Client Policy Packet

Disclaimer: Policies and reporting mandates may vary by state as well as by the specific services being engaged.

Table of Contents: Policies & Procedures

Client Policy Packet

Video Recording Policy

Northeast Family Services respects our clients and our employees' privacy. In addition to this basic respect for individuals' privacy, HIPPA and professional confidentiality preclude the recording or sharing of any client information at any time. NFS prohibits any audio or visual recording of clients at any time. NFS prohibits any audio/visual monitoring and/or recording, of any kind, of NFS personnel during working hours or during agency-related activities. At no time should any recording, pictures or likeness of any NFS employee while providing services be posted on any social media site.

Social Media Policy

Northeast Family Services prohibits the posting of any information whatsoever regarding clients or their families on any social media platform whatsoever. This applies to video or audio recordings, photographs, or any written post from which a person could deduce or know to whom it refers.

Client Policy Packet

Client Rights

1. You have the right to be treated with courtesy, respect, and dignity.
2. You have the right to be free of abuse and financial or other exploitation, humiliation, retaliation, and neglect.
3. You have the right to have all reasonable requests responded to promptly and adequately within the capacity of the facility.
4. You have the right to quality care.
5. You have the right to receive care without regard to race, sex, religious affiliation, ethnicity, or sexual orientation in a place free of architectural barriers if you have a limiting physical condition.
6. You may request at any time the name of the person who is responsible for the program that is providing you services and how they may be contacted.
7. You have the right to ask and know about the qualifications of the people who are helping you and the qualifications of those responsible for your care which includes the refusal and expression of choice of the composition of service delivery team.
8. You have the right to privacy during treatment.
9. You have the right to confidentiality of all records and communication to the full extent provided by the law. Requests for information, other than those made by persons authorized under the law, will not be granted without prior, written consent. Exceptions to confidentiality include:
    a. With your written consent
    b. To protect the safety of yourself or others
    c. Incidents of abuse of children, elderly persons, or handicapped persons
    d. To provide access to accreditation bodies, state funding agencies, and third-party payers.
10. You have the right to participate fully in the development of the treatment plan and to refuse part or all of the treatment offered without jeopardizing access to other care.
11. You have the right to examine your clinical record in the presence of agency staff, to receive a copy of it, subject to the cost of reproduction, and to add additional information to the record. To initiate this procedure, you should make a written request to the Clinical Director of the program.

12. You have the right to refuse to be examined, observed, or treated by students or any other facility staff without jeopardizing access to psychiatric, psychological, or other medical care and attention.
13. You have the right to be informed prior to any observation, taping or participation in research and may refuse to be observed or taped, or to participate in research or to receive treatment from students or other agency staff without jeopardizing access to other desired services.
14. You have the right upon request, to obtain an explanation as to the relationship, if any, of the facility to any other health care facility or educational institution insofar as said relationship relates to his care or treatment.
15. You have the right to withdraw your child from treatment at any time. If you wish to be referred to another agency or practitioner, every effort will be made to refer you to the most appropriate resource.
16. You have the right upon request to receive a copy of an itemized bill or other statement of charges submitted to any third party by the facility for care of the patient or resident and to have a copy of said itemized bill or statement sent to the attending physician of the patient or resident.
17. You have the right to file a grievance, if dissatisfied with services received and to have the agency's grievance process explained. You may file a complaint by requesting a meeting with the staff whose action/decision is the source of the complaint and his/her supervisor. At this meeting, staff will work with you to resolve the problem. The supervisor will also give you a copy of the agency's grievance procedure.

