Crosspointe Family 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

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

SUMMARY

By law we are required to provide notice to you of our Privacy Practices. This notice describes how your medical information may be used and disclosed by us. A full copy of our Privacy Practices is posted in our business lobby. It also tells you how you can obtain access to your medical information.

As a patient you have the following rights:

- The right to inspect and copy your information
- The right to request corrections to your information
- The right to request that your information be restricted
- The right to refuse to participate in Idaho Health Data Exchange
- The right to request confidential communications
- The right to a paper copy of this notice

1. Uses And Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant, or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
  - In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
  - To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below.

- To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.
  - To maintain our facility directory. If a person asks for you by name, we will only disclose your name, general condition, and location in our facility. We may also disclosure your religious affiliation to clergy.

3. Uses and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.
- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge

you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.

- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.

- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.

- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. **Changes To This Notice.** We reserve the right to change the terms of this Notice at any time, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. **Idaho Health Data Exchange.** Crosspointe Family Services has chosen to participate in the Idaho Health Data Exchange (IHDE). If you do not want to participate in the IHDE and you do not want to have your health care information shared with other medical providers involved in your care, you can opt out of participation. To opt out, you must complete and sign the IHDE "Request to Restrict Disclosure of Health Information" form and mail or fax it to IHDE. You will receive a letter of confirmation upon completion of your request. This will restrict your information from being released through the exchange only (you will need to contact direct any facility you wish to also restrict your information with). The IHDE form is available at the front desk. If you do not complete this form, we may share your protected health information with other participating healthcare providers involved in your care through IHDE. This is a secure statewide internet-based health information exchange, with the goal of improving the quality and coordination of health care in Idaho.

7. **Complaints.** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

8. **Contact Information.** If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Privacy Officer: Practice Administrator
Phone: 208-736-7090
Address: 1363 Fillmore Street, Twin Falls ID 83301

E-mail: info@crosspointemh.com

9. **Effective Date.** This Notice is effective 02/10/2016.

10. **Appointment Cancelations, Reschedules and No Shows**

I agree that if I am more than 10 minutes late to my appointment I will need to reschedule for another day. Also If I miss more than 2 appointments I may be discharged from Crosspointe Family Services and referred to another provider.

11. Court Orders, Reports, and Subpoenas

I understand that if I desire Crosspointe Family Services and its employees to testify or my attorney issues a subpoena to have my Provider appear in court to testify, that there is a standard hourly Fee of $500.00 per hour, 2 hour minimum, that is required and payable in advance of appearance and testimony being provided.

I understand that if I sign a release of information with my legal counsel, all records may be released including medical, behavioral health, and Substance Use individual session notes, which may contain sensitive and personal information about me.

Reports will be provided at the Standard Billable hourly rate of $125.00, on a pro-rata basis for actual time spent reviewing patient records and writing the report.

12. Records Copy Request

Records Requests are honored on a one-time basis annually, per patient for no-cost. Additional record requests are billed at $20.00 per request for paper copies up to 100 pages. Additional pages are billed at .20 cents per page. Electronic copies are $10.00, recipient must have the capability to receive encrypted e-mail records.

INFORMED CONSENT FOR TREATMENT-MEDICAL NECESSITY

I have selected Crosspointe Family Services to assist me in accomplishing the Goal(s) stated in my treatment plan. I understand that I must meet medical necessity to receive services (medical necessity requires that you need services to address your current condition(s) to return to a "normal" daily functional level and/or to avoid higher levels of care such as psychiatric hospitalization).

I hereby give my consent to be treated for Mental Health services. These services may include: Evaluation and Assessment, Treatment Planning, Community Based Rehabilitation Services, Case Management, SUDS Treatment, Peer Support Services, Family Support Services, Medication Assessment and Management, and/or Psychotherapy Services delivered in Individual, group, and/or Family Sessions in Clinic, within the community, or within your home as determined in your treatment plan. The services will be provided as outlined on your Treatment Plan including times, dates, frequency, and goals.

I realize there are positive and negative risks associated with all the services identified above. If you participate in treatment, your condition may get better OR it may worsen and you may need a higher level of care. I understand that I determine my treatment goals. I agree to participate in all aspects of my treatment. I may elect to involve others in planning my treatment including family members, significant others, medical providers, and teachers. I agree to keep all appointments, ask questions when I do not understand or become confused, and to complete my treatment plan to the best of my ability.

