

Behavioral Health Informed Consent

Welcome

Greater Seacoast Community Health uses a team approach to treatment. Behavioral Health clinicians are part of an integrated team that work collaboratively with primary care providers, social workers and other primary care staff to provide quality services to patients to assist them in meeting their healthcare goals. Behavioral Health treatment at Greater Seacoast tends to be shorter in duration and is focused on targeted health goals. Patients may be connected with a Behavioral Health Provider as part of their primary care visit or be referred by Primary Care and receive a follow up phone call and screening. Patients will complete an assessment with a Behavioral Health Provider to decide the best plan moving forward. Patients may meet with a provider 1-2 times for brief treatment with a focus on coping strategies or be referred for further assessment and follow up counseling. Your treatment at Greater Seacoast Community Health will be coordinated between you and your treatment team.

All Behavioral Health Clinicians are graduate-level, trained professionals who follow a code of ethics and offer quality care to patients.

Confidentiality

In most cases, clinicians may not release information regarding your treatment without your permission which is generally in the form of a signed Release of Information. However, confidentiality will not be kept if one of the following situations arises:

- The sharing of health information for supervision with a direct clinical supervisor and/or discussion with your primary care provider or another member of your healthcare team.
- It is decided you are a danger to yourself or others. This may include requesting emergency assistance and transportation to a hospital and/or police assistance.
- If you share information about the abuse or neglect of a child, elderly or disabled individual. Clinicians are mandated by law to report this to the authorities.
- In cases of a medical emergency where you aren't able to communicate information to Emergency Services Personnel or Emergency Room staff.
- If a Release of Information form is signed by you to allow sharing of your health information.
- If your insurance or third-party payer requests information to authorize coverage of services.
- If you are involved in a court proceeding and a request is made for information concerning the professional services that provided to you and/or the records thereof, such information is protected by the therapist-patient privilege law. I cannot provide information without your written authorization, or a court order.
- If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency requests information for health oversight activities, your clinician may be required to provide it.
- If you file a complaint or lawsuit against your clinician, they may disclose relevant information regarding you in order to defend themselves.

Federal law and regulations do not protect information about a crime committed by a patient or any threat to commit such a crime (See 42 U.S.C 290dd-3 and 42 U.S.C. 290ee-3 for federal laws and 42 CFR part 2 for federal regulations).

Adolescents 12 and older

In New Hampshire an adolescent 12 and older can consent for confidential treatment of a Substance Misuse Disorder. Also, in New Hampshire an adolescent age 14 and older can consent for confidential STD/HIV and reproductive health services.

Payment/Fees

Greater Seacoast Community Health offers services on a sliding fee scale based on patient household size and income. Uninsured or underinsured patients who qualify for the sliding fee can meet with a Patient Advocate to discuss their qualifications.

When you use insurance, we are required to include a diagnosis from the DSM V for billing purposes. This will be discussed between you and your clinician. Diagnoses are also used to create a treatment plan that meets your needs. Your clinician takes special care in diagnosing by gathering information from you, reviewing past treatment history records and through the use of clinical assessment tools. We strive to establish diagnoses in context by considering the person or relationship to help you learn your own way of understanding the issues that brought you in for help.

You may also be subject to copay at the time of service depending on your insurance plan.

Medical Records

The laws and standards of the behavioral health profession require that we keep records in a manner consistent with HIPPA standards. To do this, we use a secure, encrypted electronic health record that includes clinical notes, insurance billing and financial statements.

As part of the delivery of health care and counseling services at Greater Seacoast Community Health, you have the right to access and review your clinical records unless it considered harmful to your mental health by your clinician at the time. You may submit a request in writing to your clinician at any time. To protect the rights of children under the age of 18, records may or may not be shared without court orders. Clinicians will not write letters for patients in connection with legal matters.