Client Policy Packet

Consent for Treatment Services

I authorize Northeast Family Services to provide diagnostic and treatment services deemed to be necessary by the agency to myself, my minor child, or individual for whom I am legal guardian/personal agent.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

Client Policy Packet

Consent for Payment

I authorize Northeast Family Services to obtain reimbursement from any eligible health insurance coverage for services provided, which are covered under my insurance plan. I agree to disclose the identity of any other party who may be responsible for paying for the services provided by Northeast Family Services. I understand payment is expected at the time of service and that I am responsible for reimbursing Northeast Family Services for any co-pays, unmet deductibles, and non-covered services agreed to in the treatment plan. Insurance copayments and deductibles cannot be waived. If I am unable to make this payment, I understand I will be required to pay the amount owed for the service received prior to the start of my next appointment. If I do not settle this outstanding balance at my next appointment, I also understand I may not be seen that day and another appointment may not be scheduled until my outstanding balance for the previous service is paid in full.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

_____ _____

NFS Representative Signature Date

Client Policy Packet

Client's Rights/Complaint Procedure

I am aware of my rights as a client of Northeast Family Services and have been provided a copy of my rights and the agency's complaint procedure.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

Client Policy Packet

Telehealth Services

I have been provided with a choice to receive services via telehealth or to receive services in person.

At this time, I am electing to receive:

___ Both In Person & Telehealth ___ In Person ___ Via Telehealth

If both, please explain:

_____

_____.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

_____ _____

NFS Representative Signature Date

Client Policy Packet

Consent for Use of Personal Health Information

I understand that all personal health information (PHI) describing history, symptoms, diagnoses, treatment, test results, and plans for treatment can be used for the purpose of:

- Planning care and treatment;
- A means of communication among the professionals who contribute to care;
- Applying a diagnosis to a bill;
- A means by which third-party payer can verify that services billed were actually provided;
- Routine healthcare operations assessing service delivery and quality of care

I understand and have been given a Privacy Notice that provides a more complete description of information uses and disclosures of personal health information (PHI). I understand that I have the right to review this notice prior to signing this consent. I understand that the organization reserves the right to change their notice and disclosure practices, and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how personal health information (PHI) may be used or disclosed to carry out treatment, payment, or healthcare operations and the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except when the organization has already responded to a request under the provisions of the consent.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

I request the following restrictions to the use or disclosure of my personal health information (PHI):

Restriction: _____

Restriction: _____

Restriction: _____

Client Policy Packet

Restriction: _____

Restriction Accepted: ___ Yes ___ No

_____ _____

NFS Representative Signature Date

Client Policy Packet

Privacy Practices

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 read it carefully.

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your personal health information (PHI) as part of providing professional services and care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. A copy of this information is available at any time by contacting us at the location and telephone number above. Please contact us with any questions or problems you may have.

We will use information about your health that we get from you or others mainly to provide you with treatment, to arrange payment for services, and for other business activities that are called in the law health care operations. After you have read this Notice of Privacy Practices, we will ask you to sign a consent form. The consent form will allow our agency to use and share your information. If you do not sign this consent form, we cannot treat you.

For Treatment

We use medical information to provide you with psychological services or treatment. These might include individual, family, or group therapy, psychological, educational, or vocational testing, treatment planning, or measuring the benefits of our services.

We may share or disclose your PHI to others who provide treatment to you, or we might share your information with your personal physician. If you are being tested by a team, they can share some of your PHI with us so that services you receive will be able to work together. If you receive treatment in the future from other professionals, we can also share your PHI with them. These are some examples so that you can see how we use and disclose your PHI for treatment.

For Payment

We may use your information to bill you, your insurance, or others so we can be paid for the treatment or services we provide to you. We may contact your insurance company to check on exactly what your insurance covers. We may have to tell them your diagnoses, what treatments you have received, and the changes we expect in your conditions. We will need to tell them about when we have met your progress, and similar sorts of information.

For Health Care Operations

There are a few ways we may use or disclose your PHI for what are called health care operations. For example, we may use your PHI to see where we can make improvements in the care and services we provide. We may be required to supply some information to some government health agencies so they can study disorders and treatment and make plans for services that are needed. If we so, your name and personal information will be removed from what we send.

