Application for Services

Applicant Name: (full legal name) ____

Date of Birth: _______________ **Social Security #:** _________________________

Race: _____________ **Sex:** ______ **Age:** ________

Address: ________________________________

____

Phone Number: (Home/Cell) ____________________ (Work)______________________

Marital Status: (*check one*)

☐ Married ☐ Widowed ☐ Divorced ☐ Never Married ☐ Separated

School: (*circle one*) HS Diploma GED Certificate of Completion None

Highest Level of Education Completed: _____________

Military Status:
☐ Never Served ☐ Presently Serving ☐ Veteran

Employment: Are you currently working? ☐ Yes ☐ No

How many of the last six (6) months have you worked? (*Circle One*) 0 1 2 3 4 5 6

Do you have insurance? ☐ Yes ☐ No **If yes, what type of insurance?** _______________

How many individuals live in your home? ________ **How many are under the age of 18?** _________

Emergency Contact:

Name: ____ **Relationship**: __________________

Address: ____

Phone Number: (Home/Cell) ____________________ (Work)______________________

Have you ever received treatment/counseling for a mental health, emotional or substance abuse concerns?

☐ Yes ☐ No

Who referred you to agency? ____

Reason for your referral in your own words:

____

<u>Medical Information:</u>

Y	N	Pregnant or potentially pregnant	Y	N	Epilepsy or Past Seizure History
Y	N	Current IV drug user	Y	N	Diabetes
Y	N	History of IV drug user	Y	N	High Blood Pressure
Y	N	Thoughts of killing yourself or someone	Y	N	Heart Disease
Y	N	Tuberculosis or exposure to TB	Y	N	Hepatitis or Liver Disease
Y	N	Seeing things that are not there	Y	N	Cancer
Y	N	Hearing thing that are not there	Y	N	Open Sores or Wounds
Y	N	Withdrawals from alcohol or other drugs	**Other**: ________________________		

<u>Tobacco Use:</u> Current Smoker Former Smoker Never Smoked
(Cigarettes, E-Cigarettes, Dip, Chew)

Do you have any special needs that we should know about that would help your success in services?

Yes No If, yes- please share in detail your needs.

____

How did you hear about the agency's services? (circle all that apply)

Family/Friend Employer Social Media

Other Advertisement (radio/newspaper) Doctor's Office

Referring Agency Other:____________________

<u>CONSENT FOR TREATMENT:</u>

I consent for treatment to be rendered by The ALPHA Behavioral Health Center for **MYSELF** or______________________________ (***Relationship to client***: ________________). I understand that the release of information will be given only with a valid ***Release of Information Consent*** unless immediate medical attention is required in which my emergency contact may be notified. I acknowledge I have received a copy of the **HIPAA Privacy Notice** and the **Confidentiality Law 42 C.F.R., Part 2.**

______________________________ ______________________________

Signature **Date**

NOTICE OF PRIVACY PRACTICES

Effective April 2017

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.

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA) and Federal Regulation 42 C.F.R. Part 2. This Notice describes how we may use or disclose your protected health information and with whom we may share that information. "Protected health information" is individually identifiable health information. Such information may include, for example, your age, address, or e-mail address, and it relates to your past, present, and future physical or mental health or condition and related health care services. It is information that you have given to us or that we have learned about you when you were a patient. This Notice also describes your rights and our legal duties related to this information.

I. **Acknowledgement of Receipt of this Notice**. You will be asked to provide a signed acknowledgement of your receipt of this Notice to ensure that you are aware of the possible uses and disclosures of your protected health information and privacy rights. Delivery of your health care services is not conditioned upon your signature. If you decline to provide a signed acknowledgement, we will continue to provide treatment to you, and will use and disclose your protected health information for treatment, payment, and health care operations as necessary.

