Client Name:

INFORMED CONSENT FOR TREATMENT

I _____ (name of patient), agree and consent to participate in behavioral health care services offered and provided at/by Children's Respite Care Center, a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

_____ _____
Signature of Parent/Guardian Date

Relationship to Patient (if applicable):_____

CONSENT TO TREATMENT FOR A CHILD

Name of Child Client _____
The therapist named below and I have discussed my child's situation. I have been informed of the risks and benefits of several different treatment choices. The treatment chosen includes these actions and methods:

1. Family therapy
2. Individual therapy
3.

These actions and methods are for the purposes of:

1.
2.
3.

I have had the chance to discuss all of these issues, have had my questions answered, and believe understand the treatment that is planned. Therefore, I agree to play an active role in this treatment as needed, and I give this therapist (or another professional, as he or she sees fit) permission to begin this treatment as shown by my signature below.

_____ _____
Signature of Parent/Guardian Date

I, the therapist, have discussed the issues above with the child's parent or guardian. My observations of this person's behavior and responses give me no reason in my professional judgment, to believe that this person is not fully competent to give informed and willing consent to the child's treatment.

_____ _____
Therapist Signature Date

Client Name:

NOTICE OF PRIVACY PRACTICES
OF
Children's Respite Care Center

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.

Effective:9-4-03
Version 1

If you have any questions, would like more information, or you do not understand this Notice of Privacy Practices please contact:

Lori Maire- Privacy Officer

5321 S 138th Street

Omaha, NE 68137

402-895-4000

Client Name:

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your child's medical information is personal and we are committed to protecting it. We create a record of the care and services your child receive at CRCC. We need this record to provide quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about your child. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

We are required by law to:

- **Make sure that medical information about your child is kept private;**
- **Give you this Notice of our legal duties and privacy practices; and**
- **Follow the terms of the privacy notice that are currently in effect.**

How We May Use and Disclose Medical Information about Your Child

For Treatment-

We may provide medical information about your child to Doctors, Nurses, Nursing Students, Therapists, Educators or other personnel who take care of your child.

> ***EXAMPLE***: Calling your child's Doctor and verifying a prescription or medication or calling your Doctor with a progress report.

For Payment-

We may use medical information about your child so that the treatment and services your child receives can be billed and payment may be collected from you, an insurance company or another third party.

> ***EXAMPLE:*** We may need to give your child's insurance company information about a therapy your child is going to receive to obtain approval or to determine whether your health plan will cover the therapy.

For Healthcare Operations-We may use and/or disclose your PHI for all activities that are included within the definition of "health care operations" as set out in the HIPAA Privacy Regulation**.**

> **EXAMPLES:** Providing training programs for students, trainees, health care providers or non-health care professionals (for example, billing clerks or assistants, etc.) to help them practice or improve their skills. Reviewing and improving the quality, efficiency and care that we provide to your child or other children. We have not listed in this Notice all of the activities included within the definition of "health care operations," so please refer to the HIPAA Privacy Regulation for a complete list.

Other Permitted uses and Disclosures that may be made without consent-

We may use and/or disclose PHI about you for a number of circumstances in which you do not have to consent, give authorization or otherwise have an opportunity to agree or object however CRCC may never have a reason to make some of these disclosures. Those circumstances include:

- *Required by law-* We will provide medical information about your child when required by federal, state or local law or other judicial or administrative proceeding.
- *Public health activities-* we may provide information about your child that has been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- *To report victims of abuse, neglect or domestic violence.*
- *Health oversight activities-* We may provide medical information to a health oversight agency for activities allowed by law. Oversight activities that allow the government to monitor the health care

system, government programs and compliance with civil rights laws include audits, investigations and inspections.

- *Lawsuits and Disputes*- We may provide medical information about your child in response to a court or administrative order. We may also provide medical information about your child in response to a subpoena.
- *Law enforcement purposes*- We may provide medical information if asked to do so by a law enforcement official. Response to a court order, subpoena, warrant, summons or similar process.
- *Coroners, Medical Examiners and Funeral Directors*- To identify a person who has died or to determine the cause of death.
- *Organ, eye or tissue donation process*- If your child is an organ donor, we may provide medical information to organizations that handle organs for organ, eye or tissues transplantation or to an organ donation bank.
- *Medical research*- we may provide medical information about your child to people preparing for a research project.
- *To avert a serious threat to health and safety*- we may use and provide information about your child to prevent or lessen a serious and imminent threat to the health or safety of a person or public.
- *Relates to specialized government functions*- we may provide medical information about your child if it relates to military and veterans' activities, national security and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State.
- *Relates to correctional institutions and in other law enforcement custodial situations*- In certain circumstances, we may provide information about your child to a correctional institution having lawful custody of your child.
- *Workers Compensation*- We may provide medical information about your child for worker's compensation or similar programs that provide benefits for work-related injuries or illness.
- *Business Associates*- We may provide medical information to other persons or organizations, known as business associates, who provide services to us under contract. We require our business associates to protect the medical information we provide to them.

