Dickinson Center, Inc.

COMPASSION • EXCELLENCE • HOPE SINCE 1958

STUDENT ASSISTANCE PROGRAM CONSENT

I _____ agree for myself/my child _____ to voluntarily participate in the Student Assistance Program (SAP). This program may consist of a mental health screening, 3-5 supportive counseling sessions, and/or recommendations and referrals to additional services.

I understand the following:

- Staff of the Student Assistance Program do not diagnose or provide treatment.
- SAP services are provided at school and are free of charge.
- If necessary, the SAP Mental Health Liaison will meet with my child on a regular basis for approximately 3-5 supportive counseling sessions.
- Supportive counseling sessions may address any issues that could be interfering with the student's academic success. This may include, but is not limited to, education and support for issues such as anger, bereavement, healthy relationships, academic stressors, coping skills, social skills, anxiety, and/or other behavioral and emotional concerns.
- At any time, the mental health liaison may recommend additional services for the student (i.e. treatment). Referrals and assistance will be provided to navigate care coordination as needed.
- The Mental Health Liaison will attempt collaboration with the parents/guardians of the student.
- It is the parent's/guardian's responsibility to schedule any necessary appointments based on recommendations for additional services.
- If at any time the student and/or guardian refuses services, SAP services will be closed and the school will be notified of the family's choice not to participate.
- This Consent of Student Assistance Program Services will be in effect until the close of the current academic school year.
- I understand that all services provided and information given is governed as strictly confidential, in accordance with the laws and regulations of the Commonwealth of Pennsylvania and the Health Information Portability Accountability Act (HIPAA).

Copy of Consent Form: Given ____ Offered/Refused____

□ I prefer no messages from DCI Staff.

□ I agree that DCI Staff may leave voice messages at the following number : _____

□ I agree that DCI Staff may send text messages to the following number: No texting available

_____
Client Signature & Date

_____
Guardian Signature & Date

_____
Staff Signature & Date

United Way Member Agency

STUDENT ASSISTANCE PROGRAM
1 NORTH MAIN ST 3RD FLOOR
PHONE: 814.274.8651 • FAX: 814.274.8652
WWW.DICKINSONCENTER.ORG

PANO STANDARDS FOR EXCELLENCE

Acknowledgement of Receipt of Notice of Privacy Practices

CLIENT NAME: _____

**Note: If Client is under 14, parent must complete. If Client is 14 or older, Client must complete.*

After reading each section, please mark the box indicating you have read and understand the contents.

- ☐ I understand and have been provided a copy of the document entitled Notice of Privacy Practices, which provides a complete description of potential uses and disclosures of my protected health information. I understand that I have the right to review the Notice of Privacy Practices prior to signing this form.
- ☐ I understand that Dickinson, Inc. reserves the right to change its privacy practices and will see that I receive a copy of any revised notice(s).
- ☐ I understand that I have the right to request that Dickinson, Inc. restrict how my protected health information is used or disclosed to carry out treatment, payment or health care operations. I further understand that Dickinson is not required to grant any request to restrict the use or disclosure of information. If, however, the Dickinson agrees to a requested restriction, the restriction is binding to the Program, unless Dickinson, Inc. or I revoke that restriction.

Please Complete:

Name	Address	Phone #	Contact for Emergency/Scheduling Purposes		Involve in my treatment if therapist feels it is appropriate	
			Agree	Object	Agree	Object
Check here if there is no one identified at this time.						

understand that if I want anyone else involved in my treatment, schedule or change appointments for me, pick up medication or any other necessary service, I will inform Dickinson, Inc. to add this person to the above list. Furthermore, I understand that this acknowledgement is not intended to be used as an authorization to release medical records.

