First Step Counseling Services

Notice of Privacy Practices

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.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information. We are required also by law to do this. These laws are complicated, but we must provide you with important information. This pamphlet is a shorter version of the full, legally required NPP which you received along with this so refer to it for more information. However, we can't cover all possible situations so please talk to our Privacy Officer (see the end of this pamphlet) about any questions or problems.

We will use the information about health, which we get from you or from others mainly to provide you with **treatment,** to arrange **payment** for your services or for some other services or for some other business activities, which are called, in law, health care operations**.** After you have read this NPP we will ask you to sign a **Consent Form** to let us use and share your information. **If you do not consent and sign this form, we cannot treat you.**

If you or we want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization to allow this.

Of course, we will keep your health information private but there are some times when the laws require us to use or share it such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If law enforcement official requires doing so.
4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP. These are available upon request.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer Joseph A. Conte at 732-549-0401.

I have read and understand the above Notice of Privacy Practices

_____

Signature of client or his or her personal representative Date

_____

Printed name of client or personal representative Date

First Step Counseling Services

Consent to Treat/Assess, Use and Disclose your Personal Health Information

This form is an agreement between you, ⇨ _____ and First Step Counseling Services. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy by calling us at 732-549-0401 or from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

⇨ _____ _____

Signature of client or his or her personal representative | Date

_____ _____

Printed name of client or personal representative | Relationship to the client

First Step Counseling Services

Authorization to use and disclose protected health information

1. I am completing this form to allow the use and sharing of protected health information about
Printed Name: _____ Date: _____

2. I authorize this person or organization:

☑ First Step Counseling Services
16 Wernik Place
Metuchen, NJ 08840

3a. To use/disclose the following information:

☐ Inpatient or outpatient treatment records for physical and or psychological, psychiatric, or emotional illness or drug and/or alcohol abuse.

☐ Admission and discharge summaries.

☐ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.

☐ Treatment, recovery, rehabilitation, after care plans and other similar plans.

☐ Social, family, educational, and vocational histories.

☐ Social work assessments and plans.

☐ Progress, nursing, case or similar notes.

☐ Evaluations and reports of consultations.

☐ Information about how the patient's condition(s) affects or has affected his or her ability to work, and to complete tasks or activities of daily living.

☐ Vocational evaluations and reports.

☐ Billing records.

☐ Academic and educational records, including achievement and other tests' results, reports *of* teachers' observations, and all other school and special education documents.

☐ HIV-related information and drug and alcohol information

☑ Complete copy of the medical record.

3b. Dates of care included: From: _____ to discharge

4. To this person or organization:

Insurance Company: _____

_____

5. The information will be used/disclosed for the following purposes; _____

_____

6. I understand and agree that this Authorization will be valid and in effect until; DISCHARGE
7. I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.
8. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.
9. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed at number four (4) above, nor will it affect my eligibility for benefits.
10. I understand that I may inspect and have a copy of the health information described in this authorization.
11. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
12. I understand that this professional or facility will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it or it Does Not Apply.
13. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

_____

Signature of client or his or her personal representative Date

_____

Printed name of client or personal representative Relationship to client

_____

Description of personal representative's authority

First Step Counseling Services

Authorization to use and disclose protected health information

1. I am completing this form to allow the use and sharing of protected health information about
Printed Name: _____ Date: _____

2. I authorize this person or organization

☑ First Step Counseling Services
16 Wernik Place
Metuchen, NJ 08840

3a. To use/disclose the following information: **PLEASE CHECK ONE OR MORE BOXES**

- ☐ Inpatient or outpatient treatment records for physical and or psychological, psychiatric, or emotional illness or drug and/or alcohol abuse.
- ☐ Admission and discharge summaries.
- ☐ Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
- ☐ Treatment, recovery, rehabilitation, after care plans and other similar plans.
- ☐ Social, family, educational, and vocational histories.
- ☐ Social work assessments and plans.
- ☐ Evaluations and reports of consultations.
- ☐ Information about how the patient's condition(s) affects or has affected his or her ability to work, and to complete tasks or activities of daily living.
- ☐ Progress, nursing, case or similar notes.
- ☐ Vocational evaluations and reports.
- ☐ Billing records.
- ☐ Academic and educational records, including achievement and other tests' results, reports *of* teachers' observations, and all other school and special education documents.
- ☐ HIV-related information and drug and alcohol information.
- ☐ Complete copy of the medical record.