Other Uses in Healthcare: Appointment Reminders

We may use and disclose information to reschedule or remind you of appointments for treatment or care. If you want us to call or write to you only at home or work or prefer some way that we reach you please let us know.

Treatment Alternatives

We may use and disclose your PHI to tell you about or recommend possible treatment alternatives that may be of help to you

Other Benefits and Services

We may use and disclose your PHI to tell you about health-related benefits that may be of interest to you.

Business Associates

There are some jobs that we might hire other businesses to do for us. In the law they are called our Business Associates. Examples include a telephone answering service or a billing agency. These business associates need to receive some of your PHI to do their jobs properly. To protect your privacy, they have agreed in their contract with us to safeguard your information.

Uses and Disclosures That Require Your Authorization

If we want to use your information for any purpose besides those described above, we need your permission on an authorization form. If you do authorize us to use or disclose your PHI, you can revoke or cancel that permission, in writing, at any time. After that time we will not use or disclose your information for the purposes we agreed to. Of course, we cannot take back any information we have already disclosed with your permission.

Exceptions to Confidentiality and Privacy of Information

There are certain situations where we are unable to keep information private by law. They are as follows:

1. When there is a serious threat to your health or safety or the health or safety of another individual or the public.
2. When we are required by a court of law to disclose information.
3. Some instances where a law enforcement official requires us to disclose information.
4. For Worker's Compensation and similar benefit programs.
5. When we receive information about abuse or neglect of a child, disabled adult, or person over age 65.

Your Rights Regarding Your Health Information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you.
2. You have a right to ask us to limit what we tell people involved in your care or the payment for your care such as family members and friends. While we do not have to agree to your request, if we do agree we will keep our agreement except if it is against the law, in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you such as medical or billing records. You can even get a copy of these records, but we may charge you. Contact us at the location above to make such arrangements
4. If you believe the information in your records is incorrect or missing important information, you can request us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to us at the location listed above. You must tell us in your request the reasons you are requesting the changes.
5. Upon written request, you may obtain an accounting of certain disclosures of PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures prior to April 14, 2003. If you make an accounting request more than once in a twelve month period, we will charge you $0.25 per page for the accounting statement.
6. You have a right to a copy of this notice. If we change this Notice of Privacy Practices, you may obtain a copy of the new notice from the address listed above.
7. If you have a problem with how your PHI has been handled or feel your privacy rights have been violated, contact us at the location listed above. You have a right to file a complaint

with us and the Secretary of the Federal Department of Health and Human Services. We promise that we will not in any way limit your care or take any actions against you if you file such a complaint.

Client Policy Packet

Grievance Policy

The grievance procedure is submitted to caregivers and reviewed during the intake process.

NFS promotes open communication with families. Our clients and their caregivers are encouraged to speak with the clinical therapist to resolve any issues and concerns prior to initiating the grievance procedure to ensure that all previous means of conflict resolution have been exhausted.

Procedure for non-administrative team members:

1. Inform supervisor and Clinical Director of the situation immediately. Document the process in the case record, including any letters and communication.
2. The person supported or family member initiating the grievance is given a new copy of the policy for referral.
3. The person supported or family member is given a written copy of the final resolution of the grievance and a copy is filed in the clinical record.
4. The person supported or family member is entitled to respond in writing to the Executive Director.
5. Agency staff will maintain a respectful relationship with the family and continue to provide treatment throughout the process.

Procedure for administrative staff:

1. The Clinical Director will maintain communication with the Executive Director throughout the process.
2. The Clinical Director will meet with the family and/or staff within 10 business days of receiving the complaint.
3. If a satisfactory resolution is not reached, the person supported can write a letter outlining the concerns to the Executive Director or designee.
4. The Executive Director or designee will arrange a meeting within 10 business days of receiving the letter.
5. The Executive Director will send a letter stating the outcome within 10 business days of the meeting. If it is determined that services should be discontinued, appropriate notification to the applicable state agency must be communicated.

