ADMISSION FORM

Admission Date _____/_____/_____ Referral Source**:** _____

Name:_____ SS#_____/_____/_____

Address_____ Home Phone _____

City, State, Zip_____ Cell Phone_____

Place of employment: _____ Work Phone _____

Date of Birth: _____/_____/_____ Age: _____ Race: _____ Sex: Male_____ Female_____

Email: _____

Marital Status: _____ Never married _____ Now Married _____ Divorced _____ Separated _____ Widowed

Do you have an Advance Directive? Yes_____ No_____ Is Treatment Voluntary _____Mandatory_____

MEDICAL EMERGENCY INFORMATION

Because this is a multicultural area, do you have any difficulties reading or writing English? Yes No

Do you have any hearing or speech impairments requiring assistance? Yes No

EMERGENCY CONTACT (relative, legally authorized representative or other person to be notified)

Name_____
Address_____

Telephone No: (_____)-_____-_____

Relationship: _____

ALLERGIES (medication and/or food allergies) None_____

If Yes Explain: _____

CURRENT MEDICAL CONDITIONS AND TREATMENT:

_____
_____

FAMILY PHYSICIAN None_____
Name_____
Address_____
Phone_____

FAMILY DENTIST None_____
Name _____
Address_____
Phone_____

INSURANCE INFORMATION: None_____
Company_____ Group #_____ Phone # _____

Medicare___, Medicaid ___, Group Number_____ Phone # _____

Tricare: Standard _____ Prime _____ Retired Standard _____ Retired Prime _____ Other _____

Sponsor's SS#: _____ Date of Birth: _____

PRIMARY DRUG OF CHOICE_____ Last use date_____

Amount_____ Withdrawal problems_____ None_____

SECONDARY DRUG OF CHOICE_____ Last use date_____

Amount_____ Withdrawal problems _____ None_____

SECONDARY DRUG OF CHOICE_____ Last use date_____

Amount_____ Withdrawal problems _____ None_____

Client Signature: Witness Signature:

Signature of Legal Guardian, if applicable:

ASSOCIATES AT YORK, INC.

PAYMENT AGREEMENT

Patient: _____

Guarantor: _____

I understand that my payment obligations include my co-payment, outstanding deductible and any services not covered by insurance and that payment is due at the time services are rendered. I acknowledge that I am ultimately responsible for all incurred charges and agree to make prompt payment on any account balance.

I understand that I will be billed a $35.00 fee for appointments not cancelled 24 hours prior to scheduled appointment time. These charges are not covered by insurance and I accept full responsibility for payment. We have an answering service to handle after hours cancellations and problems.

I agree to pay interest at the rate of 1.5% per month or 18% per annum on any unpaid account balance. Additionally, I agree to the payment of reasonable attorney's fees (not to exceed 35% of the account balance) and to pay all costs incurred in the collection of my account, in the event I fail to pay my account balance in accordance with our above-stated agreement.

_____ _____

Signature of Patient/Guarantor Date Signed

_____ _____

Signature of Witness Date Signed

CLIENT'S RIGHTS SUMMARY

As a client of this Program, you have certain rights, which are set out in the Rules and Regulations to Assure the Rights of Clients in Community Programs (referred to as The Rules and Regulations to Assure the Rights of Individuals Receiving Services from providers of Mental Health, Mental Retardation and Substance Abuse Services). Also, there is a written policy, which sets out what this Program must do to comply with the Community Regulations. A summary of your rights is set out below.

I. Right to Notification

You must be informed of you rights every 360 days while in the Program, and you have the right to see and get a copy of the Community Regulations and the Policy upon request. Also, you must be told what the Program's rules of conduct are, and you have a right to have a copy.

II. Right to Treatment

The Program cannot deny services solely on the basis of your race, national origin, sexual orientation, age, religion, or handicap. If you think you have been discriminated against by this Program, you can contact the Executive Director, the Regional Advocate, or any other program employee.

III. Right to Confidentiality

Your records will be released only with your consent or the consent of your authorized representative or by court order, except in emergencies or as otherwise required or permitted by law. You have the right to inspect and to have copies made of your records at your own expense, except where it would be harmful to you. In that situation, a lawyer, doctor or psychologist you choose can see the records on your behalf. If you feel there are mistakes in your record you can ask to have them corrected, and if the Program doesn't change what you think is an error, you can place your statement about the error in your record.

IV. Right to Consent

A treatment or service which presents a "significant risk"-- that is, one that might cause some injury or have a serious side effect -- may not be administered unless you or your authorized representative first give informed consent to it.

V. Right to Dignity

You have the right to be called by your preferred or legal name, to be protected from abuse, and to request help in applying for services or benefits for which you are eligible. If you are in a residential program, you have the right to a safe, sanitary and humane environment; to the provision of suitable clothing if it is not otherwise available; to confidential mail and telephone communications; to personal meetings with professionals or counselors assisting you; and to observe religious practices which do not conflict with the rights of others or with the law.

