



SHERIDAN HEALTH SERVICES
CONFIDENTIALITY & CONSENT FOR CARE

CLIENT NAME: _____

DATE: _____

Note to client: If there are any words or statements below that you do not understand or would like more information about, please let us know before signing this consent form.

Confidentiality

Your confidentiality regarding your mental health and/or alcohol and drug abuse records is legally protected. We may not say to a person outside Sheridan Health Services (SHS) that you receive care at SHS or disclose any information identifying you as a client, **unless:**

- You consent in writing (or your parent consents in writing if you are under 15 years of age) ; or
- Disclosure is ordered or allowed by a court order; or
- You commit or threaten to commit a crime either at the program or against any person who works for the program (if so, your confidentiality is not protected); or
- In our clinical judgment, you become harmful to yourself or others or you have a medical emergency (we may disclose select information about you in order to protect you or others); or
- We suspect child abuse and/or neglect. We are required by state law to report all suspected abuse and neglect to state and local authorities; or

Information about you may be used for program audit or evaluation purposes.

Therapeutic, Advanced Practice Psychiatric Nursing and Outpatient Substance services at SHS are affiliated with the University of Colorado College of Nursing. If you receive behavioral health care from a licensed provider, we may be required to report your name, address, and social security number to the Division of Behavioral Health of the Colorado Department of Human Services. Also, if you are Medicaid eligible, SHS will submit billings that will include your diagnosis(es) for any reimbursable therapeutic services. This information will be released in compliance with the federal regulations governing confidentiality of mental health and drug and alcohol abuse patient records.

Violation of Federal law and confidentiality regulations by a program is a crime (See 42 U.S.C. 290 ee-3, 290ff-3 Federal laws; 42 CFR, Part 2, and 45 CFR, Parts 142, 160, 162, 164 for Federal Regulations). Questions about this can be directed to SHS clinical behavioral health staff.

Consent for Behavioral Health, Advanced Practice Psychiatric Nursing and Outpatient Substance Treatment

I consent (or assent if I am a minor) to have SHS provide assessment and treatment for my behavioral, psychiatric, substance use, emotional, social, and/or educational problems. I understand that my behavioral health care is provided by a treatment team under the supervision of a licensed clinician. I understand that my psychiatric care is also under the supervision of a nurse practitioner. I understand that my assessment may include psychiatric and psychological questionnaires and evaluations (including emotional, behavioral, and intellectual evaluations).

By signing this consent form, I hereby authorize and give my voluntary consent to be involved in mental health and/or drug/alcohol treatment by SHS. I understand my rights to confidentiality and their limits. I willfully enter into this treatment and understand my responsibility in working toward my treatment goals. I have been offered a copy of this form.

Consent for Follow-Up Contact

I hereby give permission to the staff of SHS to contact me after my discharge from the SHS program in which I was treated. The purpose of this contact is to conduct follow-up surveys to gather information concerning the effectiveness of our treatment programs. All information will be considered confidential, and is protected by federal confidentiality regulations (42 CFR, Part 2). I understand that no names or client identifying information will be used in reports which may be sent to insurance companies, managed service organizations or governmental human services agencies.

Signature of Client

Date

Parent/Legal Guardian Signature

Date

Witness Signature

Date



AUTHORIZATION TO USE AND RELEASE CONFIDENTIAL HEALTH INFORMATION

Individual's Name _____ / ____ / ____
Last name, First name, Middle Initial – please print Individual's Birth Date

Address _____ Phone () _____

City, State, Zip Code _____

I, _____
Individual's name or name of person authorizing release of information legal authority to sign for individual

give my permission to use and release my confidential health information between:
Please check the agencies that are authorized to use, receive and disclose your protected health information