NFS is committed to providing the best possible care for you and your family. In the event that you or your family is unsatisfied with the provision of care, please contact your assigned clinical therapist immediately. If you are unsatisfied with the response at this level, you may arrange to meet with the Clinical Director of the Program. In instances where the concern involves a particular staff member, the Director may arrange a mediation session between you and the staff member.

If you are dissatisfied with the response from the Clinical Director, you may submit your concerns in writing to the Executive Director or his designee within 10 business days. The Executive Director will arrange to meet with you within 10 business days of receiving your letter. Following this process, you will receive a letter indicating the suggested resolution within 10 days.

Non-Retaliation Clause: You will not be intimidated, harassed, threatened or suffer any penalty because you file a complaint. Any penalty or reprisal against you or any other involved persons is prohibited by law.

Client Policy Packet

State Reporting

State Reporting Policy

All persons , who have reasonable cause to know or suspect that any child has been abused and/or neglected or has been a victim of sexual abuse by another child, are required to report this information to the appropriate state child protective organization, within twenty-four (24) of the report.
An "abused and/or neglected child" is defined as a child whose physical or mental health or welfare is harmed or threatened with harm when his or her parent or other person responsible for his or her welfare:

- Inflicts or allows to be inflicted upon the child physical or mental injury, including excessive corporal punishment; or
- Creates or allows to be created a substantial risk of physical or mental injury to the child, including excessive corporal punishment; or
- Commits or allows to be committed against the child, and act of sexual abuse; or
- Fails to supply the child with adequate food, clothing, shelter or medical care, though financially able to do so or offered financial or other reasonable means to do so by situation or conditions such as, but not limited to, social problems, mental incompetence, or the use of drug, drugs, or alcohol to the extent that the parent or other person responsible for the child's welfare loses his or her ability or is unwilling to properly care for the child; or
- Abandons or deserts the child; or
- Sexually exploits the child in that the person allows, permits, encourages or engages in the obscene or pornographic photographing, filming or depiction of the child in a setting which taken as a whole suggests to the average person that the child is about to engage in or has engaged in any sexual act or which depicts any such child under eighteen (18) years of age performing sodomy, oral copulation, sexual intercourse, masturbation or bestiality; or
- Commits or allows to be committed any sexual offence against the child.
- Commits or allows to be committed against any child involving sexual penetration or sexual contact if the child is under fifteen (15) years of age; or if the child is fifteen (15) years or older and (1) force or coercion is used by the perpetrator, or (2) the perpetrator knows or has reason to know that the victim is a severely impaired person or is physically helpless.

Additionally, a neglected child is defined as a child whose physical or mental health or welfare is harmed or threatened with harm when his or her parent or other person responsible for his or her welfare fails to provide the child proper education as required by law.

"Person responsible for child's welfare" is defined by law as being the child's parent or guardian, any individual, eighteen (18) years of age or older, who resides in the home of a parent or guardian and has unsupervised access to a child, a foster parent, an employee or a public or private residential home or facility or any staff person providing out-of-home care, which includes family child care, group family child care and center-based care.

Please consult state specific reporting guidelines and mandates for additional information.

Client Policy Packet

Transportation Waiver *(If applicable to services being provided)*

Northeast Family Services requires staff and vehicles meet the following criteria:

- Current vehicle insurance
- Current vehicle registration
- Valid state inspection
- Seat belt and/or child restraints MUST be utilized as required by law
- Current driver's license

I, _____, the parent/guardian of _____, understand there is always a risk of injury related to transportation. I understand it is our choice to permit or deny agency personnel to transport our child as part of treatment objectives. I/We agree to release Northeast Family Services of any liability, financially or other that occurs as a result of the transportation activity.

I/We understand Northeast Family Services accepts no liability or responsibility for transportation provided by the agency.

