ESSEX COUNTY MENTAL HEALTH
Terri Morse, LMHC, CASAC-Master, *Director*
Dava Clement, LMHC, *Director of Clinical Services*
P.O. BOX 8 - 7513 COURT STREET
ELIZABETHTOWN, NY 12932
PH: (518) 873-3670 / FAX: (518) 873-3777

COMMUNITY SERVICES BOARD
Laurie Kelley, *Chairperson*
Terri Morse, LMHC, CASAC-Master
Director

WELCOME!

Essex County Mental Health provides an accessible and safe pathway to emotional, behavioral, physical, and psychological health and well-being to all clients and families. We strive to create a customized treatment plan to address your needs with your collaboration, and community partner engagement.

CONSENT FOR TREATMENT

I am consenting to treatment at Essex County Mental Health. I am choosing to enter treatment and will participate in planning my treatment with my assigned therapist and treatment team. I understand that:

- If psychiatric medications are indicated, I will be assigned to a Prescriber (psychiatrist or nurse practitioner) in addition to a therapist. My Prescriber will work with my therapist to coordinate my care.
- Essex County Mental Health requires all those receiving Psychiatric Medication services to also attend therapy unless provided a specific alternate treatment plan, approved by Administration.
- My progress will regularly be discussed during Treatment Team reviews.
- I can access crisis response services 24 hours a day, 7 days a week by calling 988 or 1-888-854-3773, after hours or 518-873-3670 during office hours Monday through Friday 8am to 5pm.
- I can stop treatment at any time.
- A therapist will review the Essex County Mental Health Statement of Understanding with me, and I can request clarification on any part of consent.

This authorization and Releases of Information on file will expire 90 days after the date of my last service. I can revoke this consent at any time by signing and dating a request, except to the extent that action has already been taken in reliance upon it. For example, if I have already received treatment based on my agreement to bill these services to my insurance provider, the services provided before I revoke my authorization may still be billed.

PRIVACY:

I understand that I have the right to confidentiality, however information may be shared to optimize my treatment, collect payment for services, and/or to operate Essex County Mental Health.

My healthcare information is protected by several Federal and State laws and rules.
I understand that:

- Notices of Privacy Practices are posted; a copy is in my welcome packet and copies are available upon request.
- The Notice of Privacy Practices explains my rights in accordance with RCW 70.02.050, 71.05.390, 71.05.630, CFR 42 Part 2, and the Health Insurance Portability and Accountability Act (HIPAA).
- Substance use disorder treatment records are specifically protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 CFR Part 2. They cannot be disclosed without my written consent unless otherwise provided for by the regulations.
- Patient Bill of Rights are posted, a copy is included in my welcome packet, and copies are available upon request.

ELECTRONIC HEALTH RECORD:

I authorize Essex County Mental Health to store my health care information in a confidential electronic health record. This includes information about my substance use disorder treatment (if applicable). Essex County Mental Health employees outside the substance use disorder program may access this information for purposes of treatment, payment, and/or to operate Essex County Mental Health.

I have the right to request that Essex County Mental Health restrict employee access to my record. If I am concerned about who can access my record, I can discuss this with my therapist and/or the Director of Clinical Services.

TELEHEALTH POLICY:

I understand that Essex County Mental Health provides some services by telehealth. In a telehealth appointment, my provider will not be in the same location as me, and we will communicate by video. My treatment team and I will work together to decide whether we use telehealth services. I can choose not to use telehealth at any time. If I choose not to use telehealth, my treatment team will help me understand the outcome of that choice –for example, some providers may not be available for in-person appointments.

I understand that:

- I will need to sign the Informed Consent Form for Telehealth to qualify for telehealth appointments.
- Telehealth Psychiatric and Therapy appointments are offered by video.
- Essex County Mental Health uses telehealth technology that is designed to protect my privacy.
- Essex County Mental Health will not record my telehealth visits unless I give specific permission.
- It is prohibited for me to record my appointments by audio or video recording devices.

FINANCIAL AGREEMENT:

I understand that Essex County Mental Health may bill my health insurance. I agree that my health insurance can pay Essex County Mental Health directly.

- I authorize ECMH to disclose my healthcare records, including mental health treatment, to my insurance company(s) to receive payment or process a claim.
- If I receive insurance payments for the services provided by ECMH, I will redirect them to ECMH.
- I will inform ECMH of any changes to my insurance or financial information.
- I am responsible for fees not covered by my health insurance. If I have insurance, I am responsible for co-pays, deductibles, or co-insurance, and it is not lawful for ECMH to adjust the required fees.
- Financial information may be released for the purposes of payment or healthcare operations.
- If I do not have insurance, I understand that it is possible to apply for the Essex County Mental Health Sliding Fee Scale Program.

Essex County Mental Health requires key information about you (or your child, if they are the one who will receive services.)

Do you have any of the following documents? If yes, please provide a copy.

- ☐ Guardianship Documents/Custody Order?
- ☐ Powers of Attorney?
- ☐ Mental Health Advance Directives?
- ☐ Evaluation and/or Treatment Court Order?