II. **Uses and Disclosures of Protected Health Information for Treatment, Payment, and Health Care Operations.**

A. *Treatment, Payment, and Health Care Operations*. The following describes different ways we use and disclose your protected health information for treatment, payment, and health operations, including examples of each.

i. Treatment. We may use or disclose your health information to provide you with medical and behavioral health services, including substance abuse prevention, treatment, and intervention. You must sign a written consent before we can share your information for treatment purposes. If you consent, we may disclose your information to people providing, managing, and coordinating your care. This includes the coordination or management of your care with a third party. For example, we may disclose your protected health information to a counselor or case manager so he or she can make decisions related to your care. We may also disclose information to a pharmacist about other drugs you have been prescribed to avoid potential adverse interactions. According to South Carolina Code section 40-75-190, a licensed counselor cannot disclose information acquired during the course of treatment except in these circumstances:

1. To report suspected child abuse, neglect, or exploitation of a vulnerable adult;

2. To prevent a clear and immediate danger to a person or persons;

3. If the counselor is a defendant in a civil, criminal, or disciplinary action arising from the course of treatment;

4. If you are a party in a criminal or civil proceeding, including a commitment proceeding;

5. If you introduce your mental condition as an element of a claim or defense in a criminal or civil proceeding;

6. If you provide a waiver of confidentiality in writing, and then only in accordance with the terms of the waiver.

ii. Payment. We may use or disclose your health information so that we can bill and collect payment from you, an insurance company, or someone else for the health care services you receive from us. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether the plan will pay for the treatment. For example, we may need to give your health plan information about a planned drug screening so your health plan will pay us or reimburse us for the screening.

iii. Health Care Operations. We may use or disclose your health information, if you sign a written consent, to run necessary administrative, business management, quality assurance, internal audit, and educational functions. For example, we may use or disclose your health information to conduct competence and qualification evaluations of our staff that care for you. We may use health information to help us decide what additional services we should offer, how we can improve efficiency, or whether certain treatments are effective.

iv. Fundraising Activities. As part of our health care operations, we may use and disclose a limited amount of your health information to contact you for fundraising efforts. The health information released for these fundraising purposes can include your name, address, other contact information, gender, age, date of birth, dates on which you received service, health insurance status, the outcome of your treatment with us and your treating physician's name. Any fundraising communications you receive from us will include information on how you can elect not to receive any further fundraising communications. You can tell us not to contact you again.

B. *Other Uses and Disclosures of Health Information Without Authorization*. In addition to uses and disclosures of your health information for treatment, payment, and health care operations, we may also use or disclose health information without authorization in the following circumstances:

i. To you, the patient;

ii. If ordered by a court;

iii. For health oversight activities such as, for example, internal and external investigations, inspections, or licensure actions.

III. Permitted Uses and Disclosures of Protected Health Information under 42 C.F.R. Part 2.

A. The confidentiality of alcohol and drug abuse patient records maintained by this Agency is protected by Federal law and regulations which, in some circumstances, may offer more or different protection than HIPAA. The Agency may not say to a person outside the Agency that a person is a patient of the Agency, or disclose any information identifying a patient as an alcohol or drug treatment patient, except in the following instances permitted by Federal law:

i. The patient consents in writing;

ii. The disclosure is allowed by a court order;

iii. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation;

iv. To report a crime committed on the Agency's premises or against Agency personnel; or

v. Pursuant to an agreement with a qualified service organization/business associate.

B. For example, the Agency can disclose information without your consent to obtain legal or financial services, or to another medical facility to provide health care to you, as long as there is a qualified service organization/business associate agreement in place.

C. Violation of the Federal law and regulations by the Agency is a crime. Suspected violations may be reported to the United States Attorney's Office for the District of South Carolina 1-803-734-3970 and the U.S. Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment at 1-240-276-1660.

D. Federal law and regulations do not protect any information about a crime committed by a patient either at the Agency or against any person who works for the Agency or about any threat to commit such a crime.

E. 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.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR part 2 for Federal Regulations.)