I/We give consent for my child to be transported by Northeast Family Services' staff in their personal vehicles for goal related activities.

Transportation: _____ Permit _____ Deny

I understand that my response will be in effect for transportation of my child in the future unless I submit a change in writing to my coordinator.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

_____ _____

NFS Representative Signature Date

Client Policy Packet

Client Policy Packet

Permission to Assist in Hygiene Activities *(If applicable to services being provided)*

I, _____, the parent/guardian of _____, give consent for my son / daughter to receive assistance with hygiene related activities such as:

Toileting: _____ Deny _____ Permit

Showering/Bathing: _____ Deny _____ Permit

Dressing: _____ Deny _____ Permit

Other (Please Specify) _____

_____ Deny _____ Permit

in order to educate caregivers on techniques needed for successful completion of daily living activities.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

_____ _____

NFS Representative Signature Date

Client Policy Packet

Permission to Use Child's Photograph / Video Footage

I, _____, the parent/guardian of _____, give consent for the use my child's photograph, likeness, or video footage for purposes of internal information, community information, training and/or documentation for each form permitted below.

Photo: _____ Deny _____ Permit

Drawing or Likeness: _____ Deny _____ Permit

Video: _____ Deny _____ Permit

I understand that my response will be in effect for any photograph, video or likeness in the future unless I submit a change in writing to my coordinator.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

_____ _____

NFS Representative Signature Date

Client Policy Packet

PCP Release of Information

AUTHORIZATION TO EXCHANGE PROTECTED HEALTH INFORMATION WITH PRIMARY CARE PHYSICIAN

Communication between your behavioral health provider and your primary care physician (PCP) is important to make sure all care is complete, comprehensive and well-coordinated. This form allows Northeast Family Services and your PCP to exchange valuable information. No information will be released without your signed authorization.

Client Name: _____

DOB: _____

Street Address:

_____

City: _____ State: _____ Zip Code: _____

I hereby authorize Northeast Family Services to:

___ Obtain From ___ Release to ___ Verbally communicate with

Primary Care Physician/Pediatrician:

_____

Agency:

_____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Information to exchange includes:

___ Assessment / Evaluation (Clinical, Social, Psych)

___ IFA/FCP/R&R

___ Discharge Summary

___ Progress Reports / Notes

___ Medical Records

___ Treatment Plan

___ Educational Records (IEP, 504 Plans, progress reports, testing, etc.)

___ Other: _____

Client Policy Packet

This information is needed for the purpose of client care and case coordination.

Dates of Service:

From: _____ To: _____ Expiration Date: _____

I understand that my records are protected under state and federal law (RI General Laws 5-37.2 and 40.1-5; and Federal Privacy Regulations 45 CFR 160-164) and cannot be disclosed without my written consent except otherwise specified by the law. Further, I understand that if my records contain information regarding drug/alcohol abuse or HIV (AIDS) testing, they are protected under Federal Regulation 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse, and RI Public Law Chapter 88-405, section 23. I understand that I have access to my protected health information as outlined in the Notice of Privacy Practices. I am aware that I can refuse to sign this authorization.

I further understand that once my information is disclosed to the above authorized agency, Northeast Family Services and its employees are not liable for the recipient's actions with regard to my information. Once this information is sent, it may no longer be protected by the federal rule of the privacy of records.

This authorization will have the duration of no longer than one year from the date upon which this form was signed. I understand that I may revoke my consent in writing at any time except to the extent action has been taken in reliance upon it. I understand I have the right to a copy of this signed authorization. I may obtain a copy of this authorization by contacting a NFS representative, and the copy will be mailed/faxed to me promptly.

I consent to the release of my records or any part thereof, through the use of a facsimile machine, with the understanding that Northeast Family Services cannot exclusively guarantee the confidential transmission of records via Fax delivery.

___ Yes ___ No

I consent to the release of my records or any part thereof, through the use of e-mail, with the understanding that Northeast Family Services cannot exclusively guarantee the confidential transmission of records through email.