WELCOME PACKET:

I have read and understand the Welcome Packet material:

- Personal Information Form
- Acknowledgement of Receipt of Notice of Privacy Practices
- Patient Bill of Rights
- Telehealth Policy and Consent
- Fee and Financial Information Agreement and Clinic Fee Guidelines
- PSYCKES Consent
- HIXNY Electronic Data Access Consent
- Social Needs Screening Tool
- Release of Information
- Health Assessment (Adult/Child)

ALL PROGRAMS:

By signing this form, I agree that I have read the information above. I have been offered a copy of the information above and this Consent for Treatment. I agree to the conditions above.

Client Signature	Printed Name	Date
Parent / Guardian Signature	**Printed Name**	**Date**
Therapist Signature	**Printed Name**	**Date**

Client Name/ID/DOB *(or affix label)*

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PATIENT INFORMATION

Client Name: First_____ MI_____ Last_____

DOB:_____ SSN: _____-_____-_____

Sex:_____ Gender Identity:_____ Marital Status: _____

Would you like reminder calls? ☐ Y ☐ N May we leave a Voicemail? ☐ Y ☐ N

Phone Number: (Home) _____ (Cell) _____

Primary Phone Number: ☐ Home ☐ Cell

Email Address: _____

Physical address: _____ Town: _____

Mailing address: _____ Town: _____

Race: _____ Ethnicity: _____

Preferred language? ☐ English ☐ Spanish ☐ Other Language _____

Preferred method of communication? ☐ Phone ☐ Email ☐ Letter ☐ Text

Have you ever served in the Military? ☐ Y ☐ N

Do you have a Care Manager? ☐ Y ☐ N

Name: _____ Agency:_____

Phone: _____

Have you had any recent hospitalizations for mental health reasons? ☐ Y ☐ N

Hospital: _____ Discharge Date: _____

Reason for Admission: _____

Primary Care Provider: [Doctor's Name]_____

Facility: _____ Phone: _____

Preferred Lab:_____ Phone: _____

Name of Parent/Guardian (If under 18) _____

Client's School District: _____ Grade: _____

Client's Name: _____ DOB: _____

Insurance Information

Please provide copy of Insurance card

Insurance Company: _____

Policy Number: _____

Group Number: _____

Policy Holder Information

Name: _____

DOB: _____ SSN: _____-_____-_____

Employer: _____

Relation to Client: _____ Phone: _____

Address if other than Client: _____

Contacts

Parent/Guardian for minors or adult dependents (*Send Legal Documentation if Guardian*).

Name: _____ Phone: _____

Relationship to Client: _____

Emergency Contact

Name: _____ Phone: _____

Relationship to Client: _____

Referral

Who referred you? _____

Reason for referral: _____

_____

_____

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STATEMENT OF UNDERSTANDING
ESSEX COUNTY MENTAL HEALTH SERVICES

Listed here are a few items that we would like to share with you, such as what you can expect from us and our expectations of you. Your therapist will review this document with you. Please feel free to ask any questions.

TREATMENT TEAM. While you will be working with a primary therapist, we also work in a treatment team approach. Your therapist will develop a Treatment Plan, identifying your goals for seeking services. If psychiatric medications are recommended, you may choose to work with our psychiatrist or nurse practitioner for your medication needs. The psychiatric prescriber will work with your therapist to coordinate your care. Your progress will regularly be discussed during Treatment Team reviews.

COORDINATION OF CARE. If you are receiving services from other providers such as a school, social services, Families First, Mental Health Association, or a case manager, your therapist may contact these agencies to coordinate care. If your primary care provider prescribes psychiatric medications for you, or is treating you for medical concerns, your therapist may need to contact them periodically as well. It is your responsibility to inform us if you are receiving psychiatric and/or opioid medications from another prescriber. Any outside agency contact will require a release of information signed by you (or your parent/guardian, if a minor). We may not prescribe psychiatric medications for you if another provider is doing so.

CONFIDENTIALITY. Confidentiality is maintained to the standards outlined by the New York State Office of Mental Health as well as New York State and Federal Law. What you say in session is held confidentially within the clinic. There are exceptions to confidentiality, such as in the reporting of child abuse, expression of suicidal/homicidal plan or intent, or a court order. Also, your insurance company has the right to access your records. Anyone to whom you authorize release of information also has right of to access information. Please refer to the Essex County Notice of Privacy Practices and/or talk with your therapist for more details regarding confidentiality.

SURESCRIPTS. This is an electronic network that connects pharmacies, care providers, benefit managers, and technology partners with access to your current and past medications. This allows our prescribers to have up to date medical information to inform your care and to manage prescriptions electronically, making prescribing more convenient and efficient. Surescripts is a component of our Electronic Health Record. Surescripts health information transmission is HIPAA compliant.

KEEPING APPOINTMENTS. The professionals in this clinic are committed to quality care and to working with you in achieving optimal mental health. Your frequency of sessions is based on your specific needs. We have the expectation that you attend appointments as scheduled. If you cannot keep an appointment, we expect you to call at least 24 hours in advance. Please refer to our Attendance Policy or ask a staff person for guidelines on attendance. Please be aware that your referral may be cancelled if you do not attend any of your first three appointments.

COMPLAINTS. If you have a complaint as to your care, please try to discuss this with your therapist or psychiatrist first. If it is not resolved, please call the Clinical Director. You may also request a copy of our grievance procedure, and a copy of the Patient Bill of Rights, at any time.

CLINIC FEES. Payment is expected at the time of service. Please refer to our Clinic Fee Guidelines Policy for further information and/or support.