Consumer Printed Name: _____ Date: _____

Consumer Signature: _____

Witness Signature: _____

If you are a legal representative of the person listed above, please check off the basis for your authority:

___ Power of Attorney (attach copy) ___ Parent of Minor
___ Guardianship Order (attach copy) ___ Other: _____

Additional Witness Signature for Verbal Consent and Mark: _____

Unable to get signature:

_____ (client name) was given a Notice of Privacy Practices on _____
No acknowledgement was signed because:

_____

Staff Name: _____ Date: _____

For Office Use Only
ID Number: _____ DICKINSON Contact: _____

Revised 1/11/11

TREATMENT PROGRAM: COUDERSPORT
NOTICE OF PRIVACY PRACTICES

This Notice describes how you/or your child's health information may be used and disclosed by Dickinson, Inc. and how you can get access to this information. Please review it carefully.

We have a legal duty to safeguard your protected health information. We will protect the privacy of the health information maintained by us that identifies you, whether it deals with the provision of health care to you or the payment for your health care. We must provide you with this Notice about our privacy practices. It explains how, when, and why we may use and disclose your health information. With some exceptions, we will use or disclose only that part of your health information that is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this Notice, which is currently in effect.

Dickinson, Inc. reserves the right to change the terms of this Notice and our privacy practices at any time. We will promptly revise and redistribute this Notice whenever there is a material change to the uses and disclosures, your individual rights, our legal duties or other privacy practices herein stated. Any changes made will apply to all of your health information that we maintain. The revised Notice will be posted in our reception area and you will be given an updated copy at the time of your next appointment. You may also request, at any time, a copy of our current Notice of Privacy Practices at any time, from the receptionist. {You may also view and obtain an electronic copy of this Notice on our website at www.dmhc.org}.

We would like to take this opportunity to answer some common questions concerning our privacy practices:

Question: How will Dickinson, Inc. use and disclose my protected health information?

Answer: We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. We may redisclose some of your health information that we received from another entity for the purposes of treatment but not without your authorization except in an emergency situation. Below, we describe the different categories of our uses and disclosures and give you some examples of each.

A. **Uses and Disclosures Relating to Treatment, Payment and Healthcare Operations.** We may, by federal law, use and disclose your health information for the following reasons:
   1. **For Treatment:** Dickinson, Inc. will share your health information within our programs but limit this practice only for the purpose of treatment, payment and health care operations. Health information used or disclosed for this purpose will be limited to the minimum necessary for that purpose. With the possible exception of information concerning mental health disorders and/or treatment, drug and alcohol abuse and/or treatment, and HIV status (for which we may need your authorization), we may disclose your general health information to other health care providers who are involved in your care. For example, we may disclose your medical history to a hospital if you need medical attention while at our facility, or to a residential care program we are referring you to. Reasons for a disclosure may be: to get them the medical history information they need to appropriately treat your condition, to coordinate your care or to schedule necessary testing.
   2. **To Obtain Payment for Treatment:** With the possible exception of some specific information concerning mental health disclosures and/or treatment, drug and alcohol abuse and/or treatment, and HIV status (for which we may need your specific authorization), we may use and disclose necessary health information in order to bill and collect payment for the treatment we have provided to you. For example, we may provide certain portions of your health information to your health insurance company, Medicare or Medicaid, in order to get paid for taking care of you.
   3. **For Health Care Operations:** We may, at times, need to use and disclose your health information to run our organization. For example, we may use your health information to evaluate the quality of treatment that our staff has provided to you. We may also need to provide some of your health information to our accountants, attorneys and consultants in order to make sure that we're complying with law; for specific information concerning mental health disorders and/or treatment, drug and alcohol abuse and/or treatment, and/or HIV status, we may be further limited in what we provide and may be required to first obtain from you specific authorization.