___ Yes ___ No

I have read carefully and understand the above standards and do herein expressly and voluntarily consent to the exchange of the above information to the Primary Care Physician (PCP) identified

above. I understand that under most circumstances Northeast Family Services may not condition treatment and/or payment on my signing of this authorization.

Printed Name: _____ Date: _____

Signature: _____ Time: _____

Check One:

___ Client ___ Parent ___ Guardian ___ Legal Authority (Description _____)

Signature of NFS Representative: _____

Client Policy Packet

Emergency Contact Release of Information

AUTHORIZATION TO EXCHANGE PROTECTED HEALTH INFORMATION WITH EMERGENCY CONTACT

Communication between staff at Northeast Family Services and your emergency contact will be limited to emergency situations only. Only information that is relevant to the immediate emergency response will be released during this communication. No communication will take place with the emergency contact outside of situations identified as emergencies by Northeast Family Services employees.

Client Name: _____

DOB: _____

Street Address:

_____

City: _____ State: _____ Zip Code: _____

I hereby authorize Northeast Family Services to:

___ Obtain From ___ Release to ___ Verbally communicate with

Emergency Contact Name: _____

Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Information to exchange includes:

___ Assessment / Evaluation (Clinical, Social, Psych)

___ IFA/FCP/R&R

___ Progress Reports / Notes

___ Discharge Summary

___ Treatment Plan

___ Medical Records

___ Educational Records (IEP, 504 Plans, progress reports, testing, etc.)

___ Other: _____

This information is needed for the purpose of client care and case coordination.

Client Policy Packet

Dates of Service:

From: _____ To: _____ Expiration Date: _____

I understand that my records are protected under state and federal law (RI General Laws 5-37.2 and 40.1-5; and Federal Privacy Regulations 45 CFR 160-164) and cannot be disclosed without my written consent except otherwise specified by the law. Further, I understand that if my records contain information regarding drug/alcohol abuse or HIV (AIDS) testing, they are protected under Federal Regulation 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse, and RI Public Law Chapter 88-405, section 23. I understand that I have access to my protected health information as outlined in the Notice of Privacy Practices. I am aware that I can refuse to sign this authorization.

I further understand that once my information is disclosed to the above authorized agency, Northeast Family Services and its employees are not liable for the recipient's actions with regard to my information. Once this information is sent, it may no longer be protected by the federal rule of the privacy of records.

This authorization will have the duration of no longer than one year from the date upon which this form was signed. I understand that I may revoke my consent in writing at any time except to the extent action has been taken in reliance upon it. I understand I have the right to a copy of this signed authorization. I may obtain a copy of this authorization by contacting a NFS representative, and the copy will be mailed/faxed to me promptly.

I consent to the release of my records or any part thereof, through the use of a facsimile machine, with the understanding that Northeast Family Services cannot exclusively guarantee the confidential transmission of records via Fax delivery.

___ Yes ___ No

I consent to the release of my records or any part thereof, through the use of e-mail, with the understanding that Northeast Family Services cannot exclusively guarantee the confidential transmission of records through email.

___ Yes ___ No

I have read carefully and understand the above standards and do herein expressly and voluntarily consent to the exchange of the above information to the agency/person identified above. I

understand that under most circumstances Northeast Family Services may not condition treatment and/or payment on my signing of this authorization.

Printed Name: _____ Date: _____

Signature: _____ Time: _____

Check One:

___ Client ___ Parent ___ Guardian ___ Legal Authority (Description _____)

Signature of NFS Representative: _____

Client Policy Packet

Release of Information

AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

Client Name: _____

DOB: _____

Street Address:

_____

City: _____ State: _____ Zip Code: _____

I hereby authorize Northeast Family Services to:

___ Obtain From ___ Release to ___ Verbally communicate with

Agency / Person:

_____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Information to exchange includes:

___ Assessment / Evaluation (Clinical, Social, Psych)

___ IFA/FCP/R&R

___ Progress Reports / Notes

___ Discharge Summary

___ Treatment Plan

___ Medical Records

___ Educational Records (IEP, 504 Plans, progress reports, testing, etc.)

___ Other: _____

This information is needed for the purpose of client care and case coordination.