The Essex County Mental Health Statement of Understanding has been reviewed with me. I understand and agree with the information contained therein.

Client (parent/guardian) Signature _____ Date _____

Therapist Signature _____ Date _____

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TELEHEALTH CONSENT FORM

Client Name: _____ Date of Birth: _____

1. I (the undersigned) authorize Essex County Mental Health (ECMH) to allow the client named above to participate in telehealth services by agency staff.
2. I understand that this service is not the same as a direct client/provider/clinician visit, because the client will not be in the same room as the clinician/provider performing the service. The provider has thoroughly explained limitations to the therapeutic process using telehealth. I understand there is an option to see an ECMH provider in person.
3. ECMH has fully explained to me the nature and purpose of telehealth technology. I understand that there are potential risks to the use of this technology, including but not limited to, interruptions, unauthorized access by third parties, and technical difficulties. I am aware that either my/the client's healthcare provider or I can discontinue the telehealth service if we believe that the videoconferencing connections are not adequate for the situation.
4. I have been informed and consent that video links and appointment confirmations for telehealth appointments may be sent by email. I acknowledge awareness of the potential risk to privacy and security of these emails.
5. I agree to create and maintain a telehealth space that is quiet and private, with a minimum of distractions or disruptions, to the best of my abilities.
6. I understand that the telehealth session will not be audio or video recorded at any time. Likewise, I agree to not audio or video record the session.
7. I acknowledge that I have the right to request the following when non-medical personnel are present in the session (e.g., front office staff, case manager, or family member):
    a. Omission of specific details of the medical history/physical examination that are personally sensitive, or
    b. For the person to leave the telehealth session at any time, when applicable, or
    c. Termination of the service at any time.
8. In the event of the need for crisis intervention during a telehealth session, the undersigned acknowledges that occasions may arise when ECMH staff will need to coordinate with appropriate ECMH staff or partner providers to arrange for necessary care and treatment to ensure safety.
9. It is the responsibility of the telehealth provider to fully disconnect the video conferencing session upon termination of the appointment.

Client Name: _____ Date of Birth: _____

10. I understand that the client's insurance will be billed for telehealth services. I understand that if the client's insurance does not cover telehealth services, the responsible party will be billed directly for the provision of the services.
11. My consent to participate in this telehealth service shall remain in effect for the duration of services with ECMH, or until the consent is revoked in writing.
12. I agree that there have been no guarantees or assurances made about the outcomes of this service.
13. I have been given an opportunity to ask questions about telehealth services, and all my questions have been answered fully and satisfactorily.
14. I confirm that I have read and fully understand both this *Consent Form* and *Telehealth: What to Expect Form* provided. All blank spaces have been completed prior to my signing. I have crossed out and initialed any paragraphs or words above, which do not pertain to me.

_____ _____

Client/Relative/Guardian Signature* Print Name

_____ _____

Relationship To Client (if required) Date

*The signature of the client must be obtained unless the client is a minor unable to give consent or otherwise lacks capacity.

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment) the proposed procedure, have offered to answer any questions and have fully answered all such questions. I believe that the client/relative/guardian fully understands what I have explained and answered.

_____ _____

ECMH Staff Signature Date

Cancellation of Telehealth Consent

I hereby revoke my consent to participate in Telehealth at Essex County Mental Health.

_____ _____

Client/Responsible Party Signature Date

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE CLIENT'S MEDICAL RECORD

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ESSEX COUNTY MENTAL HEALTH PATIENT BILL OF RIGHTS

Any individual admitted to, applying for, or receiving services from Essex County Mental Health (ECMH) is entitled to the following rights:

1. The right to be treated with courtesy and respect for your dignity, cultural background, and civil rights.
2. The right to services without regard to financial status, ethnicity, race, creed, sex, age, national origin, citizenship, sexual orientation, or gender identification. If you are a person with a disability, you have the right to reasonable accommodation to access services.
3. The right to receive clinically appropriate care provided by licensed professionals whose credentials are available for your verification.
4. The right to receive clear explanations for services and to fully participate in your individual plan of treatment, including the right to refuse any services offered unless such services are court mandated.
5. The right to have your privacy respected and the confidentiality of your records protected.
6. The right to know how your records will be maintained and how to obtain copies.
7. The right to file a complaint about a licensed professional or unlicensed practitioner with the NY State Education Department.
8. The right to be informed of the clinic's Grievance Procedure.

The websites and phone numbers below are organizations that have an interest in ensuring proper operation of this clinic and in protecting the rights of individuals engaged in mental health treatment in New York State.

NY State Education Department Office of the Professions nysed.gov 518-474-3817
NY State Justice Center 1-855-373-2122 or 518 549-0200
NYS Office of Mental Health 800-597-8481
National Alliance for Mental Illness for Champlain Valley 518-561-2685

Notice of Privacy Practices

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

ESSEX COUNTY DEPARTMENT OF MENTAL HEALTH HAS A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI). All employees, volunteers, staff, doctors, health professionals and other personnel are legally required to and must abide by the policies set forth in this notice to protect the privacy of your health information.