Duration of Services

The number of sessions is determined by the need of the patient and the professional judgement of the clinician. Behavioral Health Integration services in a primary care setting tend to be shorter term. Session length may be 30 or 45 minutes in duration. Your clinician will assess your treatment needs and progress on your identified goals at each session. Patients needing longer term counseling may be referred out to another provider or level of care in the community. Therapy by design should have clear and specific treatment goals. When these goals are achieved it may be appropriate to terminate services or transition to another provider in the community for more specialized treatment. While we recognize that

Name _____ DOB _____

termination can be difficult, it is part of the treatment process and we encourage patients to utilize this as opportunity for further growth.

Risks and Benefits

Therapy can carry both risks and benefits. Often therapy can help to reduce feelings of emotional pain, help to improve relationships and/or resolve specific issues. But there are no guarantees of improvement of any condition. Risks may include experiencing uncomfortable feelings (like sadness, guilt, anger or anxiety) or talking about difficult topics.

Conflict of Interest

New Hampshire is a small state. From time to time, actual or potential conflicts of interest may arise. In the event that your Behavioral Health Provider becomes aware of a conflict of interest in providing treatment to you, that provider may be required to refer you to another therapist. Regardless of the existence of a conflict of interest, your information will remain confidential.

Use of Interpreters

As needed, professional interpreters may be used to help a patient and a clinician communicate. Interpreters are mandated to follow the same rules of confidentiality as clinicians.

Email

Email is not a confidential means of communication. Greater Seacoast cannot ensure that email messages will be received and responded to. Please use the agency phone numbers to communicate with your provider.

Emergency Procedures

Nurse triage is available to you for concerns related to your behavioral symptoms if needed between your therapy sessions. This is not psychotherapy, but to determine the appropriate level of care or intervention for your concerns that cannot wait until your next psychotherapy session. For emergencies please dial 911. After hours please call our main number and listen to instructions for how to speak with a nurse, or go to your local hospital if unable to wait. Emergencies are situations that involve immediate physical harm to yourself or someone else.

For help needed during an emergency please call 911.

Additional crisis resources: **Mobile Crisis Services** 1-833-710-6477 | **National Suicide Hotline** #988

Signed Consent for Treatment

By signing below, you are agreeing you understand the terms of this agreement and that you are willing to take part in treatment.

Patient Signature _____ **Date** _____

Printed _____

Parent/Guardian Signature _____ **Date** _____

Clinician Signature _____ **Date** _____

Notice of Privacy Practices

Confidentiality of Substance Use and Mental Health Client Records

The Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

The confidentiality of alcohol, drug use or mental health patient records maintained by the program is protected by Federal law and regulations. Generally, Greater Seacoast Community Health may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as a person who is in treatment for a substance use or mental health disorder. These are the following exceptions:

1. The patient consents to the disclosure in writing: or
2. For Treatment: Your protected health information may be used and disclosed by staff 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 supervisors and other treatment team members.
3. For payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you.
4. Health Care Operations: We may use and disclose PHI, as needed, your PHI in order to support our business activities including, but not limited to licensing and conducting or arranging business activities.
5. Judicial and Administrative Proceedings: We may disclose protected health information in response to a court order that meets the requirements of federal regulations, 42 CFR Part 2.
6. Medical Emergencies: We may disclose your protected health information to medical personnel to the extent necessary to meet a bona fide medical emergency as defined by it CFR Part 2 and HIPAA laws.