VI. Right to Least Restrictive Alternative

Your personal or physical freedom can be limited when necessary for your safety, the safety of other clients, or for treatment. You will be involved in decisions to limit your freedom, and you will be told what has to happen for the limits to be removed. Restrictions can be applied without notice in emergencies.

VII. Right to be Paid for Compensable Work

You have the right to be paid for work you do for the Program which the law says is "compensable" work. Personal housekeeping and work which is done as a part of treatment and is not done mainly for the purpose of making money for the Program is not "compensable" work.

VIII. Right to Keep Certain Legal Rights

When you enter this Program you still keep your basic legal rights, including the right to enter into contracts; to register to vote; to marry or divorce; to make a will; to use the courts, etc.

IX. Right to Hearings and Appeals

If you believe any of your rights under the Community Regulations have been violated, you may file a complaint, and you may appeal the decision to the Program Director or Clinical Director. In answering your complaints, Program staff must inform you of your appeal rights, which include the right to appeal a decision to the Local Human Rights Committee (LHRC).

X. Right to Assistance by Regional Advocate

The state has appointed a Regional Advocate to help clients and to make programs recognize client rights. The Advocate will help you in making, resolving or appealing complaints about rights violations. You can contact the Regional Advocate yourself and ask for help, or the Program staff will help you make the contact.

Call or Write: Mr. Reginald T. Daye, Regional Advocate
Satellite Office, Building 11, 4601 Ironbound Road
P.O. Box 8791, Williamsburg, VA 23187

Telephone: (757) 253-7061
Fax: (757) 253-544

ACKNOWLEDGEMENT
FOR
CLIENT'S RIGHTS SUMMARY

I,_____ hereby acknowledge that I have received a copy of Client's Rights Summary and that these have been read and explained to me so that I understand them. I have also been informed of the role of the Regional advocate and how to contact this person.

Date:_____ Signed:_____

Date:_____ Signed:_____
(Parent, Guardian, Authorized Representative, if applicable)

_____has read his/her rights on_____
These rights were reviewed; and explained by _____

The above-named is unable/willing to sign that he/she understands the rights.

Staff name:_____ Witness:_____

Date:_____ Date:_____

ASSOCIATES AT YORK, INC
NOTICE OF PRIVACY PRACTICES
Effective September 2014

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics.* It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating , or managing your health care treatment and related services. This includes consultation with clinical supervisors or the other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes of PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for the disclosure without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients.
We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical report; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Associates at York, Inc:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person. Such request shall be furnished within 15 days of the date requested.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to this amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosure.** You have the right to request an accounting of certain of the disclosure that we make of your PHI. We may charge you a reasonable fee if you request more than three accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable request. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach of Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated you privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Associates at York Inc. or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

ASSOCIATES AT YORK, INC

Acknowledgement

I, _____, have read and understand that my records are protected under federal regulation governing Confidentiality and that this document further outlines the limits, restrictions and provisions for disclosure of any of my Protected Health Information.

_____ _____

Signature of Participant Dated

_____ _____

Signature of Witness Dated

** As a courtesy Associates at York, Inc will place a call to your residence the evening prior to your next scheduled appointment to remind you. If you do not wish to be called please acknowledge this below.

__ I would like to receive a reminder call __ I do not wish to receive a reminder call

Associates at York, Inc. Authorization
Contact by Telephone/Verbally in Event of Breach of PHI

I, _____, authorize Associates At York, Inc. to provide notice to me by telephone or verbally in the event of a breach of my protected health Information (PHI) by Associates At York, Inc. Such conversation shall be documented by Associates At York, Inc.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Associates At York, Inc.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

Associates at York, Inc. Authorization
Mental Health Treatment

I, _____, whose Date of Birth is_____,

authorize Associates At York, Inc. to disclose to and/or obtain from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed

(Patient/Client should check each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____ Psychotherapy Notes*
(*Cannot be combined with any other disclosure)
_____ Other _____
_____ Other _____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If the purpose is other than marketing, sale of information, research or as specified above, please specify:
_____
_____.

Marketing

☐ If the purpose of this disclosure is for marketing purposes, please check this box and set forth the financial remuneration amount received by Associates At York, Inc. in exchange for disclosing the information.
$_____

Sale of Information

☐ If the purpose of this disclosure is for sale, license to use or lease of the information, please check this box.