This "protected health information", or PHI for short, includes information that can be used to identify you. We collect or receive this information about your past, present or future health condition to provide health care to you, or to receive payment for this health care. We must provide you with this notice about our privacy practices that explain how, when and why we use and disclose (release) your PHI. With some exceptions, we may not use or release any more of our PHI than is necessary to accomplish the need for the information. We must abide by the terms of the notice of privacy practices currently in effect.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes to this notice will apply to the PHI already in existence. Before we make any change to our policies, we will promptly change this notice and post a new notice in our lobby. You can also request a copy of this notice from the contact person listed at the end this notice at any time and can view a copy of the notice on our web site: essexcountyny.gov.

WE MAY USE AND RELEASE YOUR PROTECTED HEALTH INFORMATION for many different reasons. For some of these reasons, we will need your permission or a specific, signed authorization. Below, we describe the different categories of when we use and release your PHI, give you some examples of each category and tell you when we need your permission.

A. WE MAY USE, OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. YOUR CONSENT IS NOT REQUIRED FOR THESE PURPOSES.

1. For Treatment. We may release your PHI to physicians, nurses, medical students, and other health care personnel and agencies and business associates who provide or are involved in your health care. For example, if you are being treated for a mental condition, we may release your PHI to other entities in order to coordinate your care.

2. To obtain payment for treatment. We may use and release your PHI in order to bill and collect payment for services provided to you. It is important that you provide us with correct and up-to-date insurance information. For example, we may release portions of your PHI with our billing department and your health plan to get paid for the health care services we provided to you. We may also release your PHI to our business associates, such as billing companies, claims processing companies and others.

3. To run our healthcare operation. We may release your PHI in order to operate our facility in compliance with healthcare regulations. For example, we may use your PHI to review the quality of our services and to evaluate the performance of our staff in caring for you.

4. To New York State and Other Departments of Essex County. We communicate information required to be given to New York State. We also communicate information with other departments/programs of Essex County to give you the best treatment plan possible.

B. WE ALSO DO NOT REQUIRE YOUR CONSENT TO USE OR RELEASE YOUR PHI:

1. **To comply with federal, state, or local law, or in response to a judicial or administrative order.** We will release your Protected Health Information if required by state of federal laws. In some cases, we may also disclose your PHI in response to a discovery request, subpoena, or other lawful process. In certain circumstances we are required to disclose your health information to law enforcement agencies.

2. For public health activities. We report information about births, deaths, and various diseases to government officials in charge of collecting that information and we provide coroners, medical examiners and funeral directors necessary information relating to an individual's death.

3. To avoid harm. In order to avoid a serious threat to health or safety of a person or the public, we may provide your demographic PHI to law enforcement personnel or persons able to prevent or lessen such harm.

4. **For worker's compensation purposes.** We may release your PHI in order to comply with worker's compensation laws. If you do not want worker's compensation notified, alternate insurance or payment information must be supplied.

6. For appointment reminders and health-related benefits and services. We may use your demographic PHI to contact you as a reminder that you have an appointment or to recommend possible treatment options or alternatives that may be of interest to you.

7. For health oversight activities. We may use PHI and may disclose PHI to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for oversight of the health care system, government benefit programs, or entities subject to government regulation or civil rights laws.

8. Military and Veterans. If you are a member of the armed forces, we may release PHI about you as required by military command authorities.

C. YOU HAVE THE OPPORTUNITY TO AGREE TO OR OBJECT TO THE FOLLOWING:

1. Information shared with family, friends or others. We may release your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. Your choice to object may be made at any time. You will be notified if one of the persons asks to access your PHI.

D. YOUR PRIOR WRITTEN AUTHORIZATION IS REQUIRED FOR ANY USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION NOT INCLUDED ABOVE.

1. We will ask for your written authorization before using or releasing any of your PHI

except as previously stated, or in an emergency situation. If you choose to sign an authorization to release your PHI, you may later cancel that authorization in writing. This will stop any future release of your PHI for the purposes you previously authorized.

2. If you have received alcohol or substance abuse treatment from an alcohol/substance abuse program that received funds from the United States government, federal regulations may protect your treatment records from disclosure without your written authorization.

3. Subject to New York and Federal Law, we may not use or disclose PHI to conduct a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to impose criminal, civil or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care.

E. YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

1. You Have the Right to Request Limits on How We Use and Release Your PHI. If we accept your request, will put any limits in writing and abide by them except in emergency situations. You may not limit PHI that we are legally required or allowed to release.

2. You Have the Right to Choose How We Communicate PHI to You. All of our communications to you are considered confidential. You have the right to ask that we send information to you to an alternative address (for example, sending information to your work address rather than your home address) or by alternative means (for example, e-mail instead of regular mail). We will agree to your request so long as it is reasonable and we can easily provide it in the format you requested. Any additional expenses will be passed onto you for payment.

