilepsy/Seizures	☐	☐	☐	
Eye Disease/Blindness	☐	☐	☐	
Fibromyalgia/Muscle	☐	☐	☐	
Glaucoma	☐	☐	☐	
Headaches	☐	☐	☐	
Head Injury/Brain	☐	☐	☐	
Hearing	☐	☐	☐	
Heart Disease	☐	☐	☐	
Hepatitis/Jaundice	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lung Disease	☐	☐	☐	
Menstrual Pain	☐	☐	☐	
Oral Health/Dental	☐	☐	☐	
Stomach/Bowel	☐	☐	☐	
Stroke	☐	☐	☐	
Thyroid	☐	☐	☐	
Tuberculosis	☐	☐	☐	
AIDS/HIV	☐	☐	☐	
Sexual Transmitted	☐	☐	☐	
Learning Problems	☐	☐	☐	
Speech Problems	☐	☐	☐	
Anxiety	☐	☐	☐	
Bipolar Disorder	☐	☐	☐	
Depression	☐	☐	☐	
Eating Disorder	☐	☐	☐	
Hyperactivity/ADD	☐	☐	☐	
Schizophrenia	☐	☐	☐	
Sexual Problems	☐	☐	☐	
Sleep Disorder	☐	☐	☐	
Suicide	☐	☐	☐	
Other:	☐	☐	☐	

Please note family history of any of the above conditions and client's relationship to that family member.

Client Name (First, MI, Last)	**Client No.**

Has client had medical hospitalizations/surgical procedures in the last 3 years?

☐ No ☐ Yes If yes, complete information below

Hospital	City	Date	Reason

Allergies/Drug Sensitivities

☐ None

☐ Food (specify)

☐ Medicine (specify)

☐ Other (specify)

Pregnancy History

Currently Pregnant? If yes, expected delivery date: ☐ N/A ☐ No ☐ Yes	Receiving prenatal healthcare? If yes, indicate provider: ☐ No ☐ Yes
Last menstrual date:	Any significant pregnancy history? If yes, explain ☐ No ☐ Yes

Last Physical Examination

Doctor	Date	Phone No. (if known)

Has client had any of the following symptoms in the past 60 days?

☐ Ankle swelling	☐ Coughing	☐ Lightheadedness	☐ Penile discharge	☐ Urination difficulty
☐ Bed-wetting	☐ Cramps	☐ Memory problems	☐ Pulse Irregularity	☐ Vaginal discharge
☐ Blood in stool	☐ Diarrhea	☐ Mole/wart changes	☐ Seizures	☐ Vision changes
☐ Breathing difficulty	☐ Dizziness	☐ Muscle weakness	☐ Shakiness	☐ Vomiting
☐ Chest pain	☐ Falling	☐ Nervousness	☐ Sleep problems	☐ Other:
☐ Confusion	☐ Gait unsteadiness	☐ Nosebleeds	☐ Sweats (night)	
☐ Consciousness loss	☐ Hair change	☐ Numbness	☐ Tingling in arms &	☐ Other:
☐ Constipation	☐ Hearing loss	☐ Panic attacks	☐ Tremors	

☐ N/A

Immunizations (required for child or MRDD only)

☐ Chicken Pox	☐ Diphtheria	☐ German Measles	☐ Hepatitis B	☐ Measles
☐ Mumps	☐ Polio	☐ Small Pox	☐ Tetanus	☐ Other:

Immunization within the past year:

Height/Weight

Height	If reporting for a child, has height changed in the past year? ☐ No ☐ Yes
Weight	Has client's weight changed in the past year? ☐ No ☐ Yes, by how much (+ or -)?

Client Name (First, MI, Last)	**Client No.**

Nutritional Screening

☐ No problem	Eating ☐ More ☐ Less ☐ Not Eating	Drinking ☐ More ☐ Less ☐ Takes liquids	Appetite ☐ Increased ☐ Decreased

☐ Nausea ☐ Vomiting ☐ Trouble chewing & swallowing

Special Diet:	**Other:**

Pain Screening

Does pain currently interfere with your activities? ☐ No ☐ Yes
If yes, how much does it interfere? ☐ Not at all ☐ Mildly ☐ Moderately ☐ Severely ☐ Extremely

Please indicate the source of the pain:

Substance Use History/Current Use

Substance	No Use	Past Use	Current Use	Substance	No Use	Past Use	Current Use	Substance	No Use	Past Use	Current Use
Alcohol	☐	☐	☐	Sleep Medication	☐	☐	☐	Cocaine/Crack	☐	☐	☐
Marijuana	☐	☐	☐	Tranquilizers	☐	☐	☐	Heroin	☐	☐	☐
Hashish	☐	☐	☐	Hallucinogens	☐	☐	☐	Pain Medication	☐	☐	☐
Stimulants	☐	☐	☐	Inhalants	☐	☐	☐	Other	☐	☐	☐

Caffeine use? If yes, form ☐ No ☐ Yes	**How much a week** (cups, bottles)?
Tobacco use? If yes, form (cigarettes, smokeless, etc.) ☐ No ☐ Yes	**How much a week** (packs, etc.)?

Print Name of person completing this questionnaire	**Signature of person completing this questionnaire**	**Date**

Clinician reviewer comments, if any:

☐ Medical Review Needed

Provider Signature/Credentials	**Date**

Comments, Recommendations, or Referrals by Medical Reviewer

Check referral(s) needed and specify action(s)

☐ None needed
☐ 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**