- Sheridan Health Services/Sheridan School Based Health Services
- Mile High Behavioral Healthcare
- ARTS Innovative Recovery Clinic
- ARTS Medication Assisted Treatment Clinics
- ARTS OTC – Outpatient Therapeutic Community
- ARTS Parkside Clinic
- ARTS Potomac Street Center
- ARTS Residential Peer I
- ARTS Residential Haven
- Sheridan School District
- Mile High Youth Corps
- ARTS Specialized Outpatient Services
- ARTS Synergy Outpatient Services
- ARTS Synergy Residential Services
- ARTS Westside Center for Change

I understand that by giving my permission, I will receive better coordinated quality health care. The focus of my care is on the whole person, with an individualized care plan developed for me. Only the amount of information reasonably necessary to achieve the purpose of this authorization will be shared.

CONFIDENTIAL HEALTH INFORMATION THAT MAY BE SHARED

I understand that confidential health information that may be shared includes:

- | Yes | No | (Please Initial) |
|------------------------------|--------------------------|--|
| ___ <input type="checkbox"/> | <input type="checkbox"/> | ___ My diagnosis (the name of my disease or problem) and any allergies |
| ___ <input type="checkbox"/> | <input type="checkbox"/> | ___ Results of my lab tests, x-rays, urine tests and any other tests |
| ___ <input type="checkbox"/> | <input type="checkbox"/> | ___ Past/current medications prescribed to me, including dosage |
| ___ <input type="checkbox"/> | <input type="checkbox"/> | ___ My contact information including name, phone, address, etc. |
| ___ <input type="checkbox"/> | <input type="checkbox"/> | ___ Information about me, including my gender, ethnic group, age, employment information, etc. |

Information in my health record may also be shared about:

- | Yes | No | (Please Initial) |
|------------------------------|--------------------------|---|
| ___ <input type="checkbox"/> | <input type="checkbox"/> | ___ My diagnostic evaluation |
| ___ <input type="checkbox"/> | <input type="checkbox"/> | ___ My treatment plan |
| ___ <input type="checkbox"/> | <input type="checkbox"/> | ___ My mental health status (not including psychotherapy notes) |
| ___ <input type="checkbox"/> | <input type="checkbox"/> | ___ Trauma history |
| ___ <input type="checkbox"/> | <input type="checkbox"/> | ___ My drug or alcohol use |
| ___ <input type="checkbox"/> | <input type="checkbox"/> | ___ HIV/AIDS status |
| ___ <input type="checkbox"/> | <input type="checkbox"/> | ___ Sexually transmitted diseases |
| ___ <input type="checkbox"/> | <input type="checkbox"/> | ___ Social support system |

I restrict sharing of information as follows:

MY RIGHTS

I understand that generally Sheridan Health Services (SHS) may not condition my treatment on whether I sign an authorization form. I also understand that in certain limited situations, I may be denied treatment if I do not sign an authorization form. For example, if funding for my treatment depends on an agency or an organization receiving reports about my treatment and my progress, I will need to sign an authorization form or I may not be admitted to care. I also understand that the people who get this information may give out my information. As a result, the information may no longer be protected. SHS will try to prevent my information from being revealed by providing a notice to those receiving my information that redisclosure of personal information provided to them is not allowed.

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Part 160 & 164. I understand that they cannot be released without my written permission unless otherwise provided for by the regulations.

I understand that if I sign this, I have a right to change my mind. If I decide I want to cancel this authorization, I must do so in writing. My cancellation will not affect any actions that have already been taken in the use of this authorization, such as confidential information that has already been shared between my care providers.

I understand that I will be given a copy of this permission once I have signed and dated it.

This authorization expires one year from the date I sign the form or when the sharing of information is longer needed to manage or to provide services to me, whichever happens first.

By signing this authorization, I agree that I have read and understand the information on this form.