3. You Have the Right to See and Get Copies of Your PHI. You must make the request in writing. We will respond to you within 5* days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, why we denied your request. You have the right to have the denial reviewed if you make a request in writing within 30* business days. We will choose another licensed healthcare professional to review your request and the denial. The person conducting the review will not be the person who denied your first request and must make a decision within 7* business days. You can request a summary or a copy of the entire medical record as long as you agree to the cost in advance. Please submit all requests for this information to: Director of Clinical Services

4. You Have the Right to Get a List of Instances of When and to Whom We Have Disclosed Your PHI.

This list **will not** include uses you have already authorized, or those for treatment payment or operations. This list will not include uses made for national security purposes, to corrections or law enforcement personnel, if you were in custody, or disclosures made before April 14, 2003. We will respond within 60 days of receiving your request. The list we provide will include the last six years of activity unless you request a shorter time. The list will include dates when your PHI was released and why, with whom your PHI was released (including their address if known), and a description of the information released. The first list you request within a 12-

month period will be free. You will be charged a reasonable fee for additional lists within that time frame. Please submit all requests for this information to: Director of Clinical Services

5. You have the Right to Correct or Update Your PHI. If you believe that the health information, we have is incorrect or incomplete, you have the right to request that we amend that information. We can do this for as long as the information is retained by our facility. You must provide the request and your reason for the request in writing. We will respond within 30* days of receiving your request. If we deny your request, our written denial will state our reasons and explain your right to file a written appeal* within 7* business days. If you choose to appeal, your appeal must be processed within 30* business days. You may also choose to submit a written statement of disagreement. If you do not file a written statement of disagreement, you have the right to request that your request and our denial be attached to all future uses or releases of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change or amendment to your PHI. Please submit all requests for this information to: Director of Clinical Services.

6. You have the Right to Get This Privacy Notice by email. Even if you have agreed to receive notice via email, you also have the right to request a paper copy of this notice. Please submit this request to: Director of Clinical Services.

F. HOW TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES: If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed below or with the Secretary of the DHHS:

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES:

Daniel T. Manning
Essex County Privacy Officer
(518) 873-3380
You will not be penalized for filing a complaint.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on November 7, 2025.

*Are New York State law requirements

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health | PSYCKES

Consent Form

Essex County Mental Health

Provider/Facility Name

About PSYCKES

The New York State (NYS) Office of Mental Health maintains the Psychiatric Services and Clinical Enhancement System (PSYCKES). This online database stores some of your medical history and other information about your health. It can help your health providers deliver the right care when you need it.

The information in PSYCKES comes from your medical records, the NYS Medicaid database and other sources. Go to **www.psyckes.org**, and click on **About PSYCKES**, to learn more about the program and where your data comes from.

This data includes:

- Your name, date of birth, address and other information that identifies you;
- Your health services paid for by Medicaid;
- Your health care history, such as illnesses or injuries treated, test results and medicines;
- Other information you or your health providers enter into the system, such as a health Safety Plan.

What You Need to Do

Your information is confidential, meaning others need permission to see it. Complete this form now or at any time if you want to give or deny your providers access to your records. What you choose will not affect your right to medical care or health insurance coverage.

Please read the back of this page carefully before checking one of the boxes below. Choose:

- "I GIVE CONSENT" if you want this provider, and their staff involved in your care, to see your PSYCKES information.
- "I DON'T GIVE CONSENT" if you don't want them to see it.

If you don't give consent, there are some times when this provider may be able to see your health information in PSYCKES – or get it from another provider – when state and federal laws and regulations allow it.[1] For example, if Medicaid is concerned about the quality of your health care, your provider may get access to PSYCKES to help them determine if you are getting the right care at the right time.

Your Choice. *Please check 1 box only.*

○ **I GIVE CONSENT** for the provider, and their staff involved in my care, to access my health information in connection with my health care services.

○ **I DON'T GIVE CONSENT** for this provider to access my health information, but I understand they may be able to see it when state and federal laws and regulations allow it.

Print Name of Patient

Patient's Date of Birth

Patient's Medicaid ID Number

Signature of Patient or Patient's Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative Patient (if applicable)

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

1 **How providers can use your health information.** They can use it only to:

- Provide medical treatment, care coordination, and related services.
- Evaluate and improve the quality of medical care.
- Notify your treatment providers in an emergency (e.g., you go to an emergency room).

2 **What information they can access.** If you give consent, Essex County Mental Health can see ALL your health information in PSYCKES. This can include information from your health records, such as illnesses or injuries (for example, diabetes or a broken bone), test results (X-rays, blood tests, or screenings), assessment results, and medications. It may include care plans, safety plans, and psychiatric advanced directives you and your treatment provider develop. This information also may relate to sensitive health conditions, including but not limited to:

- Mental health conditions
- Alcohol or drug use
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Sexually transmitted diseases

3 **Where the information comes from.** Any of your health services paid for by Medicaid will be part of your record. So are services you received from a state-operated psychiatric center. Some, but not all information from your medical records is stored in PSYCKES, as is data you and your doctor enter. Your online record includes your health information from other NYS databases, and new databases may be added. For the current list of data sources and more information about PSYCKES, go to: www.psyckes.org and see "About PSYCKES", or ask your provider to print the list for you.

4 **Who can access your information, with your consent.** Essex County Mental Health 's doctors and other staff involved in your care, as well as health care providers who are covering or on call for Essex County Mental Health. Staff members who perform the duties listed in #1 above also can access your information.

5 **Improper access or use of your information.** There are penalties for improper access to or use of your PSYCKES health information. If you ever suspect that someone has seen or accessed your information – and they shouldn't have – call:

- Essex County Mental Health at 518-873-3670, or
- the NYS Office of Mental Health Customer Relations at **800-597-8481**.

6 **Sharing of your information.** Essex County Mental Health may share your health information with others only when state or federal law and regulations allow it. This is true for health information in electronic or paper form. Some state and federal laws also provide special protections and additional requirements for disclosing sensitive health information, such as HIV/AIDS, and drug and alcohol treatment.[1]

7 **Effective period.** This Consent Form is in effect for 3 years after the last date you received services from Essex County Mental Health, or until the day you withdraw your consent, whichever comes first.