B. **Certain Other Uses and Disclosures are Permitted by Federal Law.** We may use and disclose your health information without your authorization for the following reasons:
   1. **When a Disclosure is Required by Federal, State or Local Law, in Judicial or Administrative Proceedings or by Law Enforcement.** For example, we may disclose your protected health information if we are ordered by a court, or if a law requires that we report that sort of information to a government agency or law enforcement authorities, such as in the case of a dog bite, suspected child abuse or a gunshot wound.
   2. **For Public Health Activities.** Under the law, we need to report information about certain diseases, and anything about deaths, to government agencies that collect that information. With the possible exception of information concerning mental health disorders and/or treatment, drug and alcohol abuse and/or treatment and HIV status (for which we may need your specific authorization), we are also permitted to provide some health information to the coroner or a funeral director, if necessary, after a client's death.
   3. **For Health Oversight Activities.** For example, we will need to provide your health information if requested to do so by the County and/or State when they oversee the program in which you receive your care. We will also need to provide information to government agencies that have the right to inspect our offices and/or investigate healthcare practices.
   4. **To Avoid Harm.** If one of our counselors, physicians or nurses believes that it is necessary to protect you, or to protect another person or the public as a whole, we may provide protected health information to the police or others who may be able to prevent or lessen the possible harm.
   5. **For Specific Government Functions.** With the possible exception of information concerning mental health disorders and/or treatment, drug and alcohol abuse and/or treatment and HIV status (for which we may need your specific authorization), we may disclose the health information of military personnel or veterans where required by U.S. military authorities. Similarly, we may also disclose a client's health information for national security purposes, such as assisting in the investigation of suspected terrorists who may be a threat to our nation.
   6. **For Workers Compensation.** We may provide your health information as described under workers' compensation law, if your condition was the result of a workplace injury for which you are seeking workers' compensation.
   7. **Appointment Reminders and Health Related Benefits or Services.** Unless you tell us that you would not prefer to receive them, we may use or disclose your information to provide you with appointment reminders.
   8. **Fundraising Activities.** For example, if Dickinson, Inc. chose to raise funds to support one or more of our programs or facilities, or some other charitable cause or community health education program, we may use the information that we have about you to contact you. If you do not wish to be contacted as part of any fundraising activities, please contact Jim Prosper at 776-2145.

C. **Certain Uses and Disclosures Require You to Have the Opportunity to Object.**

1. **Disclosures to Family, Friends or Others Involved in Your Care.** We may provide a limited amount of your health information to a family member, friend or other person known to be involved in your care or in the payment for you care, unless you tell us not to. For example, if a family member comes with you to your appointment and you allow them to come into the treatment room with you, we may disclose otherwise protected health information to them during the appointment, unless you tell us not to. (This information may not contain information about mental health disorders and/or treatment, drug and alcohol abuse and/or treatment and HIV status; without your specific verbal authorization which will be verified in your record).
2. **Disclosures to notify a Family Member, Friend or Other Selected Person.** When you first started our program, we asked that you provide us with an emergency contact person in case something should happen to you while you are at our facilities. Unless you tell us otherwise, we will disclose certain limited health information about you (your general condition, location, etc.) to your emergency contact or another available family member, should you need to be admitted to the hospital, for example. (This information may not contain information about mental health disorders and/or treatment, drug and alcohol abuse and/or treatment and HIV status, without your specific authorization.)

D. **Other Uses and Disclosures Require Your Prior Written Authorization.** In situations other than those categories of uses and disclosures mentioned above, or those disclosures permitted under federal law, we will ask for your written authorization before using or disclosing any of your protected health information. In addition, we need to ask for your specific written authorization to disclose information concerning your mental health, drug and alcohol abuse and/or treatment, or to disclose your HIV status.

If you choose to sign an authorization to disclose any of your health information, you can later revoke it to stop further uses and disclosures to the extent that we haven't already taken action relying on the authorization, so long as it is revoked in writing.

Question: What Rights Do I Have Concerning My Protected Health Information?

Answer: You have the following rights with respect to your protected health information.