Individual's signature

Date

Signature of Parent, Guardian and/or Authorized Representative (describe relationship)
with legal authority to sign for individual

Date

Authorized Representative (describe relationship)

Date

Witness

Date



CLIENT RIGHTS

While at Sheridan Health Services (SHS):

1. It is a client's right to not be discriminated against because of race, color, creed, gender, sexual orientation, or disability.
2. Clients have the right to be treated with respect, impartiality, and fairness.
3. Clients shall be informed of Sheridan Health Services rules and hours.
4. Clients have the right to review their case records. The client may, upon request, review the case file or it can be released or viewed by others only with a proper, signed release of information form from the client. Such reviews of the file may be conducted according to program procedures, at a time convenient to the facility and the reviewer. Professional staff must be present to explain the materials. The program may remove the following kinds of confidential information before the client or others see the file:
 - A. Information that may threaten the security of the facility or the confidentiality of other clients.
 - B. Information that may result in other peers being put in danger of physical injury
 - C. Information which, if revealed, would be psychologically damaging.
5. Clients have a right of freedom of expression as long as it does not interfere with the rights of others.
6. Clients have the right to receive services in the least restrictive setting, subject to available resources and appropriations.
7. Clients have the right to an individualized service/treatment plan and to participate in its development and any subsequent changes in the plan.
8. Clients have a right to due process in disciplinary proceedings.
9. Clients will not be discriminated against for exercising their rights.

I have read and I understand the Client Rights document, and I have been offered a copy.

Client Signature _____ Date _____

Parent/Guardian Signature *(if applicable)* _____ Date _____

Therapist Signature _____ Date _____



Client Name _____

Date _____

APPOINTMENT POLICY

Welcome to Behavioral Health, Outpatient Substance Use Treatment, and Psychiatric Nursing Services at Sheridan Health Services (SHS). We encourage you to come to all scheduled appointments. Any change to your appointment may affect other clients. If an appointment is not kept, it generally means that someone else was not able to receive services.

We request that both new and established clients provide **at least a 24-hours' notice** of cancellation of their appointment.

If three (3) appointments are cancelled or missed with less than 24-hours' notice in a three-month period, we may terminate behavioral health, outpatient substance use treatment, and/or psychiatric nursing services. Additionally, if you are 15 minutes late for your appointment, we may have to reschedule your appointment. We may also terminate behavioral health, outpatient substance use treatment, and/or psychiatric nursing services if you are consistently late for appointments within a three-month period. At the time of termination, we will provide you with information about other referral sources, if necessary. Behavioral Health Providers and/or Nurse Practitioners reserve the right to change this policy due to extenuating circumstances.

FEE AGREEMENT

It is the policy of SHS to maintain costs and fees that are consistent with locally prevailing rates or charges and are designed to cover the reasonable costs of operations for services provided to our clients. We make every reasonable effort to obtain reimbursement from third party payors including public insurance programs such as Medicaid, CHP+, Medicare and other public assistance programs, as well as private health insurance. Clients with third party coverage from public or private programs are expected to pay any required co-payments, deductibles, or co-insurance for services at the time of service.

All clients may apply for the Sheridan Sliding Fee Discount Program. This program applies to all clients and families with annual incomes at or below 200 percent of the Federal Poverty Guidelines.

All clients are charged based on the SHS fee schedule.

- Sliding Fee Scale clients will be billed and charges adjusted according to their discount rating.
- Third party insurance companies will be billed based on insurance plan, and co-payments, deductibles, or co-insurance may be due at the time of service.
- Clients not eligible for the Sheridan Sliding Fee Discount Program, or without insurance or another discount program are subject to full charge prices. A prompt pay discount is available for these charges, please ask to speak to the patient account representative.

I have read and understand the appointment policy and fee agreement.

Client Signature _____ **Date** _____

Parent/Guardian Signature (if applicable) _____ **Date** _____

Provider/Witness Signature _____ **Date** _____



ACKNOWLEDGMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of the joint Notice of Privacy Practices for University of Colorado Anschutz Medical Campus and Sheridan Health Services.

Name (Sign)

Date

Name (Print)

For Internal Use Only:

Reason Acknowledgment was not obtained: _____

Name (Sign)

Date

Name (Print)