8 **Withdrawing your consent.** You can withdraw your consent at any time by signing and submitting a Withdrawal of Consent Form to Essex County Mental Health. You also can change your consent choices by signing a new Consent Form at any time. You can get these forms at **www.psyckes.org** or from your provider by calling Essex County Mental Health at 518-873-3670. Please note, providers who get your health information through Essex County Mental Health while this Consent Form is in effect may copy or include your information in their medical records. If you withdraw your consent, they don't have to return the information or remove it from their records.

9 **Copy of form.** You can receive a copy of this Consent Form after you sign it.

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

Hixny

Mental Health

Please Return

Hixny Electronic Data Access Consent Form

Essex County Community Services

In this Consent Form, you can choose whether to allow Essex County Community Services to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), doing business as Hixny, which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Essex County Community Services to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, Essex County Community Services 's staff involved in my care may see and get access to all of my medical records through Hixny."

If you check the **"I DENY CONSENT"** box below, you are saying "No, Essex County Community Services may not be given access to my medical records through Hixny for any purpose."

Hixny is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT).

Please carefully read the information on the back of this form before making your decision. Your Consent Choices. You can fill out this form now or in the future.
You have two choices.

- ○ **I GIVE CONSENT for** Essex County Community Services **to access ALL of** my electronic health information through Hixny in connection with providing me any health care services, including emergency care.

- ○ **I DENY CONSENT for** Essex County Community Services **to access** my electronic health information through Hixny for any purpose, *even in a medical emergency.*

NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through Hixny.

Print Name of Patient

Date of Birth

Date

Signature of Patient or Patient's Legal Representative

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

Keep
Do Not
Return

Details about patient information in Hixny and the consent process:

How Your Information will be Used

Your electronic health information will be used by Essex County Community Services only to:

- Provide you with medical treatment and related services
- Check whether you have health insurance and what it covers
- Evaluate and improve the quality of medical care provided to all patients

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

What Types of Information about You Are Included

If you give consent, Essex County Community Services may access ALL of your electronic health information available through Hixny. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

- Alcohol or drug use problems*
- Birth control and abortion (family planning)
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

***If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, such as medications and dosages, lab test results, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social support, and health insurance claims history.**

Where Health Information about You Comes From

Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Hixny. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

Who May Access Information about You, If You Give Consent

Only these people may access information about you: doctors and other health care providers who serve on Essex County Community Services 's medical staff who are involved in your medical care; health care providers who are covering or on call for Essex County Community Services 's doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

Penalties for Improper Access to or Use of Your Information

There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Essex County Community Services at (518)873-3670 ; or call Hixny at (518) 640-0021; or call the NYS Department of Health at (518) 474-4987.

Re-disclosure of Information

Any electronic health information about you may be re-disclosed by Essex County Community Services to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Hixny and persons who access this information through the Hixny must comply with these requirements.

Effective Period

This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

Withdrawing Your Consent

You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Essex County Community Services . You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 640-0021.

NOTE: Organizations that access your health information through Hixny while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

Copy of Form

You are entitled to get a copy of this Consent Form after you sign it.

Client Name: _____ **DOB:** _____ **Date of Completion:** _____

We use this survey to understand needs our [Members / patients / clients] have which could interfere with good health. We may share your answers with your other healthcare providers, and with your health plan and social services organizations, so they can determine if you qualify for any free non-medical services that could be helpful. ☐ Please check this box if you agree to continue. You can choose not to answer this survey, but we can only check for services if you do answer. You can choose to be screened later and may be eligible for extra services at that time. None of this will affect your ongoing Medicaid eligibility.

AHC Health Related Social Needs Screening Questions	
Housing / Utilities	
1. What is your living situation today?	☐ I have a steady place to live. ☐ I have a place to live today, but I am worried about losing it in the future. ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park).
2. Think about the place you live. Do you have any problems with the following? CHOOSE ALL THAT APPLY	☐ Pests such as bugs, ants, or mice ☐ Mold ☐ Lead paint or pipes ☐ Lack of heat ☐ Oven or stove not working ☐ Water leaks ☐ Smoke detectors missing or not working ☐ None of the above
3. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	☐ Yes ☐ No ☐ Already shut off
Food Security	
4. Within the past 12 months, you worried that your food would run out before you got money to buy more.	☐ Often true ☐ Sometimes true ☐ Never true
5. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	☐ Often true ☐ Sometimes true ☐ Never true
Transportation	
6. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?	☐ Yes ☐ No
Employment	
7. Do you want help finding or keeping work or a job?	☐ Yes, help finding work ☐ Yes, help keeping work ☐ I do not need or want help
Education	
8. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.	☐ Yes ☐ No
Interpersonal Safety Because violence and abuse happens to a lot of people and affects their health, we are asking the following questions.	A score of 11 or more when the numerical values for answers to [the four questions] are added shows that the person might not be safe
9. How often does anyone, including family and friends, physically hurt you?	☐ Never (1) ☐ Rarely (2) ☐ Sometimes (3) ☐ Fairly often (4) ☐ Frequently (5)
10. How often does anyone, including family and friends, insult or talk down to you?	☐ Never (1) ☐ Rarely (2) ☐ Sometimes (3) ☐ Fairly often (4) ☐ Frequently (5)
11. How often does anyone, including family and friends, threaten you with harm?	☐ Never (1) ☐ Rarely (2) ☐ Sometimes (3) ☐ Fairly often (4) ☐ Frequently (5)
12. How often does anyone, including family and friends, scream or curse at you?	☐ Never (1) ☐ Rarely (2) ☐ Sometimes (3) ☐ Fairly often (4) ☐ Frequently (5)

Reviewer Signature: _____ **Date:** _____

NOTES: _____

_____

Medicaid Members - have you heard?
If you need food, housing, and/or transportation,

help is out there for you.