7. Program Audit and Evaluation: We may disclose your protected health information to qualified personnel for research, audit, or program evaluation purposes. We may disclose protected health information to a health oversight agency i.e. state licensure or certification agencies which oversee the health care system and ensures compliance with regulations and standards.
8. Program Research: We may use protected health information without your consent or authorization if our research privacy board approves a waiver of authorization of disclosure.
9. Law Enforcement Officials: We may disclose your protected health information to the police or other law enforcement officials for the purpose of seeking assistance with law enforcement agencies if you commit a crime on the premises or against program personnel or threaten to commit such a crime.
10. Duty to Warn: When the program learns that a patient has made a specific threat of serious physical harm to another specific person or the public, and disclosure is otherwise required under statute and/or common law, the program will carefully consider appropriate options which would permit disclosure, subject to 45 CFR 164.512(i).
11. Child/Incapacitated Adult Abuse/Neglect: We are required by law to report suspected child/incapacitated adult abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports and to report deaths as required by law.
12. Threat to Self: We are required to protect your life by informing health officials with or without your consent if you have a specific plan to harm yourself.
13. Incompetent or Deceased Participants: in such cases, authorization of a personal representative guardian or other substituted decision-maker may be given in accordance with 42 CFR Part 2.lth
14. 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.

Some of your protected health care information may be used and disclosed to an insurance company for the purpose of seeking authorization of payment for treatment services. Types of disclosures may include diagnosis of substance use or mental illness, severity of use, symptoms of mental illness, treatment plan, dates of treatment and treatment progress. Treatment data statistics may be required to be reported to the state to apply for and to receive funding. Also, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Violation of the Federal law and regulations is a crime. Suspected violations may be reported to the U.S. Attorney in the district where the violation occurs.

YOUR RIGHTS REGARDING YOUR PHI

1. Right of access to inspect and copy: You have the right, which can only be restricted in exceptional circumstances, to inspect and copy PHI that is maintained in a clinical record. 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. We may charge a reasonable, cost-based fee for copies.
2. Right to Amend: If you believe that the PHI we have about you is incorrect or incomplete, you may ask us to amend (revise) the information although we are not required to agree to this change. If we deny your request for this change, you have the right to file a statement of disagreement with us.
3. Right to an Accounting of Disclosures: You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
4. 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 the 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 a restriction.
5. 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 requests. 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 to explain why you are making the request.
6. Breach 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.
7. Right to a Copy of this Notice: You have the right to a copy of this notice.

Specifically, your records are protected by two different Federal Laws and regulations: the Health Insurance Portability and Accountability Act of 1996 (HIPAA) concerning individual private health information, and Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2.

I have been advised and understand the Federal Law 42 CFR Part 2 and HIPAA laws, concerning confidentiality and the Notice of Privacy Practices.

Patient Signature

Date

Witness Signature

Date

Patient Questionnaire (PHQ-9)

Today's Date _____ Patient's Name _____ Date of Birth _____

Are you currently: on medication for depression not on medication for depression not sure? In counseling

1. Over the last 2 weeks have you been bothered by any of the following problems?

	Not at all	Some Days	Most Days Half the days	Nearly Every Day
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling or staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down				
g. Trouble concentrating on things, such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual				
i. Thoughts of hurting yourself or that you would be better off dead				

Total each Column

2. If you checked off any problem on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

3. Have the above symptoms been present most of the time for 2 years or more with no symptom free periods for greater than 2 months?

Yes No

Total Score:

PrimeMD#1 – Initial
SUM: _____

PrimeMD#2 – Follow-Up
SUM: _____

DOS: ___/___/___

Provider Initials: _____

Notice to Clients and Consent to Tele-Behavioral Health Services Treatment Agreement