You can object to certain uses and disclosures.

Unless you object, we may use or disclose information about your child in the following circumstances:

- *Involved in Your Child's Care of Payment for Your Child's Care*- We may provide medical information about your child to a friend, family member or any other person you say is involved in your child's medical care or in the payment for your child's care. You may identify a person to allow picking up your child's medical supplies for your child. We will provide only the medical information needed to allow the person to complete the task. We may provide medical information about your child with a public or private agency for disaster relief purposes. Even if you object, we may still share information about you, if necessary for the emergency circumstances.

If you would like to object to our use or disclosure of information about your child in the above circumstances, please call or write to our contact person listed on the cover page of this Notice.

Client Name:

We may contact you with information about treatment, services, products or health care providers.

We may use and/or disclose information to manage or coordinate your child's healthcare. This may include telling you about treatments, services, products and/or other healthcare providers for your child.

> ***EXAMPLE:*** If your child has diabetes, we may tell you about nutritional and other counseling services that may be of interest to you.

We may contact you for fundraising activities.

We may provide information about your child to a CRCC fundraising representative and may contact you to help in raising money for CRCC and its operations. We would only release contact information and the dates you received services at our facility. If you do not want to be contacted in this way, you must notify us in writing to our contact person listed on the cover page of this Notice.

We may contact you to provide reminders.

We may use and/or disclose PHI to contact you to provide a reminder to you about an appointment you have for treatment or medical care.

Other Uses Of Medical Information

Other uses of medical information not covered by this Notice or the laws that apply to us will be made only if you agree in writing. If you give us the right to use medical information about your child, you may change your mind, in writing, at any time. If you change your mind, we will no longer use the medical information for the reasons covered by your written request. You understand that we cannot take back any information that we have already released with your written agreement and that we are required to retain records of the care we provide.

Your Rights Regarding Medical Information about Your Child

Right to Request Restrictions-

You have the right to request that we limit the medical information we use or disclose about your child for treatment, payment or health care operations. You also have a right to ask for a limit on the medical information we provide about your child to someone who is involved in your child's care or the payment of care, like a family member or friend. We do not have to agree with your request. If we do agree to a limitation, we will follow your request unless the information is needed to provide emergency treatment. You must request a limitation in writing. In your request you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply

Right to Ask for Private Communications-

You have the right to ask that we communicate with you about your child's medical matters in a certain way or at a certain place. For example, you may request that we contact you at your work address or phone number or by email. Your request must be in writing. Your request must say how or where you wish to be contacted.

Right to Look At and Copy-

You have the right to look at and copy medical information that may be used to make decisions about your child's care. Usually this includes medical and billing records. Your request must be in writing. If you ask for a copy of information, we may charge a fee for the cost of copying, mailing or other supplies needed to meet your request. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial.

Client Name:

Right to Change-

If you feel that medical information we have about your child is not correct, you may ask us to change the information. You have the right to ask for a change as long as the information is kept by Children's Respite Care Center.

Your request for a change must be in writing and sent to the Client Care Coordinator. In addition, you must provide a reason that supports your request for a change.

We may deny your request for a change if it is not in writing or does not include a reason to support the request. In addition, we may deny your request to change information, if the information is:

- Not created by Children's Respite Care Center
- Not part of the information kept by Children's Respite Care Center
- Not part of the information you would be allowed to look at and copy under the law
- Correct and complete

Right to an Accounting of Disclosures-

- You have the right to ask for an accounting of disclosures, which is a list of medical information given out about your child. Your request must state a time period for the disclosures, which may not be longer than six (6) years and may not include dates before September 4, 2003. Your request should indicate in what form you want the list to be provided to you: for example, on paper or electronically.

If you request a list of disclosures more than once in 12 months, we can charge you a reasonable fee.

You have the right to a copy of this Notice.