Research

☐ If the purpose of this disclosure is for research purposes, please check this box and identify the current and future research studies as well as whether each research study is conditioned upon execution of this authorization and the individual's ability to opt into each study.
_____

Revocation

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Associates At York, Inc. at 142 W. York St. Ste 915 Norfolk, VA. 23510. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: _____or as otherwise indicated: _____

Conditions

I further understand that Associates At York, Inc. will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me failure to sign this authorization may have the following consequences: Information will not be transferred or released to any other agency or outside party in regards to treatment without signing this authorization.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

_____ _____

Signature of Patient/Client Date

_____ _____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ Check here if patient/client refuses to sign authorization

_____ _____

Signature of Staff Witness Date

Military History

Branch of Service: _____ Dates of Service: _____

Type of Discharge:_____ Service in Vietnam: _____

Educational

Highest grade completed in high school: _____ Years of College: _____ Trade/Degree: _____

Reason for leaving school: _____

Degrees/Certificates: _____

Employment History

Name of Company: Position From/To Reason for Leaving:

_____
_____
_____

Occupation/Trade: _____ Licenses/Certificates_____

Monthly
Income$_____ADC_____SSI/SSDI_____Other_____

Describe Family's Financial Status:_____

Legal Status

Probation: _____Parole:_____City _____Officer_____

Expiration Date_____ Stipulations_____

Court Ordered Treatment: _____ How Does Legal Situation Relate to current treatment_____

_____

List All Arrests Which Resulted In Convictions:

Charge: Date: Disposition: Comments:

_____
_____

Present Family History (Spouse, Living Together)

Name: _____Relationship _____DOB_____/_____/___

Address: _____ Phone Number _____/_____

Place of Employment: _____ Work Number _____/_____

Sex: Male ____Female____ Number of years living together _____ and/ or Number of years married_____

Describe marital history and/or significant relationships:

_____
_____

Children

Names of children	age	sex	your natural child	his/her natural child
_____	____	____	Yes____ No____	Yes ____ No____
_____	____	____	Yes____ No____	Yes ____ No____
_____	____	____	Yes____ No____	Yes ____ No____
_____	____	____	Yes____ No____	Yes ____ No____

Family History

Describe your family_____

_____

Does your family have a history of Mental, Physical, Sexual or Emotional Abuse? None_____
If Yes explain_____

Does your family have a history of Mental Illness or Substance Abuse? None_____
If Yes explain_____

Mental Health and/or Substance Abuse Treatment History

Inpatient:

Facility	Dates	Type	Reason	Outcome

Outpatient:

Facility	Dates	Type	Reason	Outcome

Presenting Symptoms – Last 6 Months

In the past (6) months, which of the following have you experienced?

_____Trouble sleeping	_____nervousness	_____suicide thoughts
_____nightmares	_____violence	_____attempted suicide
_____withdrawal	_____hyperness	_____homicidal thoughts
_____constant worries	_____strong fears	_____loss of sexual desire
_____less sex	_____paranoia	_____excessive anger
_____severe stress	_____hallucinations	_____unwanted thoughts
_____irritability	_____more sex	_____memory/concentration
_____helpless	_____hopeless	_____anxious
_____isolated/withdrawn	_____suspicious	_____hostile

In the past (6) months, which of the following stressors have you experienced

Primary Support Group	Social Environment
_____Death Of A Family Member	_____Death Or Loss of Friend
_____Health Problems in the Family	_____Inadequate Social Support
_____Disruption Of Family by Separation, Divorce	_____Living Alone
_____Removal From the Home	_____Difficulty With Acculturation
_____Remarriage Of Parent	_____Discrimination
_____Sexual/Physical Abuse	_____Adjustment To Life-Cycle
_____Parental Overprotection	

_____Neglect of a Child
_____Inadequate discipline
_____Discord With Siblings
_____Birth Of A Sibling

Educational
_____Academic Problems
_____Discord With Teacher, Students
_____Inadequate School Environment
_____Discord With Teacher, Students

Economic
_____Homelessness
_____Extreme Poverty
_____Inadequate Finances
_____Insufficient Support

Health Services
_____Inadequate Health Care Services
_____ Inadequate Health Insurance
_____Transportation To Health Care Unavailable

Occupational
_____Unemployment
_____Threat Of Job Loss
_____Stressful Work Schedule
_____Difficult Work Conditions
_____Job Dissatisfaction
_____Job Change
_____Discord With Boss or Coworker
_____Discord with Neighbors or Landlord
_____Unsafe Neighborhood

Legal
_____Arrest and/or Incarceration
_____Victim of Crime
_____Litigation

If you checked any of the above, please explain_____
_____

Health History

How would you rate your present state of health? _____ Excellent _____Good _____Fair _____Poor

Do you have any communicable diseases? Yes No

If yes, explain _____

Are you presently under a doctor's care? Yes No

If yes explain_____

How long? _____ In past month _____In past 6 months _____In past 12 months _____ Over 12 months

Do you have a chronic medical condition? Yes No
Explain_____

Do you suffer from seizures? Yes No
If Yes, Are on medication? Yes No

Have you ever had surgery or hospitalization for serious illness? Yes No

a. _____ For _____
b. _____ For _____

Do you have any physical limitations/restrictions or handicaps? If so, explain _____
_____

Questions for women:
Are you currently pregnant? _____ Yes _____ No If yes, due date _____/_____/_____
Number of pregnancies _____Miscarriages _____Stillbirths _____Abortions_____
Birth control method_____ None_____