1. I understand that tele-Behavioral Health therapy involves the use of either an encrypted audio/video application that complies with HIPAA (Health Insurance Portability and Accountability Act) or a HIPAA-compliant telephone platform to communicate with my Behavioral Health therapist during my therapy sessions.
2. I understand that tele-Behavioral Health sessions will follow the same format, time-frames and structure as face-to-face sessions. I understand that information and notes from these sessions will be stored in the same way as face-to-face Behavioral Health sessions. I also understand that all patient policies and procedures of Greater Seacoast Community Health continue to apply.
3. I understand that the laws that protect the confidentiality of my medical information in face-to-face sessions also apply to tele-Behavioral Health sessions. I understand that the information disclosed by me through tele-behavioral health during the course of my therapy is generally confidential. However, the mandatory reporting exceptions to confidentiality that apply in face-to-face sessions also apply to tele-behavioral health sessions.
4. I understand that to ensure my safety I must provide my therapist with the address of where I am located during my tele-Behavioral Health sessions along with my phone number and the name and number of an emergency contact.
5. I understand that if during a tele-Behavioral Health session, my therapist suspects that I am at imminent risk of harm to myself or others, that by law, my therapist must contact the authorities to ensure safety for myself and others.
6. I understand that it is my responsibility to insure the confidentiality of tele-Behavioral Health sessions in the environment in which I participate. I further understand that my provider may also elect to reschedule the session.
7. I understand that no dissemination of any personally identifiable images or information from the tele-Behavioral Health session will occur without my written consent.
8. I understand that I have the right to withhold or withdraw consent at any time without impacting my right to future treatment or risking the loss or withdrawal of any Greater Seacoast Community Health services to which I would otherwise be entitled.

NAME: _____ DOB: _____

9. I understand that there are both risks and benefits associated with tele-Behavioral Health therapy.
- a. Benefits may include increased access for those who may be challenged by geographic location, transportation, and/or other barriers. Though I understand that I may benefit from tele-Behavioral Health therapy, I also understand that results cannot be guaranteed or assured.
 - b. Risks related to tele-Behavioral Health therapy include certain limits to confidentiality in electronic communication. These risks include, but are not limited to, the possibility, despite reasonable efforts on the part of my behavioral health provider, that the video (or telephone) interaction between me and my behavioral health therapist could be interrupted due to technical failures or faulty internet connection; and the potential for confidentiality breaches due to technical failures. These risks will be offset with the use of our chosen platform. Furthermore, when using the video platform, the contents of my behavioral health counselor's computer are encrypted to further ensure my privacy and confidentiality.

ACKNOWLEDGEMENT AND ACCEPTANCE

My signature below indicates that I have read and understand this document and have discussed the contents with my Behavioral Health counselor. This signature also indicates my consent for tele-Behavioral Health services.

Patient Signature

Date of Birth

Date

Patient Email

Patient Phone Number

Clinician Signature

Date



Things to Know About Your Counseling Appointments

Our Commitment to You: Greater Seacoast Community Health tries to meet the needs of all our patients. These policies help us provide high-quality care for you and for all our patients.

Arriving on Time for Appointments

Our schedule is based on the amount of time needed to complete behavioral-health intake assessments or followup appointments. When patients arrive late for an appointment, it makes it harder for us to offer everyone high-quality, safe and efficient care.

Please arrive 15 minutes before your scheduled appointment time. This allows us to complete any paperwork needed and have you ready for your appointment time with your behavioral-health provider.

Giving Enough Notice if You Need to Cancel or Reschedule

We understand that things come up unexpectedly. **If you need to cancel, please let us know as soon as you know** that you cannot come to your appointment. **We ask that you call at least 4 hours ahead of time** if at all possible. This may allow us to give your time slot to another patient waiting for care.

Goodwin Community Health and Lilac City Pediatrics: (603) 749-2346 | Families First: (603) 422-8208

What happens if I arrive late for my appointment?

- You may be asked to reschedule to a different day if you are more than 10 minutes late (including time needed to check in and fill out your paperwork).
- If you are having an acute problem, a provider will decide if you need to be seen or if you can safely reschedule to another day.

What happens if I miss my appointment, or if I cancel with less than 4 hours' notice?

- If you miss **two** appointments or late-cancel twice within 60 days, we may initiate **Same Day Scheduling**. This means you may call on a day you are available and be scheduled on that day if the provider has an opening. Same Day status will be apply for a two-month period.

What happens if I am a new patient and miss my first appointment?

- You will be allowed to schedule another intake. If you miss your second scheduled visit, we will not be able to reschedule your appointment to establish care for six months.

I have read and understand the information about scheduling and keeping counseling appointments.

Patient name (printed): _____ Date of birth: _____

Signature of patient or guardian: _____ Date _____