Other _____

3b. Dates of care included: From: _____ to ___discharge_____

4. To this person or organization _____
_____
_____
_____

5. The information will be used/disclosed for the following purposes; _____
_____
_____

6. I understand and agree that this Authorization will be valid and in effect until; DISCHARGE
7. I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.
8. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.
9. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed at number four (4) above, no will it affect my eligibility for benefits.
10. I understand that I may inspect and have a copy of the health information described in this authorization.
11. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
12. I understand that this professional or facility will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it, or it Does Not Apply.
13. I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

_____

Signature of client or his or her personal representative Date

_____

Printed name of client or personal representative Relationship to client

_____

Description of personal representative's authority

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

- I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

- I understand that telehealth services can only be provided to patients, including myself, who are residing in the State of New Jersey at the time of this service.

- I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

  • *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*

  • *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*

  • *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

- I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

- I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

- I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

- I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

- The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

- I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

- I understand that electronic communication cannot be used for emergencies or time-sensitive matters.

TELEHEALTH INFORMED CONSENT

- I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

- To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

- I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

For electronic communication between First Step Counseling and staff and _____.
(Patient's name)

_____ _____
Patient or Legal Representative Signature Relationship to Patient

_____
Print Patient or Legal Representative Name

_____
Witness Signature

First Step Counseling Services

We are committed to providing you with the best possible care, and we are pleased to discuss our fees with you at any time. Your clear understanding of our policies is important to our professional relationship. Please ask if you have any questions about our fees, policies, or your responsibility.

- All clients should complete the "Questionnaire Form" before seeing the counselor
- Deductible/co-pay and/or full payment is DUE AT THE TIME OF SERVICE
- We accept cash, checks or credit/debit cards
- There is a $35 fee for any bounced checks

Insurance

If you have insurance, we will help you receive the maximum benefits available to you. Insurance is a contract between you and your insurance company. We are NOT a party to this contract. This is not a guarantee of your benefits or co-pay rate. Final determination is made by your Insurance Company.
We file insurance claims as a courtesy to our patients. By signing below, I understand that if my health insurance company denies payment, I agree to be personally and fully responsible for payment. If a urine drug screening should be needed for today's visit, please be aware that there will be an additional **$35** fee for this service. We do not bill your Insurance Company for this service.

Missed Appointment

Unless cancelled at least twenty-four (24) hours in advance, our policy is to charge **$50** for missed appointments. Please help us to serve you better by keeping scheduled appointments.

Please be aware that at times, there may be the need for interagency communications between clinicians, staff and/or supervisors.

_____

Patients Signature Date

_____

Policy Holder Date

_____

Witness Signature Date

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT INFORMATION
42 CFR-PART 2 SUMMARY

Patient Name: _____

By Federal Law and State of New Jersey regulations, all programs are required to communicate to each patient that fact that Federal Law and regulations protect the confidentiality of all alcohol and drug abuse patient records. A summary of the law, which appears below, can also be given to you for your future reference.

SUMMARY

Federal Law and regulations protect the confidentiality of alcohol and drug abuse patient records maintained by this program. Generally, the program may not say to a person outside the program that a person attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless:

- The patient consents to the disclosure in writing
- The disclosure is allowed by an order of the court
- The disclosure is made to medical personnel in a medical emergency
- To qualified governmental personnel for purposes of research audit or program evaluation

Violation of the Federal Law and Regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal Law 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 C.290dd-3and 42 U.S.C 290ee-3 for Federal Laws and 42 CFR for Federal regulations)

⇨ _____ _____

Patient Signature Date

_____ _____

Witness Date

First Step Counseling Services

Consent for how to communicate with me

I do not need to provide any reason and simply request the following alternatives or limitations relating to communications directed to me by you or this practice:

Please telephone me at the following number(s): _____

Approved to leave a Voicemail on the above listed number(s)? ☐ YES ☐ NO

Can we text the above listed number(s)? If yes, which one(s) _____

When you call, please follow these directions: _____

_____

Please direct all postal mail to this address: _____

_____

Use this e-mail because it is private or password protected: _____

First Step Counseling does not do online counseling. However, we recognize that people sometimes prefer to communicate by online means such as text or email. Occasionally, we may use these methods to communicate "housekeeping items" (i.e.: appointments, materials you might like us to look at, etc.) As such, please be aware of the following: 1) Emails are not necessarily read or responded to immediately. 2) While using every reasonable means to protect and encrypt conversations and records of treatment, when doing therapy by internet or other electronic means, such encryption cannot be guaranteed. 3) By agreeing to engage in therapy by internet or other electronic means, the patient will assure that any text messages or recorded discussions will be destroyed within fifteen days of receipt. 4) You, the patient, are encouraged to protect your own confidentiality by controlling access to your communications with your counselor, such as by using passwords, controlling access to your computer, deleting data, etc.

⇨ _____

Printed Name (Client) Signature of client or personal representative Date

_____

Printed Name of personal representative Relationship to the client

_____

Witness Signature Date

First Step Counseling Services

Family Release for Contact and Referral

Patient Name: _____

Please Check One:

☐ 1. Patient wants to give permission to the following family members listed below:

Name of Relative	Relationship	Telephone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ 2. Patient has no family

☐ 3. Patient does not want family contacted

Reason: _____

_____

_____

I understand that part of my treatment at this facility is to involve my family/significant other. I hereby give permission for the person(s) listed above to be contacted.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Patient Rights

1. The right to be free from unnecessary or excessive medication.
2. The right to not be subjected to non-standard treatment or procedures, experimental procedures or research, psychosurgery, sterilization, electro-convulsive therapy or provider demonstration programs, without written informed consent, after consultation with counsel or interested party of the clients' choice.
3. The right to treatment in the least restrictive setting free from physical restraints and isolation.
4. The right to be free from corporal punishment.
5. The right to privacy and dignity.
6. The right to the least restrictive condition necessary to achieve the goals of treatment services.
7. To not be deprived of any civil right solely by reason of you receiving mental health facility.
8. To not be presumed incompetent for receiving services at a mental health facility.
9. You have the right to an individualized treatment plan based on your individual needs, which you will assist in developing. The plan will include goals, which you will agree to work towards.
10. You have the right to considerate and respectful care.
11. You have the right to be free of personal involvement with any facility staff member.
12. You have the right to expect to receive services from a competent, caring staff, inadequate numbers.
13. You have the right to be treated in a way which recognized and responds to your cultural identity and/or disability, and/or sexual orientation and/or sex.
14. You have the right to know the name of your Primary Counselor who is responsible for your care. Further, you have the right to know the names of any other individuals providing care of you.
15. You have the right to obtain from your Primary Counselor, at any time, information concerning your diagnoses and treatment in terms you can easily understand.
16. You have the right to know all facility rules that apply to your conduct as a patient.
17. You have the right to receive treatment in a physical environment that is safe, sanitary, reflective of human dignity, conductive to effective treatment and which appropriately safeguards your privacy and confidentiality.
18. You have the right to expect that no treatment requiring the order of a physician will be rendered to you except upon the prior written order of a physician based on the physicians' personal examination of you.
19. You have the right to receive and examine an explanation of your bill regardless of the source of payment.
20. You have the right to object to conditions at the facility and you have the right to a prompt and reasonable reply to your objection from the management of the facility. You have the right to complain to the Program Director and the Board of Directors of First Step Counseling Center and you have the right to complain to our regulatory state agency, The New York State Office of Alcoholism and Substance Abuse Services. First Step Counseling staff will assist you in lodging these complaints by informing you of the procedure for filing such complaints at any time.
21. You have the right to expect not to be discriminated against in any fashion on the basis of race, religion, creed, sex, sexual orientation, age or national origin.
22. You have the right to only perform tasks as they relate to your treatment plan and can expect not to be required to do any tasks involving work or training for the direct or indirect benefit of First Step Counseling Services.
23. You have the right to have a member of the staff help you to understand these rights.
24. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
25. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
26. You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records but we may charge you. Contact our Privacy Officer to arrange how to see your records. See Below.
27. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons.
28. You have the right to a copy of this notice. If we change this NPP we will post it in our waiting room and you can always get a copy.
29. 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 any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer who is Joseph A. Conte and can be reached by phone at 732-549-0401 or by mail at the address listed below.

The effective date of this notice is April 14th 2007

Client Signature Date Counselor Signature Date