Please understand that participation in your treatment is expected. If you fail to engage in treatment you may require a higher level of treatment care, your outcome may not meet your expectations and/or you may be discharged from services. You are encouraged to meet with any of our staff to discuss any concerns, to seek education, or to ask questions you have at any point in your treatment.

Crosspointe Family Services maintains a 24-hour Crisis Line at 208-731-4773.

The Services which may be provided to me have been explained to my satisfaction. My informed consent expires one year from date or whenever interim circumstances or changes in the treatment plan substantially affect the risks or other consequences or benefits reasonably to be expected; or annually or when rescinded by me, my parent, and/or guardian. I realize that I may withdraw my consent and discontinue treatment at any time without prejudice by giving written notice.

Participant Rights and Grievance Procedure

Crosspointe Family Services provides the following rights for all participants:

a. To receive Humane care and treatment
b. Not be put in isolation
c. Be free of mechanical restraints, unless necessary for the safety of that person or for the safety of others
d. Be free of mental and physical abuse
e. The right and ability to voice grievances and recommend changes in policies or services being offered
f. Practice his/her own religion
g. Wear his/her own clothing and to retain and use personal possessions
h. Be informed of his medical and habilitative condition, of services available at the agency and the charges for the services
i. Reasonable access to all records concerning himself
j. May refuse services and exercise all civil rights, unless limited by prior court order
k. Privacy and confidentiality
l. Be treated in a courteous manner
m. Receive a response from the agency to any request made within a reasonable time frame
n. Receive services that enhance the participant's social image and personal competencies and, whenever possible, promote the agency in the community
o. Refuse to perform services for the agency. If the participant is hired to perform services for the agency the wage paid must be consistent with state and federal law
p. Review the results of the most recent survey conducted by the Department and the accompanying plan of correction
q. All other rights established by law
r. Be protected from harm.

In accordance with the Participant Rights Statement, participants, their families, and advocates are offered the opportunity to report complaints and/or grievances. Complaints and/or grievances may be filed as a result of problems with training, service delivery, supervision, funding, planning, service barriers, staff, etc. Crosspointe Family Services has a

rigorous, internal process for assuring quality services and resolving problems in a prompt fashion. All grievances will be solved verbally as quickly as possible when appropriate. If a formal written grievance is filed, the right to file a grievance is outlined below:

A grievance is made by calling the Administrator at 208-736-7090 or by filling out a grievance report.

- The Administrator or designee of will investigate the grievance in a timely fashion (within 1 week).
- The Administrator or designee will consult with other Administrative team members regarding the appropriate actions required.
- The Administrator or designee will implement any required changes (Within 1 week).
- The Administrator will report findings of the investigation to the participant/guardian and advocate within 1 week.
- Any grievances made by a participant and their family, must be documented and placed in their file.
- At any time, the participant and his/her family may appeal the findings of the review and request a second, independent review of the complaint and/or grievance.
- A local mediator will be procured if necessary to resolve the complaint and/or grievance. The mediator will be agreed upon by all parties to the grievance in writing.
- All Complaint/Grievance reports are handled with the utmost confidentiality.

Patient Authorization for Third Party Payor Reimbursement of Provider and Verification

I understand that if I have questions or concerns regarding my privacy rights that I may contact this person listed above. I further understand that the practice will offer me updates to this Notice of Privacy Practices should it be amended, modified, or changed in any way.

I request that payment of authorized Medicare, Medicaid and/or Private Insurance benefits be made on my behalf to Crosspointe Family Services for services rendered by the in-house provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, and/or any other applicable third-party payor(s) and their agents any information needed to determine these benefits or the benefits payable for related services.

I agree and give my permission for my medical care provider(s) to access and verify my prescription history with via Idaho Prescription Monitoring program, requests from pharmacies, and previous medical care providers.

I agree that if I am more than 10 minutes late to any scheduled appointment I will need to cancel and reschedule for another day. If I miss 2 or more scheduled appointments I may be discharged and referred to another provider.

Please sign the form provided to you at the front desk indicating you have read and were offered and or provided a copy of this document.