Dates of Service:

From: _____ To: _____ Expiration Date: _____

I understand that my records are protected under state and federal law (RI General Laws 5-37.2 and 40.1-5; and Federal Privacy Regulations 45 CFR 160-164) and cannot be disclosed without my written consent except otherwise specified by the law. Further, I understand that if my records contain information regarding drug/alcohol abuse or HIV (AIDS) testing, they are protected under Federal Regulation 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse, and RI Public Law

Chapter 88-405, section 23. I understand that I have access to my protected health information as outlined in the Notice of Privacy Practices. I am aware that I can refuse to sign this authorization.

I further understand that once my information is disclosed to the above authorized agency, Northeast Family Services and its employees are not liable for the recipient's actions with regard to my information. Once this information is sent, it may no longer be protected by the federal rule of the privacy of records.

This authorization will have the duration of no longer than one year from the date upon which this form was signed. I understand that I may revoke my consent in writing at any time except to the extent action has been taken in reliance upon it. I understand I have the right to a copy of this signed authorization. I may obtain a copy of this authorization by contacting a NFS representative, and the copy will be mailed/faxed to me promptly.

I consent to the release of my records or any part thereof, through the use of a facsimile machine, with the understanding that Northeast Family Services cannot exclusively guarantee the confidential transmission of records via Fax delivery.

___ Yes ___ No

I consent to the release of my records or any part thereof, through the use of e-mail, with the understanding that Northeast Family Services cannot exclusively guarantee the confidential transmission of records through email.

___ Yes ___ No

I have read carefully and understand the above standards and do herein expressly and voluntarily consent to the exchange of the above information to the agency/person identified above. I understand that under most circumstances Northeast Family Services may not condition treatment and/or payment on my signing of this authorization.

Printed Name: _____ Date: _____

Signature: _____ Time: _____

Check One:

___ Client ___ Parent ___ Guardian ___ Legal Authority (Description _____)

Signature of NFS Representative: _____

Client Policy Packet

Outpatient Financial and Cancellation Policy

Appointments canceled with less than 24 hours notification will be charged to me at the full fee per hour. I am responsible for the entire balance of services performed regardless of whether there is insurance coverage. Secondary insurance will be billed as a courtesy.

I agree to make arrangements for payment prior to the start of care.

I agree to attend appointments as scheduled. Should more than two appointments be missed, it will be at the discretion of the treating clinician if services will be paused or terminated.

I understand and agree to the above stated financial and cancellation policy.

In the case of an emergency, clients can request in writing a waiver of cancellation fee. All requests will be taken into consideration by the Program Director and decisions will be rendered promptly.

Signature: _____ Date: _____

Client Policy Packet

No Call & No Show Policy

Please be advised that cancellations for in-home services must occur more than 24 hours in advance, in ALL but emergency situations (illness, death in the family, etc.).

Cancellations with less than 24 hours notice or no-call/no-show require the monitor/therapist to obtain permission from the therapist/program director before reporting to the home for the next scheduled shift.

The NFS treatment team will review cases to assess whether services should continue if:

1. Not canceling within 24hour period or no- call/ no-show two consecutive times or;
2. Not canceling within 24hour period or no- call/ no-show two times within a thirty day time frame.

The above mentioned policy is set up to provide the best services to all of our clients.

Agency Representative Signature: _____

I have read and understand this policy and agree to abide by it as a condition of receiving services from Northeast Family Services.

Client/Parent/Guardian Printed Full Name: _____

Client/Parent/Guardian Signature: _____ Date: _____