IV. **Uses and Disclosures of Protected Health Information Only With Authorization.**

A. Except for the purposes defined and listed above, we will not use or disclose your health information for any purpose unless you give us your written authorization. Circumstances that may require written authorization include use or disclosure of psychotherapy notes, for marketing purposes, and for the sale of your health information.

B. *Revocation of Authorization*. If you give us an authorization, you can withdraw or amend this written authorization at any time. To withdraw your authorization, deliver or fax a written revocation to **ALPHA Center or fax: 803-432-6890 attention: Corporate Compliance Officer**. If you revoke your authorization, we will no longer use or disclose your health information as allowed by your written authorization, except to the extent that we have already relied on your authorization.

V. **Your Rights Regarding your Protected Health Information.**

A. You have certain rights regarding your health information, which are listed below. If you want to exercise any of your rights, you must do so in writing by completing a form that you can obtain from **ALPHA Center** or on our website at **www.alphabehaviorahealthcenterorg.** In some cases we may charge you for the costs of providing materials to you. You can get more information about how to exercise your rights and about any costs that we may charge for materials by contacting **ALPHA Center Corporate Compliance Officer**.

i. *Right to Inspect and Copy*. With some exceptions, you have the right to inspect and get a copy of the health information that we use to make decisions about your care. For the portion of your health record maintained in an electronic health record, if any, you may request we provide that information to or for you in an electronic format. If you make such a request, we are required to provide that information for you electronically

(unless we deny your request for other reasons). We may deny your request to inspect and/or copy in certain limited circumstances, and if we do this, you may ask that the denial be reviewed.

ii. *Right to Amend*. You have the right to amend your health information maintained by or for us, or used by us to make decisions about you. We will require that you provide a reason for the request, and we may deny your request for an amendment if the request is not properly submitted, or if it asks us to amend information that (a) we did not create (unless the source of the information is no longer available to make the amendment); (b) is not part of the health information that we keep; (c) is of a type that you would not be permitted to inspect and copy; or (d) is already accurate and complete.

iii. *Right to an Accounting of Disclosures*. You have the right to request a list and description of certain disclosures by us of your health information.

iv. *Right to Request Restrictions*. You have the right to request a restriction or limitation on the protected health information we use or disclose about you (a) for treatment, payment, or health care operations, (b) to someone who is involved in your care or the payment for it, such as a family member or friend, or (c) to a health plan for payment or health care operations purposes when the item or service for which we have been paid out of pocket in full by you or someone on your behalf (other than the health plan). For example, you could ask that we not use or disclose information about a laboratory test ordered or a medical device prescribed for your care. Except for the request noted in iv(c) above, we are not required to agree to your request. Any time we agree to such a restriction, it must be in writing and signed by our Privacy Officer or his or her designee.

v. *Right to Request Confidential Communications*. You have the right to request that we communicate with you about health matters in a certain way or at a certain place. We will accommodate reasonable requests. For example, you can ask that we only contact you at work or by mail.

vi. *Right to a Paper Copy of This Notice*. You have the right to a paper copy of this Notice, whether or not you may have previously agreed to receive the Notice electronically.

vii. *Right to be Notified of a Breach*. You have the right to be notified if there is a breach – a compromise to the security or privacy of your health information – due to your health information being unsecured. We are required to notify you within 60 days of discovery of a breach.

VI. **Revisions to this Notice.** We have the right to change this Notice and to make the revised or changed Notice effective for health information we already have about you, as well as any information we receive in the future. Except when required by law, a material change to any term of the Notice may not be implemented prior to the effective date of the Notice in which the material change is reflected. We will post the revised Notice at clinical locations and on our website and provide you a copy of the revised notice upon your request.

VII. **Questions or Comments**. If you have any questions about this Notice, please contact us at 803-432-6902. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact us at 803-432-6902 Corporate Compliance Officer. You will not be penalized for filing a complaint. This Notice tells you how we may use and share health information about you. If you would like a copy of this Notice, please ask your health care provider.

Revised 6/29/2018 mhj