A. **The Right to Request Limits on Uses and Disclosures of Your Health Information.** You have the right to ask us to limit how we use and disclose your health information. We will certainly consider your request, but you should know that we are not required to agree to it. If we do agree to your request, we will put limits in writing and will abide by them, except in the case of an emergency. Please note that you are not permitted to limit the uses and disclosures that we are required or allowed by law to make.

B. **The Right to Choose How We Send Health Information to You or How We Contact You.** You have the right to ask that we contact you at an alternate address or telephone number (for example, sending information to your work address instead of your home address) or by an alternate means (for example, by mail instead of telephone). We must agree to your request so long as we can easily do so.

C. **The Right to See or to Get a Copy of Your Health Information.** In most cases, you have the right to look at or get a copy of your health information which is a part of your medical record set, but you must make the request in writing. A request form is available at the receptionist desk. We will respond to you within 30 days after receiving your written request. If we do not have the health information that you are requesting, but we know who does, we will tell you how to get it. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial. In certain circumstances, you may have a right to appeal the decision.

If you request a copy of any portion of your protected health information, we will charge you for the copy only as allowed under Pennsylvania State law. We need to require that payment be made in full before we will provide the copy to you. If you agree in advance, we may be able to provide you with a summary or an explanation of your records instead. There will be a charge for the preparation of the summary or explanation.

D. **The Right to Receive a List of Certain Disclosures of Your Health Information That We or Our Business Associates Have Made.** You have the right to get a list of certain types of disclosures that we or our Business Associates have made of your health information. This list would not include uses or disclosures for treatment, payment or healthcare operations, disclosures to you or with your written authorization, or disclosures to your family for notification purposes or due to their involvement in your care. This list also would not include any disclosures made for national security purposes, disclosures to corrections or laws enforcement authorities if you were in custody at the time, or disclosures made prior to April 14, 2003. You may not request an Accounting for more than a six (6) year period.

To make such a request, we require that you do so in writing; a request form is available upon asking at the receptionist desk. We will respond to you within 60 days of receiving your request. The list that you may receive will include the date of the disclosure, the person or organization that received the information (with their address if available), a brief description of the information disclosed, and a brief reason for the disclosure. We will provide such a list to you at no charge; but, if you make more than one request in the same twelve month period, you will be charged $15.00 for each additional request that year.

E. **The Right to Ask to Correct or Update Your Health Information.** If you believe that there is a mistake in your health information or that a piece of important information is missing, you have a right to ask that we make an appropriate change to your information. You must make the request in writing, with the reason for your request, on a request form that is available at the receptionist desk. We will respond within 60 days of receiving your request. If we approve your request, we will make the change to your health information, tell you when we have done so, and will tell others that need to know about the change.

We may deny your request if the protected health information: (1) is correct; (2) was not created by us; (3) is not allowed to be disclosed to you; or (4) is not part of our records. Our written denial will state the reasons that your request was denied and explain your right to file a written statement of disagreement with the denial. If you do not wish to do so, you may ask that we include a copy of your request form, and our denial form, with all future disclosures of that health information.

F. **The Right to Get a Paper Copy of This Notice.** If you have agreed to receive this Notice via e-mail, you will always have the right to request a paper copy of this Notice. You may view an electronic copy of this Notice at our website, www.dmhc.org.

Question: How Do I Complain or Ask Questions About This Organization's Privacy Practices?

Answer: If you have any questions about anything discussed in this Notice or about any of our privacy practices, or if you have any concerns or complaints, please contact Jim Prosper at 776-2145. You may register a verbal complaint or complete a Privacy Complaint Form which is available at the reception desk at all Program sites. If you file a complaint, it authorizes us to conduct an investigation in order to validate the complaint and correct any violation. You also have the right to file a written complaint with the Secretary of the U.S. Department of Health and Human Services. We may not take any retaliatory action against you if you lodge any type of complaint.

Question: When Does This Notice Take Effect?
Answer: This Notice takes effect on April 14, 2003