You have the right to request a paper copy of this Notice at any time by contacting CRCC's Privacy Officer. You may also get a copy of this Notice at our website, www.crccomaha.org

Complaints

If you think your child's privacy rights have been violated, you may complain to CRCC's Privacy Officer or the Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact

Children's Respite Care Center
5321 S 138th Street
Omaha, Nebraska
68137
Privacy Officer
(402) 895-4000

Effective Date of this Notice

This notice was published and first became effective on 9-4-03

Client Name:

Consent for Use and Disclosure of Health Information

I give my consent for the use or disclosure of my child's protected health information (PHI) by the staff of Children's Respite Care Center for the purpose of treatment, payment, and healthcare operations. By signing this form, I am agreeing to let CRCC use my child's information and send it to others. The Notice of Privacy Practices explains this in more detail. I have received the Notice of Privacy Practices and understand I should read it before signing this consent.

- I understand that if I do not sign this consent form agreeing to what is in the Notice of Privacy Practices, CRCC cannot treat my child.
- CRCC reserves the right to change its privacy practices. In this case, all current or revised Notices of Privacy Practices may be obtained from CRCC's Privacy Officer or on our web site, www.crccomaha.org.
- I have a right to request (in writing) a restriction of how my child's PHI is used or disclosed to carry out treatment, payment, or healthcare operations. CRCC is not required to agree to the restrictions that I may request. However, if CRCC agrees to a restriction that I request, the restriction is binding on CRCC. Additionally, I understand that I have the right to revoke this consent, in writing, at any time.
- My PHI means health information, including demographic information, collected from me and created or received by my child's physician or health plan. This PHI relates to my child's past, present or future physical or mental health or condition and identifies my child.

_____ _____

Signature of parent or legal guardian Date

_____ _____

Witness Client's Name

❑ Copy given to Parent/Legal Guardian

Date of NPP 9/4/2003

Client Name:

Children's Respite Care Center
Client Rights & Responsibilities

1. You have the right to be informed of your rights and have a copy given to you upon entering into a therapeutic relationship.
2. You are entitled to receive mental health services and be treated fairly regardless of sex, race color, religion, national origin, age, degree of disability, marital status, or sex orientation
3. You have the right to be treated with dignity and respect
4. You have a right to confidentiality. No information about you may be released to any other agency or individual without your prior consent or the consent of your parent or legal guardian, unless otherwise required by law.
5. You have the right to know if you are being photographed or recorded by video or audio tapes.
6. You have the right to a program of treatment that is especially designed for your individual needs.
7. You have the right to a safe environment, free from sexual, physical or emotional abuse.
8. You have the right to be informed of the type of treatment you receive and to be told of alternative ways you can receive care and treatment.
9. You have the right to be informed of your progress and to discuss any questions or problems.
10. You will be informed of your therapist's credentials, licensure, experience, professional associations, specialization, and limitations.
11. You have the right to terminate services at any time or to receive second opinions
12. You have the right not to reveal yourself to visitors and to be told when visitors from outside agencies or group are coming
13. You have the right to be informed of confidentiality laws. The laws of the State of Nebraska require that most issues discussed during the course of therapy with a psychotherapist are confidential. These laws permit you to waive the privilege of confidentiality by signing a release of information form. However, the release of confidential materials is required by law in situations of suspected child abuse or neglect, of potential harm to oneself or others and in instances where the court may subpoena records or testimony.
14. You have the right and the duty to report an unethical or illegal behavior by a therapist.
15. You have the right to refuse to be a part of any study or research project
16. You have the right to know the cost of your care
17. You have the right to second-opinion consultations, at your own expense
18. You have the right to choose or to refuse treatment offered, unless there is an immediate danger to yourself or others. Refusing treatment however can be grounds for terminating care.
19. You have the right to complain if you think your rights or the rights of someone else have been violated.

These are the actions and behaviors that are expected of you as a client of Children's Respite Care.

1. Participate actively and honestly in your treatment
2. Treat all staff, clients and visitors with dignity and respect.
3. Ask questions about any policy, procedure, or treatment that you do not understand or if you do not agree.
4. You are expected to respect other's confidentiality
5. Clients are expected to follow staff directions at all time
6. Use are to use appropriate language
7. Clients need to be on time for all groups and sessions
8. Turn all cell phones and pagers off while in sessions
9. Please clean up after yourself
10. Respect other's personal property as well as the property of the facility
11. Complete all assigned homework or treatment goals
12. Dress appropriately, this a place of business and one should dress accordingly.