Your Social Care Network (SCN) is focused on getting you the support you need. Take the first step to get help by telling us more about you. Here's how:

FILL OUT THIS FORM

The information you share is only used to understand your needs and eligibility.
Visit www.healthyalliance.org/member to learn more.

healthy alliance

Brought to you by Healthy Alliance, your Social Care Network (SCN).

ESSEX COUNTY MENTAL HEALTH SERVICES HEALTH ASSESSMENT – ADULT

Client Name _____ DOB _____ Date _____

Do you identify as: ☐Male ☐Female ☐Other _____

Referred by ☐Self ☐Other _____

Psychiatric Assessment

Why are you seeking treatment? _____

How do you think we could help you? _____

Do you feel safe at your home or residence? ☐ Y ☐ N Comments _____

Do you feel stressed out or under a lot of pressure? ☐ Y ☐ N Comments _____

Have you had psychiatric hospitalizations? ☐ Y ☐ N If yes, Date, facility, diagnosis _____

_____

Please check current symptoms and circle if symptom has recently changed.

	Anxiety		Depressed/sad		Appetite/weight changes
	Panic attacks		Crying frequently		Sleep disturbance
	Hearing voices		Hopelessness		Repetitive behaviors
	Fear/phobia		Racing thoughts		Irritable/moody
	Mania		Feel "on edge"		Low energy/fatigue
	Low self esteem		Poor concentration		Difficulty making decisions
	Lack of enjoyment		Lack of motivation		Other - describe

If you are currently experiencing thoughts of suicide or self-harm, please call immediately 518-873-3670 or 1-888-854-3773

Physical Assessment

Primary Care Provider _____ Phone # _____ Date last visit _____

Date last well visit _____ Diagnosis _____

Check vaccines up to date ☐flu ☐pneumonia ☐Tdap ☐hepatitis A ☐hepatitis B ☐ covid

Other Provider _____ Phone # _____ Date last visit _____

Other Provider _____ Phone # _____ Date last visit _____

Other Provider _____ Phone # _____ Date last visit _____

Preferred Pharmacy _____ Preferred Laboratory _____

Allergies ☐ No ☐Yes List here _____

Current weight _____pounds Height ___ft __inch

Current medications/supplements ☐none or list here (may attach separate page for additional medications) _____

_____

Are you currently being treated for a medical problem? ☐Y ☐N If Yes: Describe _____

_____

Have you ever been treated for a medical problem? ☐Y ☐N If Yes: Describe _____

_____

In the past year have you had: List type surgeries and dates: _____ or ☐ none

List type medical hospitalizations and dates: _____or ☐ none

List type serious accidents and dates: _____ or ☐ none

Have you ever lost consciousness? ☐Y ☐N List dates and specifics _____

Have you ever had a seizure? ☐Y ☐N List date and specifics _____

Have you ever had a head injury? ☐Y ☐N List date and specifics _____

Are there medical or psychiatric problems that run in your family? ☐Y ☐N Describe. _____

_____

Do you consume caffeine? (coffee, tea, soda, chocolate) ☐Y ☐N Type/Amount_____

Do you use nicotine? ☐Y ☐N Type/Amount_____

For women Are you pregnant? ☐Y ☐N Planning to get pregnant? ☐Y ☐N Using contraception? ☐Y ☐ N

Type of contraception _____

FOR OFFICE USE ONLY

Recommendations: _____

_____

☐Obtain ROI and most recent medical records. ☐ Continue intake process. ☐ Schedule PCP visits as indicated.

Staff Signature: _____ Date _____

Physician Signature: _____ Date _____

ESSEX COUNTY MENTAL HEALTH SERVICES HEALTH ASSESSMENT - AGES 0 TO < 18

Completed by *(the client and/or an adult who knows the client's health history)* _____

Client Name (child/adolescent) _____ DOB _____ Date _____

Do you identify as: ☐Male ☐Female ☐Other _____

Referred by ☐Self ☐Other _____

Psychiatric Assessment

Why are you seeking treatment? _____

How do you think we could help you? _____

Do you feel safe at your home or residence? ☐Y ☐N Comments _____

Do you feel stressed out or under a lot of pressure? ☐Y ☐N Comments _____

Have you had psychiatric hospitalizations? ☐Y ☐N If yes, Date, facility, diagnosis _____

_____

Please check current symptoms and circle if symptom has recently changed

	Anxiety		Depressed/sad		Appetite/weight changes
	Panic attacks		Crying more frequently		Sleep disturbance
	Hearing voices		Hopelessness		Repetitive behaviors
	Fear/phobia		Racing thoughts		Irritable/moody
	Mania		Feel "on edge"		Low energy/fatigue
	Low self esteem		Poor concentration		Difficulty making decisions
	Lack of enjoyment		Lack of motivation		Running away
	School refusal		Separation anxiety		Sexualized behavior
	Bed wetting		Regression		Other - describe