Client Name:

Member Rights

Members of Magellan's programs have many rights. As a member you have the right:

- to be treated with dignity and respect
- to receive the behavioral services you need in a convenient place and at a time that works well for you
- to ask for a therapist who understands your language and culture, or who speaks American Sign Language (ASL)
- to learn about the mental health and substance abuse services in your program
- to get information about your illness and treatment
- to participate in decisions about your treatment
- to receive information on available treatment options and alternatives
- to request and receive information about Magellan
- to choose an accessible service provider from Magellan's network
- to change your service provider if you are unhappy with your current provider
- to ask questions and get answers before and during treatment
- to refuse treatment and get an explanation of what may happen if you don't get treatment
- to make a grievance about your services and get a timely answer
- to ask for a fair hearing
- to privacy and confidentiality, including to allow or refuse the release of information, except when release is required by law
- to request and receive copies of your records and request that records be amended or corrected
- to make an Advance Directive
- to freely exercise your rights without affecting how you're treated
- to get a second opinion when appropriate

Nebraska Medicaid enrollees have the following additional rights:

- to be free from restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- to file an appeal or grievance about a Magellan action or decision
- You can request a fair hearing from DHHS if you are not satisfied with the outcome of your appeal.

Member Responsibilities

Members of Magellan's programs also have these responsibilities:

- to treat others with dignity and respect
- to take your Medicaid ID card to all appointments
- to learn about your mental health and substance abuse services and receive those services from Magellan or a Magellan service provider
- to tell your provider about symptoms and ask questions
- to be a part of the treatment
- to tell your service provider if you do not agree with their recommendations
- to tell your doctor or therapist if you want to end treatment
- to tell your service provider about your medical doctor
- to be at appointments on time and call ahead if you must cancel
- to learn about Magellan procedures and follow them
- to take your medication as prescribed and tell your doctor if there is a problem
- to pay for any mental health services that are not covered under the Nebraska Medicaid Managed Care Program
- to take part in Medicaid program surveys

Client Name:

Advance Directives
Power of Attorney for Health Care

Nebraska's Health Care and Treatment Decisions statute allows you to appoint an agent (called an "Attorney in fact") to make health care decisions for you if you become incompetent to make those decisions yourself. "Health care" may include mental health care. A recommended form for this purpose is called a Power of Attorney for Health Care.

An Advance Directive or Power of Attorney for Healthcare is a legal document that talks about how you want to be treated if you are not able to speak for yourself – for example, if you become very ill, or if you are put in a hospital without your permission. You can use an Advance Directive – Power of Attorney for Health Care to:

- Tell a doctor, hospital or judge what types of confinement and treatment you do or do not want.
- Name a friend or family member who can make mental health care decisions for you if you are not able to make them for yourself.

Additional information is available from the National Resource Center on Psychiatric Advance Directives: http://www.nrc-pad.org

Once your Power of Attorney for Health care form is ready, you should give copies and explain your choices to:

- Your Doctor
- The person you have appointed to make mental health care decisions for you.
- Your family
- Anyone else who might be involved in your care

I have reviewed and understand this information.

_____ _____

Client Date

_____ _____

Legal Guardian Date

Client Name:

Behavioral Health
Payment Policy

Third Party Payer

CRCC works with each family to access third party authorizations and payment when available. If there is changes in your third party payer please notify CRCC immediately because the parent/guardian is ultimately responsible for payment if the third party payer does not reimburse services. This means if your Medicaid, insurance or other third party payer refuses to pay, or fails to pay, you are responsible for full payment.

If a parent/guardian receives payment directly from a payer for any service CRCC has provided, it is the parent/guardian's responsibility to reimburse CRCC in full and provide CRCC with a copy of the Explanation of Benefits received with the reimbursement.

No Show Fees

If you are unable to keep an appointment with a member of the behavioral health department please call and cancel your appointment. Initial Diagnostic Interviews (or MSEs) must be cancelled 24 hours before your scheduled appointment time. Therapy and CTA services must be cancelled 2 hours prior to your appointment time. Failure to cancel your appointments will result in the no show fees as outlined below:

1. $50 for missed initial diagnostic interview (otherwise referred to as a Mental Status Exam).
2. $25 for missed individual/family therapy appointments.
3. $25 for missed CTA appointments.

CRCC Accounts

Please be proactive and keep your accounts with CRCC in good standing to avoid a lapse in services. CRCC is willing to work with families and arrange payment schedules for those communicating with us and making good faith payments.

I have read, understand and accept all above terms of enrollment in Children's Respite Care Center (CRCC).

_____ _____

Parent/Guardian Signature Date