If you are currently experiencing thoughts of suicide or self-harm, please call immediately 518-873-3670 or 1-888-854-3773

Physical Assessment

Primary Care Provider _____ Phone # _____ Date last visit _____

Date last well visit _____ Diagnosis _____

Vaccines up to date? __Y __N Comments _____

Other Provider _____ Phone # _____ Date last visit _____

Other Provider _____ Phone # _____ Date last visit _____

Other Provider _____ Phone # _____ Date last visit _____

Preferred Pharmacy _____ Preferred Laboratory _____

Allergies ☐ No ☐Yes List here _____

Current Age _____ Current weight _____pounds Height ___ft __inch

Current medications/supplements ☐none or list here (may attach separate page for additional medications) _____

Are you currently being treated for a medical problem? ☐Y ☐N If Yes: Describe _____

In the past year have you had ☐hospitalizations ☐surgeries List date, reason, hospital _____

For women: Are you pregnant? ☐Y ☐N Planning to get pregnant? ☐Y ☐N Using contraception? ☐Y ☐N

Type contraception _____

Current Diagnosis _____

Birth History (prematurity, complications) _____

Physical or behavioral health problems that run in the family _____

Concerns regarding the client's growth or development _____

Have you ever had a head injury? ☐Y☐N List date and outcome _____

Have you ever had a seizure? ☐Y ☐N List date and outcome _____

Have you fainted or lost consciousness? ☐Y ☐N List date and outcome _____

Have you been absent from school for illness for a week or more in the past year? ☐Y ☐N

Are you having school/work problems ☐Y ☐N Describe _____

Are there concerns about ☐ alcohol use ☐ illicit drug use ☐ nicotine/vaping use ☐ marijuana use

Do you have: Day bladder control ☐Y ☐N Night bladder control ☐Y ☐ N

Do you have concerning nervous habits? ☐Y☐N If yes, Describe: _____

Do you have concerning eating habits? ☐Y ☐N Do you consume energy drinks or other caffeine? ☐Y ☐N

Do you have concerning sleep habits? ☐Y☐N If yes, Describe: _____

FOR OFFICE USE ONLY

Recommendations: _____

☐Obtain ROI and most recent medical records. ☐ Continue intake process. ☐ Schedule PCP visits as indicated.

Staff Signature: _____ Date _____

Physician Signature: _____ Date _____

ESSEX COUNTY MENTAL HEALTH
Terri Morse, LMHC, CASAC-Master, *Director*
Dava Clement, LMHC, *Director of Clinical Services*
P.O. BOX 8 – 7513 COURT STREET
ELIZABETHTOWN, NY 12932
PH: (518) 873-3670 / FAX: (518) 873-3777

COMMUNITY SERVICES BOARD
Laurie Kelley, *Chairperson*
Terri Morse, LMHC, CASAC-Master
Director

INFORMATION RELEASE AUTHORIZATION

NAME: _____ DOB: _____ SS#: _____

I authorize Essex County Mental Health Services to: ☐ Obtain from: ☐ Provide to:

Person or Agency & address: _____

_____

Phone Number: (____) _____ - _____ Fax Number: (____) _____ - _____

the following information:

☐ Treatment Plan/Summary	☐ Verbal Consultation	☐ Academic Status/School Records
☐ Psychiatric Evaluation	☐ Discharge Summary	☐ Educational Testing
☐ Psychological Testing	☐ Recommendations	☐ Involvement in Program
☐ Progress in Treatment	☐ Social/Family History	☐ Physical/Medical History
☐ Drug and/or Alcohol Evaluation	☐ Other (specify):	

This information will be used for the following purpose(s): ☐ Coordinating Care ☐ Evaluation & Continuing Treatment

Other (Specify) _____

This information is being released: ☐ One time only ☐ Periodically as needed

For information being provided by or obtained from Essex County Mental Health Services, this authorization expires after one year unless otherwise specified below:

☐ 90 days following discharge from treatment, ☐ Will expire on ____/____/_____,

☐ When following condition is fulfilled _____

I understand that the information to be released is confidential and protected from disclosure. I understand that this authorization can be revoked by a written statement at any time, except for action already taken.

NOTICE TO RECIPIENT: This information has been disclosed to you from medical records that are protected by Federal and State regulations governing confidentiality of Alcohol and Drug Abuse patient records, 42 C.F.R Part 2 and/or the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R Pts. 160 and 164 and cannot be disclosed or re-disclosed without written consent unless otherwise provided for in the regulations.

The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I have the right to revoke the authorization at any time and this must be done in writing. Such revocation will not apply to information that has already been released in response to this authorization. The revocation will not apply to requests from Government Agencies, Health Insurance Companies, certain Law Enforcement Officials, and others who are entitled to information without authorization under HIPAA, Federal Regulations, and State Regulations. Any disclosure of information has the potential for unauthorized disclosure or re-disclosure.

Signature of Client, Legal Guardian, or Healthcare Proxy	**Relationship to Client**	**Date**
Signature of Minor *(17 years of age or younger), if applicable*	**Date**	
Witness *(Required)*	**Title**	**Date**